BUDGET DEEP-DIVE INTO MEDICAID REIMBURSEMENT RATES

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ISSUE BRIEF

SUMMARY

In FY 2012 the state spent $2.0 billion total funds on Medicaid services and in FY 2016 the state spent $2.4 billion total funds. From 2012 through 2016, the number of Medicaid fee-for-service enrolled providers for 27 provider categories has decreased 3 percent while the number of licensed Utah providers has increased 8 percent.

LEGISLATIVE ACTION

Staff Recommendations Supported by the Affected Agency

1. *The Social Services Appropriations Subcommittee directs the chairs to write a letter to Utah's congressional delegation asking for help for the federal government to improve the timeliness of review and approval of Medicaid managed care rates (see page 7 for more information).*
2. *The fiscal analyst recommends that the Legislature open a bill to add notification of all submitted and approved capitated rate changes by the federal government to the required notification list to the Social Services Appropriations Subcommittee in UCA 26-18-3 (see pages 7 and 9 for more information).*
3. *The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by January 1, 2018 on the trend over time of the number of Medicaid service providers from 2012 through 2017 for physical and occupational therapists, physicians, and speech and hearing therapists (see pages 21-23 for more information).*
4. *The Social Services Appropriations Subcommittee requests the Department of Health to provide an update on the status of moving more Medicaid claims from American Indian and Alaskan Native Medicaid clients to a higher match rate by June 1, 2018. The update shall an include a best guess on the outlook of potential savings (see page 34 for more information).*
5. *The Legislature may want to open a bill file to allow the department to place a lien against a client's estate once the client enters into permanent long-term care paid for by Medicaid (see pages 37-38 for more information).*
6. *The Legislature may want to open a bill file to require all parties to notify the state of any probate actions. This action may help improve estate collections by the State for Medicaid long term care expenses incurred (see pages 37-38 for more information).*
7. *The Social Services Appropriations Subcommittee directs the Department of Health to amend the State plan to pursue estate collections for Medicaid clients using long term care services after a surviving spouse has died. The Department of Health is to end the practice of waiving state claims to estates because there is a surviving spouse by December 31, 2017 (see pages 37-38 for more information).*

Staff Recommendations Where the Affected Agency is Neutral

8. *The Social Services Appropriations Subcommittee intends that the Department of Health work with the Utah State Office of Education to encourage school districts and charter schools with large student populations to bill Medicaid for eligible medical services provided at school. The Department of Health shall work with the Utah State Office of Education to provide a report on the status of and financial impact to newly participating school districts and charter schools to the Office of the Legislative fiscal analyst by June 1, 2018 (see pages 35-37 for more information).*

Staff Recommendations Opposed by the Affected Agency

9. *The Social Services Appropriations Subcommittee removes ongoing the funding from the FY 2019 base budget associated with the 20 percent reimbursement enhancements for dentists. The Department of Health may opt to request the funding as a building block, which would provide the Legislature an opportunity to reassess the policy of enhanced payments for rural dentist and oral surgeons in Medicaid. The Department of Health and the fiscal analyst shall work together to identify the proper funding amount for removal (see pages 10-11 for more information).*
10. *The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative fiscal analyst by January 1, 2018 on the feasibility and advisability of incorporating more services into accountable care organization contracts (see pages 12-13 for more information).*
11. *The Social Services Appropriations Subcommittee removes ongoing the funding from the FY 2019 base budget associated with the 12 percent reimbursement enhancements for rural physicians. The Department of Health may opt to request the funding as a building block, which would provide the Legislature an opportunity to reassess the policy of enhanced payments for rural physicians in Medicaid. The Department of Health and the fiscal analyst shall work together to identify the proper funding amount for removal (see pages 16-17 for more information).*
12. *The fiscal analyst recommends that Legislature open a bill file to request the Department of Health to annually provide a prioritized list for provider reimbursement changes for all provider groups with explanations of each ranking by December 15th of each year to the Office of the Legislative fiscal analyst to help inform the Legislature in making its funding decisions (see pages 20-25 for more information).*
13. *The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative fiscal analyst by January 1, 2018 on the feasibility and advisability of expanding Medicaid accountable care organizations into any of the remaining sixteen fee-for-service counties (see pages 28-29 for more information).*
14. *Is it time to shut down the state's medical and dental clinics? Are they still serving an appropriate purpose? (see page 44 for more information)*

Legislative Options Supported by the Affected Agency

1. *If the Legislature wanted to increase federal funds via full adult Medicaid expansion or increasing the income eligibility level for Utah's Medicaid extension, then the Legislature would want to open a bill file(s) or pursue other legislative action (see pages 34-37 for more information).*

2. *The Legislature may want to consider opening a bill file to lower the extrapolation threshold from $200,000 to $25,000 (see pages 37-39 for more information).*
3. *When the Office of Inspector General proposes funding for a new data analysis tool, the Legislature may want to consider granting that request (see pages 37-39 for more information).*
4. *If the Legislature wanted to increase Medicaid funds from local governments, then it may want to consider full adult Medicaid expansion and/or revisit the 80/20 state/local county partnership (see pages 41-42 for more information).*

Legislative Options Where the Affected Agency is Neutral

5. *The Legislature may want to consider opening a bill file to enact a comprehensive false claims act (see pages 37-38 for more information).*
6. *If the Legislature wanted to increase Medicaid funds from current provider contributions, then it may want to consider raising one or all four current provider assessments via opening a bill file(s) or other legislative action (see pages 40-41 for more information).*
7. *If the Legislature wanted to exclude non-emergency use of the emergency room as a covered service in Medicaid as is done in South Dakota, then the Legislature would want to open a bill file (see pages 42-43 for more information).*
8. *If the Legislature wanted to increase provider rates for specific provider groups and/or increase funding resources for Medicaid, then the Legislature may want to consider implementing one of the eight provider assessments used in other states or explore an entirely new provider assessment (see page 45 for more information).*
9. *If the Legislature wanted to pursue any changes in Utah like those in Missouri or Mississippi, then a bill file(s) would need to be opened (see pages 45-46 for more information).*

Legislative Options Opposed by the Affected Agency

10. *The fiscal analyst recommends that the Legislature open a bill for a resolution to request that the federal government allow Medicaid to not cover drugs approved by the Food and Drug Administration with unproven efficacy (see pages 47-48 for more information).*

Table of Contents

DISCUSSION AND ANALYSIS

The discussion regarding Medicaid reimbursement rates has the following sections below. Each section has a brief discussion of the question.

1. What are we attempting to accomplish?
2. How do we know if we are successful?
3. How are we organized?
4. What are we buying and how are we paying for it?
5. What non-governmental sources are involved?
6. What are other states doing for Medicaid reimbursement rates?

The majority of the discussion focuses on 29 provider groups in Medicaid. These 29 groups have been formed from a potential total of 63 provider types and 66 categories of service.

What are we Attempting to Accomplish?

General Medicaid Reimbursement Requirements

All proposed reimbursement rate methodologies must be submitted for approval to the federal government. The Medicaid.gov site, which was accessed in August 2017, states: "To change the way they pay Medicaid providers, a state must submit a State Plan Amendment (SPA) for [Centers for Medicare and Medicaid Services] to review and approval. Before the amendment's effective date, the state must also issue a public notice of the change. The notification is intended to widely inform providers and other stakeholders of changes to Medicaid payment rates."

The Department of Health: "DMHF would recommend that states be allowed more flexibility in calculating rates and more timely approval of rates. Currently, all managed care rates must be reviewed and approved by the [Centers for Medicare and Medicaid Services] Office of the Actuary and the CMCS Division of Managed Care Plans. This process is very prescriptive and can take a significant amount of time. Historically, rate review and approval has taken 6 months to 1 year. DMHF cannot pay new managed care rates until they have been approved. Delays in the approval process result in DMHF paying the previously approved rates until the new rate is approved. At which point, all capitation payments made to the managed care organization between the effective date of the rate through the point of certification are recouped and replaced. This presents challenges in terms of budgeting and financial reporting for both DMHF and the managed care organizations."

The fiscal analyst recommends that the Social Services Appropriations Subcommittee consider the following motion: The Social Services Appropriations Subcommittee directs the chairs to write a letter to Utah's congressional delegation asking for help for the federal government to improve the timeliness of review and approval of Medicaid managed care rates.

Agency Response: Support - "The Department would appreciate any support the Legislature can provide in addressing these challenges with [Centers for Medicare and Medicaid Services]."

Additionally, the Department of Health must report any reimbursement change that is contained in the Medicaid State Plan or a rate change requiring public notice to the Legislature's Social Services Appropriations Subcommittee as per UCA 26-18-3. The department must also report fiscal impacts and impacts to services.

Provider Specific Additional Reimbursement Requirements Beyond Setting a Fixed Price		
Medical Provider Group	**State**	**Federal**
Chiropractic		
Dentists	FFS = 20% bonus for rural and oral surgeons on referral list (SPA)	actuarial certification (managed care)
Mental Health		actuarial certification (managed care)
Substance Abuse Treatment		actuarial certification (managed care)
Personal Care		
Pharmacy	Lowest of four prices (1) Average Wholesale Price - 17.4% (2 & 3) federal or State maximum allowable cost (4) usual and customary charges (SPA)	
Physical & Occupational Therapy		
Physicians & Other Similar Practitioners	FFS = 12% bonus for rural (SPA)	
Podiatry		
Speech and Hearing Therapists		
Vision Care		
Hospice		hospice provider must reimburse the nursing facility provider at 95% of the daily nursing home reimbursement rate
Intermediate Care Facilities for Intellectually Disabled		
Nursing Facility	(1) three components to each facility's rate (A) fixed - costs common to all facilities, (B) property - fair rental value, and (C) case mix - level of clients' needs with a rural vs. urban adjustment (SPA) and (2) rates cannot go below June 2004 levels (UCA)	
Ambulatory Surgical		
End Stage Renal Disease (Kidney Dialysis)		
Home Health		
Inpatient Hospital		
Outpatient Hospital	Medicare's Outpatient Prospective Payment System is the basis for outpatient hospital services reimbursement rates (SPA)	
Home/ Community Based Waiver Contract		
Medical Transportation		
Rural Health Clinic		prospective payment based on reasonable costs divided by total visits
Federally Qualified Health Center		annual adjustment to pay full cost of providing services
Independent Lab and/or X-Ray		
Medical Supply		
School Based Skills Development		
Accountable Care Organizations	Per-member-per- month funding at least 100 percent to 102 percent to match the projected growth rate of General Fund revenues. (UCA)	actuarial certification (managed care)
27	**6**	**7**
FFS = fee-for-service program, SPA = Medicaid State Plan Amendment, UCA = Utah state law.		

The following types of reimbursement changes do not need to be reported under current state law:

1) Changes to capitated rates (all calculations below based on FY 2016 spending levels)
    a. Accountable care organizations – each 1 percent change is $1,172,500 state funds and $3,950,500 total funds
    b. Mental health – each 1 percent change across the entire system is $461,300 state/local funds and $1,551,000 total funds
    c. Dental services – each 1 percent change is $113,400 state funds and $382,100 total funds
    d. Substance abuse – each 1 percent change across the entire system is $45,800 state/local funds and $151,900 total funds

The fiscal analyst recommends that the Legislature open a bill to add notification of all submitted and approved capitated rate changes by the federal government to the required notification list to the Social Services Appropriations Subcommittee in UCA 26-18-3.

Agency Response: Support - "Annually the Legislature authorizes reimbursement changes, including changes to the [accountable care organization] budget pool as well as other provider reimbursement changes. The Department reports on implementation of the authorized changes to the Legislature through performance measures. In addition, any change in reimbursement methodology requires a change to the Medicaid State Plan and/or Medicaid Waiver and the Department includes notification of the State Plan and Waiver changes in its quarterly report to the Legislature. If the Legislature would find it useful to know when capitation rates have been submitted to [Centers for Medicare and Medicaid Services] and approved by [Centers for Medicare and Medicaid Services], the Department is willing to include that information in its quarterly reports to the Subcommittee."

On the previous page is a table with some of the additional state and federal reimbursement regulations for different provider groups. Of the 27 provider groups, six groups have additional state regulations, and seven groups have additional federal regulations beyond just getting approval for a fixed price. The requirement of "actuarial certification (managed care)" in the federal column of the table exists because the State has opted to use managed care to deliver a particular service. If the State chose a different delivery method, then there would be no actuarial certification requirement. The report focusses on these 27 provider groups as well as accountable care organizations administrative services rate and other providers for a total of 29.

The Medicaid.gov site, which was accessed in August 2017, directs: "States can establish their own Medicaid provider payment rates within federal requirements. States generally pay for services through fee-for-service or managed care arrangements.

Under fee-for-service arrangements, states pay providers directly for services. States may develop their payment rates based on:

- The costs of providing the service
- A review of what commercial payers pay in the private market
- A percentage of what Medicare pays for equivalent services

Under managed care arrangements, states contract with organizations to deliver care through networks and pay providers…where providers are paid on a monthly capitation payment rate.

Payment rates are often updated based on specific trending factors, such as the Medicare Economic Index or a Medicaid-specific trend factor that uses a state-determined inflation adjustment rate. The methodologies for service rates are described in the Medicaid state plan."

Utah has about 84 percent of clients in managed care for medical services and 16 percent are served by the fee-for-service program.

By federal law, Medicaid must be the payer of last resort behind any other insurers, including Medicare, who may have responsibility for payment. Additionally, Medicaid reimburses providers up to the Medicaid level of reimbursement for services to clients with other insurance, whose insurance did not fully cover a Medicaid-covered service. On average, around 7 percent of all Medicaid recipients have Medicare or other insurance. The Federal Deficit Reduction Act of 2005 required insurers to verify insurance eligibility information for Medicaid clients. The Office of Recovery Services in the Department of Human Services maintains the database with this information.

Providers for Medicaid must meet Federal Program Integrity requirements to receive reimbursement for serving Medicaid clients. Additionally, they must accept Medicaid reimbursement as payment in full. The provider may charge the patient for services not covered by Medicaid only when the provider has advised the patient in advance that Medicaid does not cover the services and the patient has agreed in writing to pay for the services. Medicaid does not pay for any services not considered medically necessary.

Below is a discussion of the 29 provider groups in Medicaid included in this report. There are three groupings for these providers groups explained below:

1) Primarily managed care – the service is provided to the majority of Medicaid clients via a managed care contractor. The clients in some counties are still being served via the fee-for-service system.
2) Managed care – the service is entirely provided via managed care contractors.
3) Fee-for-service - the State sets the reimbursement rate and clients find any provider willing to accept that rate.

Additionally, there are two primary sources for cited materials in the 29 provider groups discussed below:

1) Medicaid.gov website – includes explanations for individual service sections of https://www.medicaid.gov/medicaid/benefits for accessed September 12, 2017
2) Utah Medicaid Provider Manuals, see https://medicaid.utah.gov/utah-medicaid-official-publications?p=Medicaid%20Provider%20Manuals/ – accessed July through September 2017

Dental (Primarily Managed Care)

The Medicaid.gov website states: "Dental services must be provided at intervals that meet reasonable standards of dental practice, and at such other intervals, as indicated by medical necessity, to determine the existence of a suspected illness or condition. States must consult with recognized dental organizations involved in child health care to establish those intervals. A referral to a dentist is required for every child in accordance with each State's periodicity schedule and at other intervals as medically necessary…Medicaid offers dental benefits for pregnant women. Medicaid members who qualify for the CHEC program have dental benefits until age 21. Non-pregnant adults only have limited emergency dental benefits."

Utah Medicaid has separate dental managed care contracts that serve about 65 percent of Medicaid clients statewide that are eligible for dental benefits. All clients living in Davis, Salt Lake, Utah, and Weber counties participate. The Department must pay actuarially certified rates to the dental plans.

The department has a fee-for-service program that covers about 35 percent of Medicaid clients that intends to "increase access to dental service and reward dentists who treat a significant number of Medicaid clients" (Utah Medicaid Provider Manual). Since FY 1998, dentists in urban areas who agree to see an average of two clients per week receive a 20 percent increase in their Medicaid reimbursement. Dentists in rural areas automatically receive the 20 percent increase. Oral surgeons can receive the 20 percent increase by agreeing to be on a Medicaid-provider referral list for dentists.

The fiscal analyst recommends that the Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee removes ongoing the funding from the FY 2019 base budget associated with the 20 percent reimbursement enhancements for dentists. The Department of Health may opt to request the funding as a building block, which would provide the Legislature an opportunity to reassess the policy of enhanced payments for rural dentist and oral surgeons in Medicaid. The Department of Health and the fiscal analyst shall work together to identify the proper funding amount for removal.

Agency Response: Oppose - "The Department opposes eliminating the 20% reimbursement enhancement for dentists in rural areas due to the potential impact on access to care. Under Section 1902(a)(30)(A), States must assure that payments to Medicaid providers "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The enhanced rate was the result of an increase in funding from the 1997 legislature and recommendations made to Medicaid by a Dental Task Force composed of dentists, Medicaid staff, and member representatives. The intent of the program is to increase access to dental service and to reward dentists who treats a significant number of Medicaid members. This rate reduction would require a State Plan Amendment (SPA) and would trigger an access to care evaluation by [Centers for Medicare and Medicaid Services]. Depending on the results of [Centers for Medicare and Medicaid Services]'s evaluation, the SPA may or may not be approved."

Mental Health (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "Behavioral health services are covered benefits when the services are medically necessary services. Behavioral health services include psychiatric diagnostic evaluation, mental health assessment by a non-mental health therapist, psychological testing, psychotherapy with patient and/or family member, family psychotherapy with patient present and family psychotherapy without patient present, group psychotherapy, multiple family group psychotherapy, psychotherapy for crisis, psychotherapy with evaluation and management services, evaluation and management services (i.e., pharmacologic management), therapeutic behavioral services, psychosocial rehabilitative services and peer support services."

In order to qualify for managed care Capitated Mental Health Services, a Medicaid client must live in a county covered by a Prepaid Mental Health Plan 1915(b) Freedom of Choice waiver. Prepaid Mental Health Plans cover 28 of Utah's 29 counties and provide inpatient hospital and outpatient mental health services through at-risk, capitated contracts. The Department must have the rates paid be actuarially-certified. Local mental health authorities must either provide the services or contract for the services. In Wasatch

County, the only county without a Prepaid Mental Health Plan, mental health services are provided on a fee-for-service basis.

Substance Abuse Treatment (Primarily Managed Care)

State statute assigns substance abuse local authority responsibility to each county. The Division of Substance Abuse and Mental Health is the state's public substance abuse authority. It has the duty to consult and coordinate with local substance abuse authorities regarding programs and services. The Division of Substance Abuse and Mental Health sets policy for programs funded with state and federal money. It accomplishes this objective by establishing rules and minimum standards for local substance abuse authorities. It establishes minimum quality standards, funding formulas for distribution of public funds, and other public and substance abuse policies with input from various stakeholders. Twenty-five of Utah's twenty-nine counties provide substance abuse services through at-risk, capitated contracts.

Accountable Care Organizations, Administrative Rate (Managed Care)

The capitation rates paid to the accountable care organizations contain both a medical cost and an administrative cost component. The administrative money received covers the following: case management, disease management, Healthcare Effectiveness Data and Information Set reporting, quality improvement programs, performance improvement projects, quality committees, health needs assessments, utilization management, prior authorization, provider credentialing and re-credentialing, newsletters, and outreach.

Accountable Care Organizations, Services Rate (Managed Care)

The Medicaid.gov website states: “Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.”

Accountable care organizations receive a per member per month payment for each Medicaid client in their program and assumes the risk of paying for all of the incurred costs. The negotiated care includes funding for administrative costs. The contracted accountable care organizations are responsible to pay for all medical services except for the following:

1. Dental services
2. Targeted case management
3. Non-emergent medical transportation
4. Apnea monitors
5. Nursing facility (if the stay is anticipated to be longer than 30 days)
6. Waiver Services
7. Mental health services
8. Substance abuse services, except for medical detoxification in a facility.
9. Mental health and immunosuppressive drugs
10. Any services performed at an Indian Health Services, tribal facility, or an Urban Indian Facility.
11. Chiropractic services
12. Services performed at the state hospital, and
13. Services performed at the state developmental center.

UCA 26-18-405(2)(c) directs the Department of Health to do the following: "Identify the evidence-based practices and measures, risk adjustment methodologies, payment systems, funding sources, and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost, including mechanisms that: pay providers for packages of services delivered over entire episodes of illness rather than for individual services delivered during each patient encounter; and reward providers for delivering services that make the most positive contribution to a recipient's health status." The Department of Health reports that it has complied with this law by submitting a waiver to Centers for Medicare and Medicaid Services in 2012 which authorized the accountable care organization (ACO) delivery model. The Department of Health reports: "UCA 26-18-405(2)(c) directs the Department of Health to develop a waiver program to replace the fee-for-service delivery model with one or more risk-based delivery models. Through the ACO model, the ACOs have developed shared savings and other value based payment methodologies which meet the requirements of this statute. The topic of integration of additional services into the ACO model merits an indepth review and could be a suitable subject for a future deep dive review. In particular, the integration of mental health services, long-term support services, or dental services into the ACO model all merit continued discussion and analysis."

The fiscal analyst recommends that the Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative fiscal analyst by January 1, 2018 on the feasibility and advisability of incorporating more services into accountable care organization contracts.

Agency Response: Oppose - "The Department of Health opposes this recommendation as it is currently proposed. The Department continues evaluate on a regular basis the feasibility of including additional services in the ACO contracts. Our review of feasibility includes an analysis of potential cost savings and impact to Medicaid member access to care. There are specific reasons why the Department has not included the services listed above into the ACO contracts. For example, federal regulations place requirements on the state in relation to IHS providers, the state hospital, and waiver services which makes their incorporation into managed care impractical. The psychotropic drugs are paid fee for service because the ACOs are not responsible for paying mental health services and the county mental health authorities do not supply the state match payments for the pharmacy benefits. In order to provide apnea monitors to fee for service clients, the state bid out the contracts statewide in order to ensure that the services would be available to rural clients while taking advantage of economies of scale to lower prices charged to the state. Finally, the list identified by the Fiscal analyst above includes some services which are already incorporated into a managed care payment model: dental services, mental health services, some nursing facility stays, and substance use disorder services."

Ambulatory Surgical (Primarily Managed Care)

Ambulatory surgical centers provide certain outpatient surgical services that require 24 hours or less of care. These centers exist independently or are physically separated from another health care facility, such as hospitals.

End Stage Renal Disease/Kidney Dialysis (Primarily Managed Care)

Utah Medicaid covers kidney dialysis services primarily for 90 days until a client becomes eligible for similar services under Medicare. If a client is not eligible for Medicare, then Medicaid will continue to cover the dialysis services.

Home Health (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "An in-depth physical and psychosocial assessment must be made by a registered nurse initially or at recertification to assess the beneficiary's overall condition, needs, adaptability of the beneficiary's place of residence to the provision of health care, capability of the beneficiary to participate in his or her own care, identify family support systems or persons willing to assume responsibility for care when the beneficiary is unable, and establish a plan for delivery of care."

Home health is a mandatory benefit under the Medicaid program. In the fee-for-service system, services may require a prior authorization and may include therapy, nursing services, home health aides, and some medical supplies.

Independent Lab and/or X-Ray (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "Covered services are medically necessary diagnostic and therapeutic services, appropriate for the adequate diagnosis or treatment of a patient's illness. Services must be consistent with principles of efficacy (evidence-based), economy and quality of care."

Inpatient Hospital (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "An inpatient stay is defined as an admission which meets established criteria for severity of illness and intensity of service. The patient receives room, board, and professional services in an institution. The physician identifies the patient as inpatient status."

A hospital which accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives all medically necessary services from Medicaid providers. In reviewing claims for readmissions within 30 days for the same or similar principal diagnosis, the State may deny or combine the claim with the first admission.

Non-pregnant Medicaid adult clients have, as of July 1, 2017, a $75 per visit co-insurance payment for non-emergency inpatient hospital services. The most frequent claims for inpatient hospital service for Medicaid usually are for the care of newborns, delivery of babies, and respiratory flu treatments.

Hospitals that serve a disproportionate share of Medicaid and uninsured patients may receive Disproportionate Share Hospital Payments. The intent of the payments is to offset some of the hospitals' uncompensated costs in serving these individuals. There are state and hospital-specific federal limits on the maximum payment amounts that can be paid based on the actual amount of uncompensated care provided. The majority of the seed money comes from government-owned hospitals and the remainder is made up of General Fund appropriations.

Medical Supply (Primarily Managed Care)

Medicaid pays for disposable or semi-disposable supplies based upon the lower amount of billed charges or the Medicaid fee schedule in the fee-for-service system. There are over 250 medical supply companies enrolled to provide services in Utah to Medicaid clients.

In order to ensure medical appropriateness and/or unit limitations, in the fee-for-service system some items require prior authorization. About half of all medical supplies require a prior authorization. Medicaid maintains a specific list of potentially approvable supplies for use in an emergency. After the emergency providers must submit claims to determine if the supply qualifies for reimbursement. Following are some items approved for possible reimbursement due to a medical emergency:

- Feeding through tubes via veins or stomach
- Hospital bed equipment
- Respiratory equipment
- Oxygen

Other (Primarily Managed Care)

This other category includes the following categories of service: autism spectrum disorder services, buy out premiums, custody medical services, early intervention services, federal buy-in parts A and B, group pre/postnatal education services, health information technology payments, the UNI HOME program, interpretive services, perinatal care coordination services, pre/postnatal home visit services, and qualified Medicare beneficiary only services. Some of these services do not have significant amounts of expenditures and were not analyzed separately in this report.

Outpatient Hospital (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "Outpatient Hospital service is preventive, diagnostic, therapeutic, rehabilitative, or palliative service. Covered services must be services that meet the following conditions: (1) Are furnished to outpatients; (2) Are furnished by or under the direction of a physician or dentist; and (3) Are furnished by an institution that — (a) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; (b) Meets the requirements for participation in Medicare as a hospital."

Medicaid clients subject to co-pay requirements have a $3 co-payment for outpatient hospital services. Medicaid clients subject to co-pay requirements have a $6 co-payment for non- emergency use of the emergency room. Medicaid staff contact clients, who excessively use the emergency room for non-emergency reasons, to connect them with a primary care provider and educate them on proper emergency room usage. Medicare's Outpatient Prospective Payment System is the basis for outpatient hospital services reimbursement rates.

Personal Care (Primarily Managed Care)

In the fee-for-service system, a physician must be the one to prescribe personal care services, which are to help a client with everyday activities, for clients that live in their own homes. A licensed registered nurse must supervise the provision of personal care services. A qualified aid, who is not a legally responsible relative and works for a licensed home health agency, may provide the services.

Pharmacy (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "The Utah Department of Health, Division of Medicaid and Health Financing covers prescription medications that are prescribed by qualified practitioners who are enrolled with Utah Medicaid as a Medicaid benefit in compliance with Federal law (42 U.S.C. 1396r-8). All covered medications must: require a prescription for dispensing, have a National Drug Code number, be eligible for the federal Medicaid drug rebate, be approved by the Food and Drug Administration, meet the Center for Medicare and Medicaid Services definition of a 'covered outpatient drug' (42 CFR 447.502), and be listed in the Medi-Span drug file. Utah Medicaid also covers some over-the-counter (non-prescription) medications, immunizations, and medical supplies as described in this manual."

Utah Medicaid directly administers the pharmacy benefit for all fee-for-service Medicaid members. Nearly all pharmacies in the state provide pharmacy services to Medicaid members.

The lowest price of four different calculations, plus a dispensing fee, for each drug determines reimbursement. Below is a list of each calculation:

1. Estimated Acquisition Cost –-- Wholesale Acquisition Cost.
2. Federal Maximum Allowable Cost –-- Federal law establishes maximum price.
3. Utah Maximum Allowable Cost –-- National Average Drug Acquisition Cost published by the Centers for Medicare and Medicaid Services.
4. Usual and Customary Charges –-- This is the amount the provider typically charges the general public.

Physical and Occupational Therapy (Primarily Managed Care)

Physical and occupational therapy both try to help clients maximize physical functionality. Service delivery in the fee-for-service system must include an assessment of current functionality and a specific plan and timeline for what functions will be improved.

Physicians and Other Practitioners (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "Physician services involve direct patient care and securing and supervising appropriate diagnostic ancillary tests or services, within the parameters of established Medicaid policy, to diagnose the existence, nature, or extent of illness, injury, or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, disability, defect, or other impairments to a member's physical or mental health."

Medicaid clients, who are not in a managed care plan, may visit any willing physician provider to receive services. This includes any specialist physician. Most non-pregnant adults have a $3 co-pay per doctor's visit. Medicaid reimburses medical providers to perform basic dental checks and apply varnishes. Payment for approved services will be made at the lower of the usual and customary charge or the established physician's fee schedule. Licensed nurse practitioners may bill Medicaid directly for approved procedure codes.

There are two types of physician enhanced payments: (1) payments to the University of Utah Medical Group (UUMG) for the difference between the average commercial rate and the Medicaid fee schedule, which is seeded by UUMG, as well as (2) a 12 percent enhancement for payments to rural physicians.

The fiscal analyst recommends that the Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee removes ongoing the funding from the FY 2019 base budget associated with the 12 percent reimbursement enhancements for rural physicians. The Department of Health may opt to request the funding as a building block, which would provide the Legislature an opportunity to reassess the policy of enhanced payments for rural physicians in Medicaid. The Department of Health and the fiscal analyst shall work together to identify the proper funding amount for removal.

Agency Response: Oppose - "The Department opposes eliminating the 12% reimbursement enhancement for physicians in rural areas due to the potential impact on access to care. Under Section 1902(a)(30)(A), States must assure that payments to Medicaid providers "are consistent with efficiency, economy, and

quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." This rate reduction would require a State Plan Amendment (SPA) and would trigger an access to care evaluation by [Centers for Medicare and Medicaid Services]. Depending on the results of [Centers for Medicare and Medicaid Services]'s evaluation, the SPA may or may not be approved."

Podiatry (Primarily Managed Care)

For Utah Medicaid podiatry includes treatment of the ankle or foot for difficulty walking or impairment which limits independent function.

Speech and Hearing (Primarily Managed Care)

The Utah Medicaid Provider Manual states: "A written plan of care established by the speech-language pathologist is required. The plan of care must include:

- Patient information and history
- Current medical findings
- Diagnosis
- Previous treatment (if applicable)
- Planned treatment
- Anticipated goals
- The type, amount, frequency and duration of the services to be rendered."

Pregnant women and children may receive speech and hearing services.

Vision Care (Primarily Managed Care)

The Utah Medicaid Provider Manual explains: "Optometry care services covered by the Utah Medicaid Program include the examination, evaluation, diagnosis and treatment of visual deficiency; removal of a foreign body; and prescription and provision of corrective lenses by providers qualified to perform the service(s)."

Federal law requires that Medicaid pays for vision care for children up to age 21. Additionally, the State has opted to pay for vision care services to pregnant women. In the fee-for-service program, clients may receive one routine eye exam per year unless there is a documented medical necessity for more (corrective lenses are limited to children and pregnant women). Medicaid expects frames for glasses to last two years. A client would receive contact lenses only if eye glasses cannot serve the medical necessity.

Chiropractic (Fee-for-service)

The Utah Medicaid Provider Manual states: "Chiropractic services may be provided when medically necessary and include examination, diagnosis and manual manipulations to influence joint and neurophysiological function of the regions of the spine, including x-rays of the spine." Pregnant women and children over age six may receive up to 12 chiropractic visits annually without prior authorization.

Federally Qualified Health Center (Fee-for-service)

For specifically designated medical clinics that qualify as federally qualified health centers, Utah Medicaid must pay these clinics their full cost of providing Medicaid services. This is done through an annual

adjustment at the end of each fiscal year and usually results in a payment that is higher than what Medicaid would normally pay.

Home/Community Based Waiver Contract (Fee-for-service)

The Medicaid.gov website states: "Home and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses."

Medicaid clients must meet nursing facility level of care as described in Administrative Rule R414.502 in order to be eligible for the Home and Community Based Waiver Services. Clients must meet two of the following three conditions: (1) require substantial physical assistance for activities of daily living, (2) certain level of dysfunction in cognition, and (3) a less structured setting cannot meet the level of care needed.

Hospice (Fee-for-service)

The Medicaid.gov website states: "The Hospice benefit is an optional state plan service that includes an array of services furnished to terminally ill individuals. These services include: nursing, medical social services, physician services, counseling services to the terminally ill individual and the family members or others caring for the individual at home, short-term inpatient care, medical appliances and supplies, home health aide and homemaker services, physical therapy, occupational therapy and speech-language pathology services."

Hospice services are an optional benefit under the Medicaid program. To qualify, a physician must certify that the eligible person is within the last 6 months of life. The State has no limits on the amount of hospice care a client may receive.

For individuals residing in nursing facilities, Federal law requires that the hospice provider reimburse the nursing facility provider at 95 percent of the daily nursing home reimbursement rate. Reimbursement rates for hospice services are online at http://health.utah.gov/medicaid/stplan/hospice.htm.

Intermediate Care Facilities for Intellectually Disabled (Fee-for-service)

A special group of nursing facilities is Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID). These facilities specialize in the care of people with intellectual disabilities. The individuals served by ICFs/ID need more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/ID are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs. Nursing services are available for those requiring nursing and medical services.

Reimbursement rates for Intermediate Care Facilities for Individuals with Intellectual Disabilities and the methodology for calculating those rates are online at http://health.utah.gov/medicaid/stplan/longtermcareicfidra.htm.

Medical Transportation (Fee-for-service)

Medical transportation includes:

- Air and ground ambulance for medical emergencies
- UTA (Utah Transit Authority) bus/TRAX passes
- Non-emergency door-to-door service if no working vehicle in household and unable to ride on UTA bus services

Nursing Facility (Fee-for-service)

The Utah Medicaid Provider Manual states: "The cost of care in a nursing facility must be less than the cost of care for alternative, non-institutional services for the Department to approve nursing facility coverage for an applicant. The Department may not consider the availability of Medicaid reimbursement for alternative services as a factor in determining the relative costs of alternative services. Unless the cost of care through alternative, non-institutional services is higher than the cost of care in a nursing facility, the Department will deny nursing facility coverage for an applicant whose health, rehabilitative, and social needs may reasonably be met through alternative non-institutional services."

Reimbursement rates for nursing home services and calculation methodology are online at http://health.utah.gov/medicaid/stplan/longtermcareicfidra.htm. State law requires, at a minimum, state-funded expenditures paid to nursing care facilities stay at June 2004 levels. There are quarterly adjustments to the rates paid to each nursing care facility based on the facility's average case mix (client severity). The Department of Health determines the nursing care rate based on three components:

5. Fixed - to pay for costs common to all facilities, such as food, laundry, and housekeeping.
6. Property - based on the fair rental value as well as property tax and insurance subject to a minimum reimbursement level. On average thirty-eight facilities have made improvements annually for the last five years.
7. Case Mix - distributes the remaining funds after the two components above based on the level of clients' needs with a rural vs. urban adjustment.

The federal government allows local (non-state) government-owned nursing homes to provide seed money to be paid up to the Medicare Upper Payment Limit. Local government-owned nursing homes in Utah may provide seed money to receive supplemental payments.

Medicaid nursing home clients may retain a fixed monthly amount for personal needs. For most individuals expected to stay longer than six months in long-term care the permitted allowance is $45 monthly. In most cases, the client's account balance cannot exceed $2,000 without risking a loss of Medicaid eligibility due to asset level requirements. Medicaid determines the amount of income the Medicaid client must pay to the facility to be eligible for Medicaid. Medicaid reduces this income from the reimbursement paid to the facility.

Rural Health Clinic (Fee-for-service)

Rural health clinics are in rural, medically underserved areas and employ non-physician practitioners. These clinics receive a prospective payment based on reasonable costs divided by the total visits by Medicaid clients. The state makes supplemental payments to rural health clinics that contract with Medicaid accountable care organizations to bring reimbursement levels up to the prospective payment level.

School Based Skills Development (Fee-for-service)

School-based skills development services are medically necessary services covered by Medicaid that are included in a Medicaid-eligible disabled student's individualized educational program. Those services may include evaluation and assessment, motor skills development, communication skills development, nursing and personal services, behavioral health services, as well as vision and hearing adaptation services.

How do we Know if we are Successful?

Utah Medicaid's mission statement is "We provide access to quality, cost-effective health care for eligible Utahns."

The discussion of how we know if we are successful has the following sections:

1) Provider Participation Rates – is the number of Medicaid providers increasing or decreasing over time?
2) Client Satisfaction – are adult and children clients satisfied with their access to medical care?
3) Access to Care – do clients report getting the care they need?

The survey results for client satisfaction and access to care for Utah's three to four managed care plans in any given year have been combined into one weighted average based on client enrollment in each managed care plan. Below is a brief history of managed care arrangements in Utah from FY 2009 through FY 2016:

1. July 2008 – the following providers are participating in Medicaid in non-risk contracts
    a. Select Access (Intermountain Healthcare)
    b. Molina
    c. Healthy U
2. September 2009 – Molina moves to a fully risk-based capitated contract
3. May 2012 – Health Choice joins the Utah Medicaid market
4. January 2013 – Select Health (formerly Select Access), Healthy U, and Health Choice move to fully risk-based capitated contract and all plans are now accountable care organizations
    a. Clients in four counties (Utah, Salt Lake, Davis, and Weber) must sign up with one of the four accountable care organizations
5. July 2015 – additional counties served by accountable care organizations include Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, Wasatch, and Washington.

The Department of Health's Annual External Quality Review Report of Results report for 2016 included the following findings for all Medicaid and CHIP medical and mental health managed care plans:

"Standards with the highest scores (best performance) were:

- Coordination and Continuity of Care.
- Enrollee Rights and Protections.
- Subcontracts and Delegation.
- Quality Assessment and Performance Improvement."

"Standards with the lowest scores (needing improvement) were:

- Enrollee Information.

- Grievance System.
- Provider Participation and Program Integrity."

For more information please see https://sites.google.com/a/utah.gov/cqm/home/external-quality-review-2015-2016.

Provider Participation Rates – Is the number of Medicaid Providers Increasing or Decreasing Over Time?

Medicaid Providers Enrolled in Fee-for-Service by Provider Group	2012	2013	2014	2015	2016	Diff.	% Diff.
Chiropractic	192	183	169	150	203	11	6%
Dentists	781	820	803	860	762	(19)	-2%
Mental Health	11	71	129	169	174	163	1482%
Substance Abuse Treatment	40	45	55	59	45	5	13%
Personal Care	60	59	56	47	49	(11)	-18%
Pharmacies	580	583	603	604	651	71	12%
Physical & Occupational Therapists	288	283	287	270	239	(49)	-17%
Physicians	3,827	3,619	3,460	3,206	3,278	(549)	-14%
Podiatry	123	117	114	121	133	10	8%
Speech and Hearing Therapists	87	95	96	84	84	(3)	-3%
Vision Care	263	259	272	259	260	(3)	-1%
Home Health (as proxy for Hospice)	183	189	200	186	184	1	1%
Intermediate Care Facilities for Intellectually Disabled	15	15	16	17	26	11	73%
Nursing Facility - Level One Care	112	109	114	134	142	30	27%
Ambulatory Surgical	43	42	43	47	43	-	0%
End Stage Renal Disease (Kidney Dialysis)	42	41	42	40	43	1	2%
Home Health	183	189	200	186	184	1	1%
Inpatient Hospital Services, General	192	204	202	179	188	(4)	-2%
Outpatient Hospital Services, General	395	382	361	333	355	(40)	-10%
Home/Community Based Waiver Contract (2014 base year)	-	-	95	96	87	(8)	-8%
Medical Transportation	129	115	116	121	121	(8)	-6%
Rural Health Clinic	23	23	20	19	18	(5)	-22%
Federally Qualified Health Center	27	27	31	35	36	9	33%
Independent Lab and/or X-Ray	110	107	115	115	124	14	13%
Medical Supply	481	472	456	452	467	(14)	-3%
School Based Skills Development - Number of Local Education Agencies	33	34	35	34	35	2	6%
Accountable Care Organizations (2013 base year)	-	4	4	4	4	-	0%
Total	**8,220**	**8,087**	**8,094**	**7,827**	**7,935**	(285)	-3%
Medicaid clients (fiscal years)	289,950	296,260	304,658	325,410	335,888	45,938	16%
Source:							
https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2016.pdf							

Overall from 2012 to 2016 the number of providers enrolled in Medicaid fee-for-service has decreased 3 percent while the Medicaid population has increased 16 percent. The table above shows the change in the number of fee-for-services providers by provider group from 2012 to 2016. The Department of Health: "The information in this table is aggregated from data in the 2016 Annual Report of Medicaid and CHIP. Utah Medicaid implemented significant delivery system changes in fiscal year 2013 and fiscal year 2015 by moving to mandated managed care in specified counties. The Medicaid provider counts in the table only represent the count of provider enrollments (a single provider may enroll multiple times) paid on a fee for

service basis in the fiscal years presented and do not capture managed care provider networks." Additionally, changes in ownership would artificially inflate the number of providers by counting the same service location twice in the year that ownership changed.

The table below shows the change from 2012 through 2016 in the number of Utah licenses or fiscal analyst estimate by provider type that most closely matches or approximates the Medicaid provider categories. Many of the provider categories likely include providers residing outside of Utah but who provide services via telehealth or other means. Overall from 2012 to 2016 the number of providers in Utah has increased 8 percent while the state population has increased 7 percent.

Medical Provider Group - Utah Licenses	2012	2013	2014	2015	2016	Diff.	% Diff.
Chiropractic	789	909	899	945	922	133	17%
Dentists	2,431	2,822	2,824	2,146	2,109	(322)	-13%
Mental Health (Clinical Mental Health, Marriage and Family Therapy, Psychology, Social Work)	9,065	9,296	9,280	10,291	10,231	1,166	13%
Substance Abuse Treatment (Certified/Licensed Substance Use Disorder Counselors)	455	452	456	434	443	(12)	-3%
Personal Care (Certified Nursing Assistants)	22,559	22,583	22,244	22,061	21,694	(865)	-4%
Pharmacies (With Store Fronts)	709	719	746	751	801	92	13%
Physical & Occupational Therapists (Excludes Assistants)	2,512	2,617	2,858	2,767	3,051	539	21%
Physicians & Other Similar Practitioners (Physicians, Osteopath Physician, PA, APRN)	11,365	12,816	12,920	14,043	14,255	2,890	25%
Podiatry	198	202	203	215	215	17	9%
Speech and Hearing Therapists (Excludes Assistants)	916	947	1,067	1,129	1,265	349	38%
Vision Care (Optometrists Only)	482	472	455	487	486	4	1%
Hospice	79	83	84	90	90	11	14%
Intermediate Care Facilities for Intellectually Disabled	16	16	17	17	18	2	13%
Nursing Facility	99	98	99	98	99	-	0%
Ambulatory Surgical	41	41	41	39	40	(1)	-2%
End Stage Renal Disease (Kidney Dialysis)	38	38	39	41	43	5	13%
Home Health	107	106	104	102	100	(7)	-7%
Inpatient Hospital	50	51	53	55	55	5	10%
Outpatient Hospital	50	51	53	55	55	5	10%
Home/Community Based Waiver Contract (2014 base year)	-	-	95	96	87	(8)	-8%
Medical Transportation (Ambulance Providers)	103	105	105	108	107	4	4%
Rural Health Clinic	23	23	20	19	18	(5)	-22%
Federally Qualified Health Center	30	30	42	50	52	22	73%
Independent Lab and/or X-Ray (LFA estimate)	116	116	127	132	136	20	17%
Medical Supply (LFA estimate)	239	248	251	254	253	14	6%
School Based Skills Development - Number of Local Education Agencies	122	123	129	138	144	22	18%
Accountable Care Organizations for Medicaid (2013 base year)	-	4	4	4	4	-	0%
Total	**52,594**	**54,968**	**55,215**	**56,567**	**56,773**	4,179	8%
Utah population	2,855,200	2,902,800	2,941,800	2,990,600	3,051,200	196,000	7%

Licensed Providers Increasing and Medicaid Providers Decreasing - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Physical & Occupational Therapists	539	21%	-17%	(49)
Physicians	2,890	25%	-14%	(549)
Speech and Hearing Therapists	349	38%	-3%	(3)

The provider groups where the number of Medicaid providers is decreasing even though the number of licensed Utah providers is increasing is listed in the on the bottom of the previous page.

The Department of Health states: "The Medicaid provider counts used in the comparison solely represent the count of provider enrollments (a single provider may enroll multiple times) paid on a fee for service basis in the fiscal years presented and do not capture managed care provider networks. Therefore, Medicaid provider trends identified based on this data do not accurately represent availability of provider services for Medicaid members."

The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by January 1, 2018 on the trend over time of the number of Medicaid service providers from 2012 through 2017 for physical and occupational therapists, physicians, and speech and hearing therapists.

Agency Response: Support - "The Department is supportive of this recommendation and will provide the requested data by January 1, 2018."

The provider groups where the number of Medicaid providers is decreasing even through the number of licensed Utah providers is relatively constant (growing up to the rate of Utah population growth) is listed in the table below:

Licensed Providers at 0% to State Population Growth and Medicaid Providers Decreasing - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Vision Care	4	1%	-1%	(3)
Medical Transportation	4	4%	-6%	(8)
Medical Supply	14	6%	-3%	(14)

The provider groups where the number of Medicaid providers is remaining constant (growing up to the rate of Utah population growth) even through the number of licensed Utah providers is increasing is listed in the table below:

Licensed Providers Increasing and Medicaid Providers at 0% to State Population Growth - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Chiropractic	133	17%	6%	11
Home Health (as proxy for Hospice)	11	14%	1%	1
End Stage Renal Disease (Kidney Dialysis)	5	13%	2%	1
School Based Skills Development - Number of Local Education Agencies	22	18%	6%	2

The Department of Health states: "The Medicaid provider counts used in the comparison solely represent the count of provider enrollments (a single provider may enroll multiple times) paid on a fee for service basis in the fiscal years presented and do not capture managed care provider networks. Therefore, Medicaid provider trends identified based on this data do not accurately represent availability of provider services for Medicaid members."

The provider groups where the number of Medicaid providers is remaining constant (growing up to the rate of Utah population growth) even through the number of licensed Utah providers is decreasing is listed in the table below:

Licensed Providers Decreasing and Medicaid Providers at 0% to State Population Growth - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Ambulatory Surgical	(1)	-2%	0%	-
Home Health	(7)	-7%	1%	1

The provider groups where the number of Medicaid providers is following the overall trend in the number of licensed Utah providers is listed in the two tables below:

Licensed Providers Decreasing and Medicaid Providers Decreasing - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Dentists	(322)	-13%	-2%	(19)
Personal Care	(865)	-4%	-18%	(11)
Rural Health Clinic	(5)	-22%	-22%	(5)

Licensed Providers and Medicaid Providers Increasing - 2012 to 2016 Data	Utah Licenses		Medicaid Providers	
	Diff.	% Diff.	% Diff.	Diff.
Pharmacies	92	13%	12%	71
Podiatry	17	9%	8%	10
Federally Qualified Health Center	22	73%	33%	9
Independent Lab and/or X-Ray	20	17%	13%	14

The following provider groups in Utah have seen a change of over 20 percent from 2012 to 2016. Below is an explanation of why the number of providers in those categories has changed over 20 percent:

1. Number of providers that increased over 20 percent from 2012 to 2016:
    a. Physical & Occupational Therapists (Excludes Assistants), Physicians & Other Similar Practitioners (Physicians, Osteopath Physician, PA, APRN), Speech and Hearing Therapists (Excludes Assistants)
        i. "My best guess is that the license numbers have jumped due to the increasing utilization of telehealth or increased availability of mobile practitioners." September 1, 2017 email from Mark Steinegal, Director of the Division of Occupational and Professional Licensing
    b. Home/Community Based Waiver Contract
        i. "Enrollment in the various waiver programs increased by more than 30% between FY 2012 and FY 2016. In addition, there has also been a push in these programs to offer more integrated care, which typically means that fewer individuals are being served in a particular location. Fewer people served per location means that there will need to be more locations available to meet their needs. Finally, both the Autism Waiver and the Medically Complex Children's Waiver were introduced between FY 2012 and FY 2016." September 5, 2017 email from Janica Gines, Assistant Director with Division of Medicaid and Health Financing

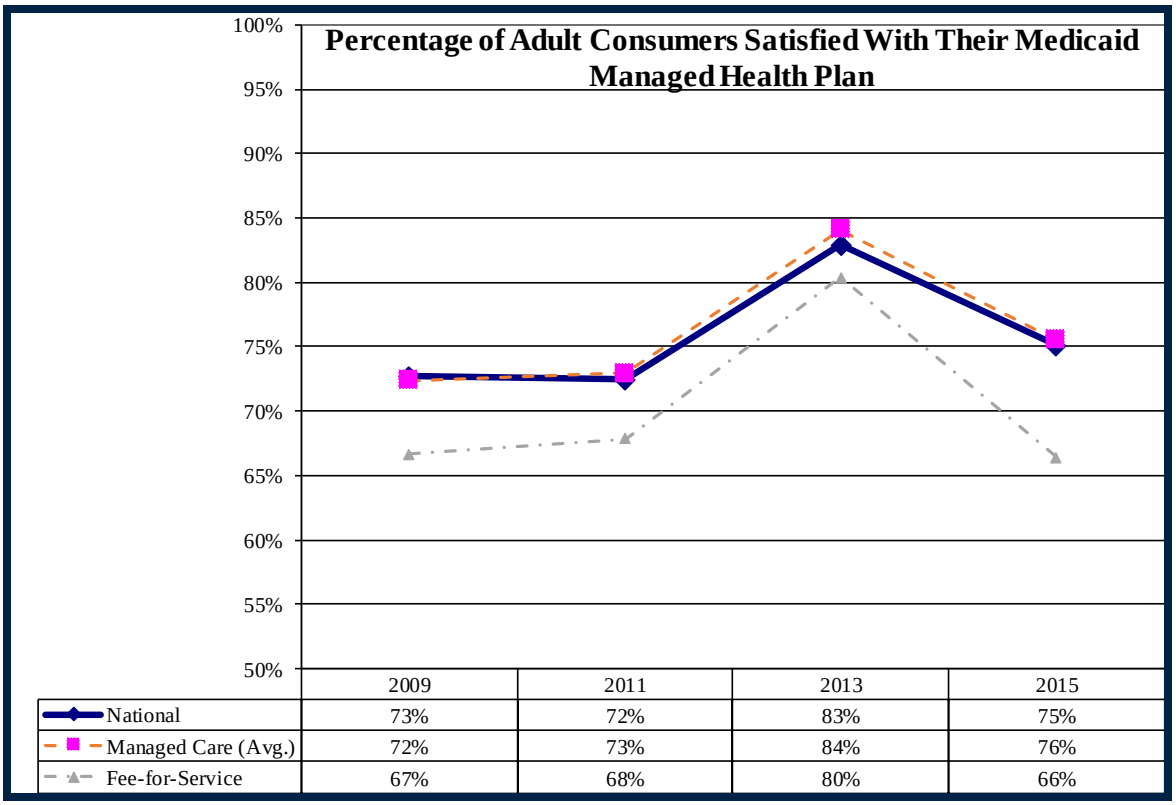
   c. Federally Qualified Health Center
      i. "The growth of Health Center Program grantees and clinics is directly related to the growth in program funding made available in the Affordable Care Act and extended under bi-partisan support through the Medicare Access and CHIP Reauthorization Act. We were very successful in competing for program grant funding to expand access to care through new clinic locations and/or services offered. There was a concerted effort to identify high need areas and target growth to such. As a result, the Utah Health Centers are now serving over 150,000 patients (52% are uninsured) and providing over 460,000 clinic visits annually (medical, dental, and mental health services combined)." September 1, 2017 email from Alan Pruhs, Executive Director of the Association for Utah Community Health
2. Number of providers that decreased over 20 percent or five clinics from 2012 to 2016:
   a. Rural Health Clinic
      i. "4 contracts closed because the clinics merged with Central Utah Clinic and they lost their [rural health clinic] designation through [Centers for Medicare and Medicaid Services]...1 contract was closed for billing inactivity." September 7, 2017 email from Janica Gines

The Department of Health submitted an access to care analysis for Utah's rural and frontier counties primarily served by the fee-for-service reimbursement system, see https://medicaid.utah.gov/Documents/pdfs/Utah_Access_Monitoring_Review_Plan.pdf to the federal government for the following categories:

1. Primary care
2. Physician specialists
3. Home health
4. Obstetrics – pre and post labor delivery
5. Behavioral health

The fiscal analyst recommends that Legislature open a bill file to request the Department of Health to annually provide a prioritized list for provider reimbursement changes for all provider groups with explanations of each ranking by December 15th of each year to the Office of the Legislative fiscal analyst to help inform the Legislature in making its funding decisions.

Agency Response: Oppose - "The Department is opposed to this recommendation as it is currently proposed. A provider reimbursement change would require a change in the Department's budget. The Department uses the Executive Branch's budget process to identify and prioritize requests for increases in appropriations. In addition, based on previous Legislative actions, it is unclear what factors the Legislature considers most important when advancing a reimbursement change. The topic of provider reimbursement changes merits an indepth review and could be a suitable subject for a future deep dive review. In particular, the length of time since the last provider reimbursement change, percent of providers accepting Medicaid, and the ratio of Medicaid reimbursement to a benchmark reimbursement all merit additional review and analysis."



	2009	2011	2013	2015
National	73%	72%	83%	75%
Managed Care (Avg.)	72%	73%	84%	76%
Fee-for-Service	67%	68%	80%	66%

Client Satisfaction - Adults

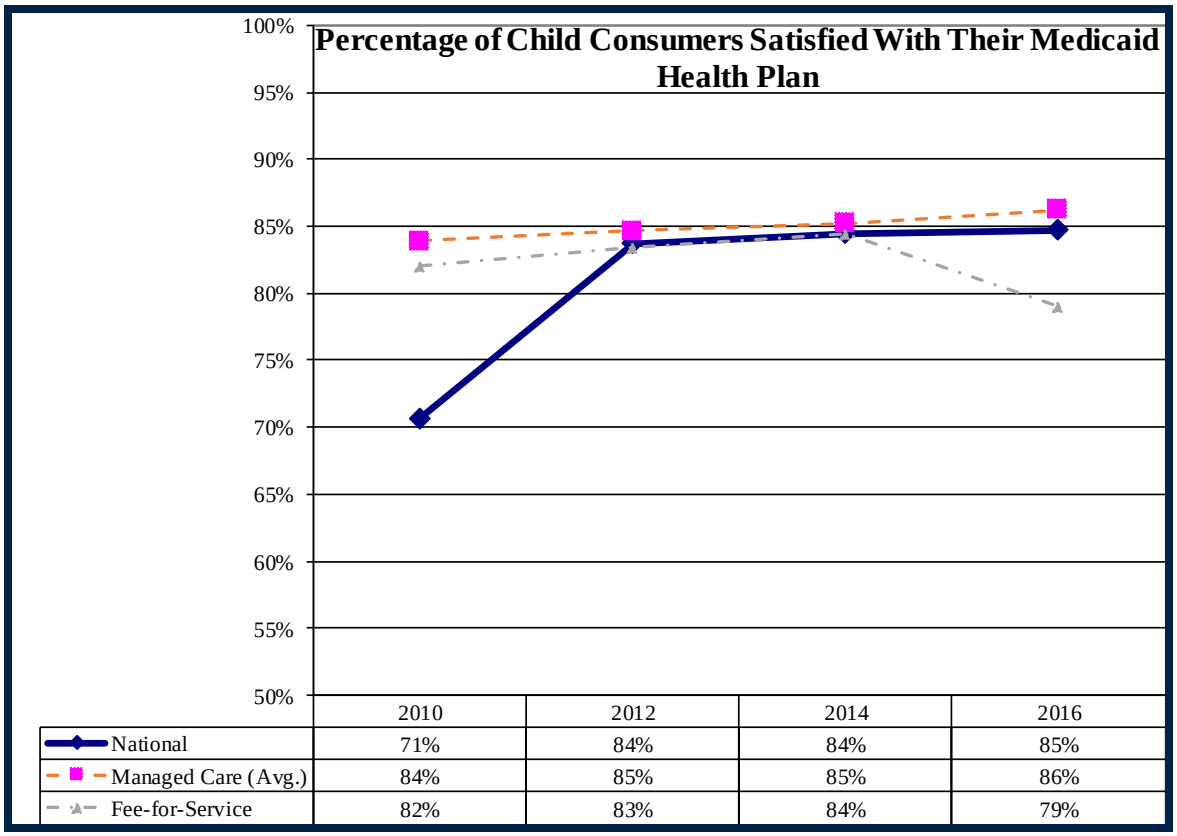
Above is a table that shows the trend over time biennially from 2009 through 2015 in the percentage of adult consumers satisfied with their Medicaid managed health plan. The data shows the following for Utah Medicaid adults:

1) Consumers have been more satisfied with their managed health care plans than their fee-for service plans by four to nine percentage points.
2) Consumers in Utah on managed care have been about as satisfied with their plans as clients nationwide.

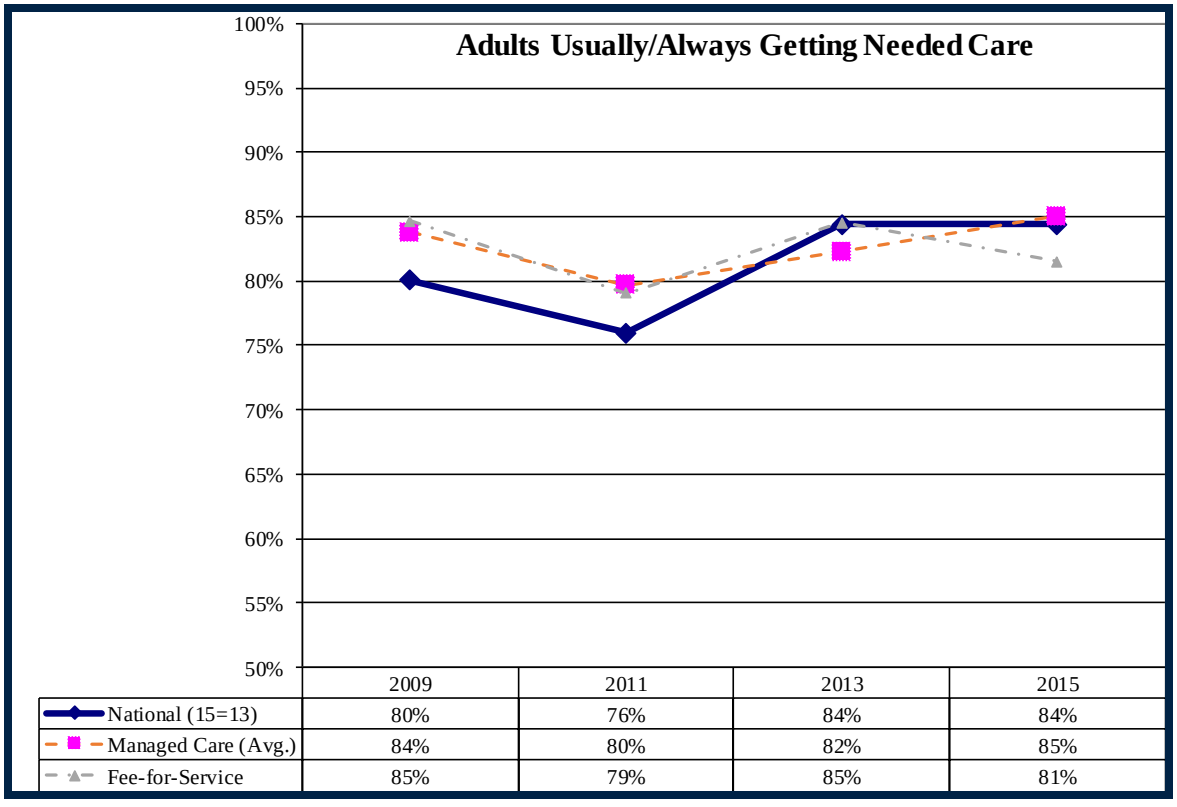
Client Satisfaction - Children

On the top of the next page is a table that shows the trend over time biennially from 2010 through 2016 in the percentage of child consumers satisfied with their Medicaid managed health plan. The data shows the following for Medicaid children:

1) Consumers have been more satisfied with their managed health care plans than their fee-for service plans by one to seven percentage points.
2) Since 2012, consumers in Utah on managed care have been about as satisfied with their plans as clients nationwide.



	2010	2012	2014	2016
National	71%	84%	84%	85%
Managed Care (Avg.)	84%	85%	85%	86%
Fee-for-Service	82%	83%	84%	79%



	2009	2011	2013	2015
National (15=13)	80%	76%	84%	84%
Managed Care (Avg.)	84%	80%	82%	85%
Fee-for-Service	85%	79%	85%	81%

Access to Care - Adults

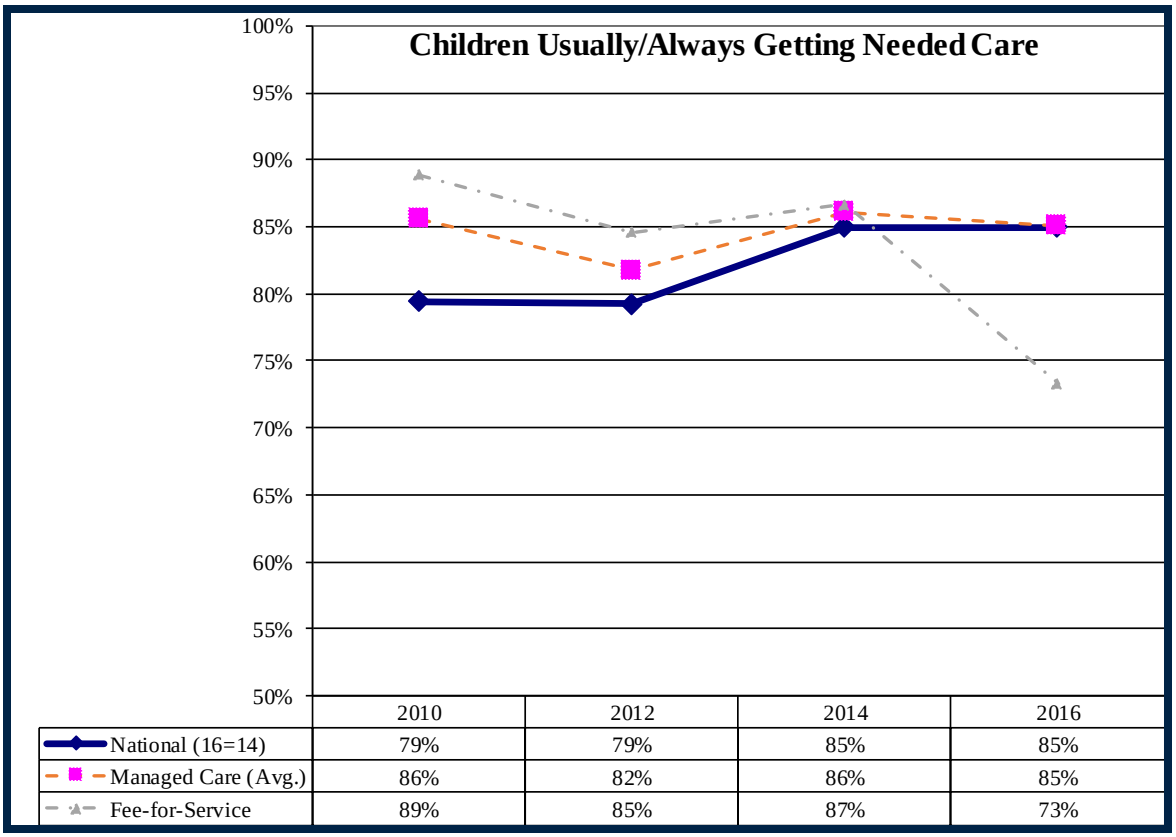
On the previous page on the bottom is a table that shows the trend over time biennially from 2009 through 2015 in the percentage of adult consumers reporting that they usually/always get needed care. The data shows the following for Utah Medicaid adults:

- There has not been a clear trend in clients being more satisfied between managed care plans and fee-for-service.

Access to Care - Children

Below is a table that shows the trend over time biennially from 2010 through 2016 in the percentage of child consumers reporting that they usually/always get needed care. The data shows the following for Utah Medicaid children:

1) From 2010 through 2014 fee-for-service clients were more satisfied than managed care clients by between one and three percentage points.
2) In 2016 clients in managed care were twelve percentage points more satisfied than fee-for-service clients.

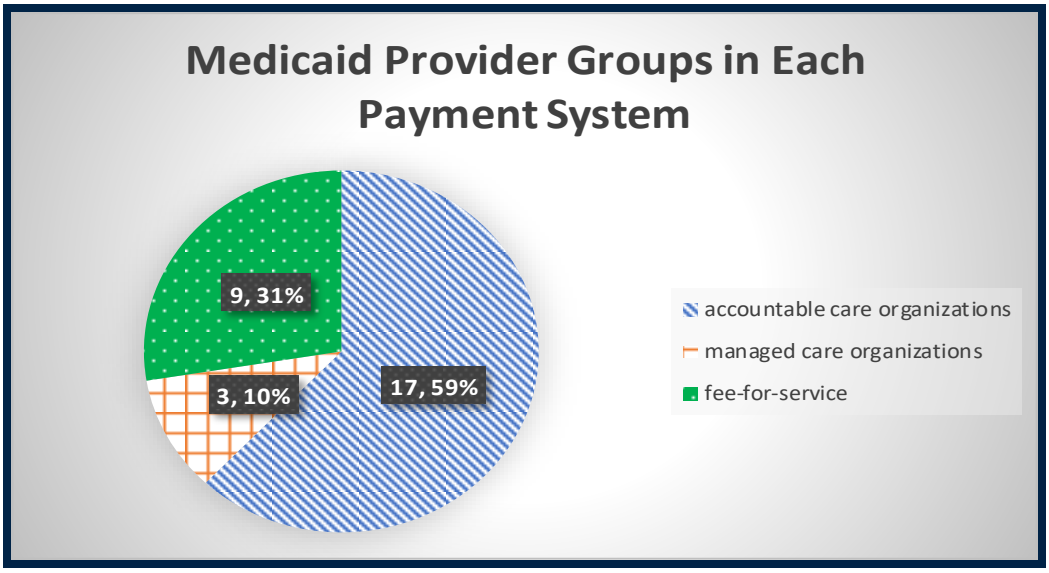


	2010	2012	2014	2016
National (16=14)	79%	79%	85%	85%
Managed Care (Avg.)	86%	82%	86%	85%
Fee-for-Service	89%	85%	87%	73%

How are we Organized?

This section addresses how provider rates increase for the 29 major provider groups in Medicaid. The State directly controls the reimbursement rate for all providers in 9 or 31 percent of provider groups. The remaining 20 providers primarily are paid via managed care systems (accountable care organizations and managed care organizations) where the State pays a set rate per member per month to a managed care provider who determines the reimbursement levels for its providers. On the next page is a graph showing

how many Medicaid provider groups are in each payment system within counties where enrollment in accountable care organizations is required.



Below is a more detailed definition of each payment system used in the chart above:

1. Four accountable care organizations (managed care) are primarily responsible for the reimbursement rates for 17 or 59 percent of Medicaid provider groups. Accountable care organizations serve most eligible Medicaid clients in 13 of Utah's 29 counties. This represents about 84 percent of Medicaid clients. The remaining 16 percent of clients primarily live in sixteen rural counties that are served under the fee-for-service payment system for these 18 Medicaid provider groups. There are also clients in the fee-for-service system who reside in nursing homes or have not yet enrolled in an accountable care organization.
2. Fee-for-service payments are primarily responsible for 9 or 31 percent of Medicaid provider groups. This system is where the State sets the reimbursement rate and clients find any Medicaid-enrolled provider willing to accept that rate. In addition, in counties with managed care, services are paid on a fee-for-service basis until a newly eligible client enrolls in managed care plans.
3. Managed care organizations (managed care plans and prepaid mental health plans) are primarily responsible for the reimbursement rates for 3 or 10 percent of Medicaid provider groups. This group is different from the accountable are organizations in that each of the three provider groups in these categories have different managed care arrangements and contracts instead of one contract covering many services. Four counties without a managed care plan for the service, clients are served via fee-for-service.

Optional Provider Rate Increases	FY 2017	
	General Fund	Total Fund
Nursing Homes	$ 1,000,000	$3,400,000
Physicians	$ 1,000,000	$3,400,000
Pediatric Dentists	$ 700,000	$2,300,000
Total	**$ 2,700,000**	**$9,100,000**

FY 2017 included changes to reimbursement rates to at least nine of 29 Medicaid provider groups (eight increases and one decrease). The Legislature opted to provider rate increases totaling $2,700,000 ongoing General Fund beginning in FY 2017 to three groups as shown in the table above. Of the 29 categories of

provider rates, 13 or 45 percent have been raised in the last four years. Of the 13 reimbursement rates raised seven were raised directly raised by the State and six were raised automatically without additional legislative action.

The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health report to the Office of the Legislative fiscal analyst by January 1, 2018 on the feasibility and advisability of expanding Medicaid accountable care organizations into any of the remaining sixteen fee-for-service counties.

Agency Response: Oppose - "The Department of Health opposes this recommendation as it is currently proposed. The Department continues to evaluate on a regular basis the feasibility of moving the remaining counties to mandatory managed care. Our review of feasibility includes an analysis of potential cost savings and impact to Medicaid member access to care. Because the remaining sixteen counties are all rural counties and there are a limited number of providers available in those counties, the Department has not pursued this change and would not have meaningful information to report by January 1, 2018. The topic of [accountable care organization] expansion to additional counties merits an indepth review and could be a suitable subject for a future deep dive review."

Fee-for-Service

Fee-for-service payments are primarily responsible for 9 or 31 percent of Medicaid provider groups. Five of the nine provider groups received a reimbursement rate increase in FY 2017. All but three of these nine provider groups do not see a reimbursement rate increase unless the State decides to increase rates through additional appropriations. Seven of the nine groups have seen provider increases from FY 2014 to the present. Home and Community Based Waiver Contracts have not seen an increase at or above 0.1 percent since FY 2008 and chiropractors have not seen an increase since FY 2009. The three provider groups below have federal law requirements related to the rates paid:

1) Federally Qualified Health Center – for specifically designated medical clinics that qualify as federally qualified health centers, federal law via section 702 of the Benefits Improvement and Protection Act of 2000 says that Utah Medicaid must pay these clinics their full cost of providing Medicaid services. This is done through an annual adjustment at the end of each fiscal year and usually results in a payment that is higher than what Medicaid would normally pay.
2) Hospice – federal law requires that the hospice provider reimburse the nursing facility provider at 95 percent of the daily nursing home reimbursement rate. So when the State opts to change the nursing home daily rate, the hospice rate is automatically changed.
3) Rural Health Clinic – The State to pay these clinics at the cost of providing services in compliance with section 702 of the Benefits Improvement and Protection Act of 2000. This tends to result in annual increase in reimbursement to these clinics.

The table on the next page lists each provider group as well as annual reimbursement rate changes for fiscal years 2014 through 2017 and how rate changes are determined.

Accountable Care and Managed Care Organizations

Managed care plans (accountable care organizations, managed care organizations, and prepaid mental health plans) are primarily responsible for the reimbursement rates for 20 or 69 percent of Medicaid provider groups. In the table on page 32 there are four provider groups where the "how increases?" column indicates "decision." Since these are the rates paid to the managed care plans, the State contracts

with an actuary who sets the allowable range of rates that could be paid to the managed care organizations in accordance with federal requirements. The managed care plans determine for the other provider categories if changes in its reimbursement rate translates into changes in rates paid to providers. Additionally, the State can provide funding with the intent to increase specific provider groups' reimbursement rates, as it did for physicians and other practitioners in FY 2016. In FY 2017 at least five provider groups saw changes to their Medicaid reimbursement rates (four increases and one decrease). The four provider groups below have reimbursement rates that are changed automatically via state or federal law. The table on page 32 lists each provider group as well as annual reimbursement rate changes for fiscal years 2014 through 2017 and how rate changes are determined.

Medicaid Provider Group[1]	Payment Changes[2]	FFS Rate Changes[3] (Fiscal Year)				Last Increase	How Increases?[4]
		2014	2015	2016	2017		
Chiropractic	FFS	0.0%	0.0%	0.0%	0.0%	2009	decision
Federally Qualified Health Center	FFS	4.0%	3.2%	2.3%	2.5%	2017	federal law
Home/Community Based Waiver Contract	FFS	0.0%	0.0%	0.0%	0.0%	2008[5]	decision
Hospice	FFS	2.0%	2.0%	0.8%	1.1%	2017	decision/ federal law
Intermediate Care Facilities for Intellectually Disabled	FFS	0.0%	5.1%	1.8%	-0.1%	2016	decision
Medical Transportation	FFS	0.0%	0.0%	388%	1.6%	2017	decision
Nursing Facility	FFS	0.0%	3.8%	7.3%	1.9%	2017	decision
Rural Health Clinic	FFS	4.0%	3.2%	2.3%	2.5%	2017	federal law
School Based Skills Development	FFS	8.0%	0.0%	0.0%	0.0%	2014	decision
Count	**9**	**4**	**5**	**6**	**6**		

(1) Combined groups from a total of 63 provider types and 66 categories of services. Groups with insignificant expenditures have been excluded.

(2) FFS = fee-for-service where the State sets the reimbursement rate and clients find any Medicaid-enrolled provider willing to accept that reimbursement rate.

(3) Provider increases are shown as a percentage increase off of all providers in the category, even though some increases were only give to a subset of providers. Increases are given by increasing the per unit rate for specific procedures. Often a procedure will be used by multiple providers resulting in multiple categories receiving increases.

(4) Decision = all changes decided by the Legislature. Federal law = there is a law mandating automatic changes in rates paid.

(5) There have been other changes since 2008, but 2008 was the last time two of the waivers saw increases in the same year. Some subsequent increases did not register at 0.1% due to small size.

1) Accountable Care Organizations, Services Rate – UCA 26-18-405.5 requires an appropriation in the base budget to make per-member-per- month funding for Medicaid accountable care organizations at least 100 percent to 102 percent of the current fiscal year. The actual amount depends upon the projected growth rate of General Fund revenues.

Medicaid Provider Group[1]	Payment Changes[2]	FFS Rate Changes[3] (Fiscal Year)				Last Increase	How Increases?[4]
		2014	2015	2016	2017		
Dental Services (65% HMO 35% FFS)	HMO	0.0%	2.8%	12.6%	3.8%	2017	decision
Mental Health	HMO	0.0%	0.0%	0.0%	0.0%	2002	decision
Substance Abuse Treatment	HMO	0.0%	0.0%	0.0%	0.0%	2002	decision
Accountable Care Organizations, Administrative Rate[5]	ACO	10.2%	-9.3%	8.4%	0.0%	2016	decision
Accountable Care Organizations, Services Rate[5]	ACO	1.0%	2.0%	2.0%	2.0%	2017	state law
Ambulatory Surgical	ACO	0.0%	0.0%	0.0%	0.0%		contract
End Stage Renal Disease (Kidney Dialysis)	ACO	0.0%	0.0%	0.0%	0.0%		contract
Home Health	ACO	0.0%	0.0%	0.0%	0.0%		contract
Independent Lab and/or X-Ray	ACO	0.0%	0.0%	0.0%	0.0%		contract
Inpatient Hospital	ACO	0.0%	0.0%	0.0%	0.0%		contract
Medical Supply	ACO	0.0%	0.0%	0.0%	0.0%		contract
Other	ACO	0.0%	0.0%	0.0%	0.0%		contract
Outpatient Hospital	ACO	1.9%	1.8%	1.7%	2.1%	2017	Medicaid plan
Personal Care	ACO	0.0%	0.0%	0.0%	0.0%		contract
Pharmacy	ACO	3.5%	1.9%	1.6%	4.9%	2017	Medicaid plan
Physical & Occupational Therapy	ACO	0.0%	0.0%	0.0%	0.0%		contract
Physicians & Other Practitioners	ACO	0.0%	0.0%	26.3%	-11.1%	2016	contract
Podiatry	ACO	0.0%	0.0%	0.0%	0.0%		contract
Speech and Hearing	ACO	0.0%	0.0%	0.0%	0.0%		contract
Vision Care	ACO	0.0%	0.0%	0.0%	0.0%		contract
Count	**20**	**4**	**5**	**6**	**5**		

(1) Combined groups from a total of 63 provider types and 66 categories of services. Groups with insignificant expenditures have been excluded.

(2) ACO = accountable care organizations who serve about 84% of Medicaid clients statewide in thirteen counties since FY 2016 (the remaining 16% of clients in sixteen rural counties are served by fee-for-service) and HMO = health maintenance organization/managed care plans for separate services provided by managed care organizations.

(3) Provider increases are shown as a percentage increase off of all providers in the category, even though some increases were only give to a subset of providers. Increases are given by increasing the per unit rate for specific procedures. Often a procedure will be used by multiple providers resulting in multiple categories receiving increases.

(4) Contract = providers might receive a rate increase from their contractor when the contractor's rates are increased. Decision = all changes decided by the Legislature. State law = there is a law mandating automatic changes in rates paid. Medicaid plan = the state has decided to make these changes

(5) The rate increases listed for these provider groups were given on a calendar year basis.

2) Outpatient Hospital – the State has historically decided to keep outpatient hospital reimbursement rates at 100 percent of Medicare rates. So when Medicare rates change, then the State rates change automatically.

3) Pharmacy – the State pays for drugs based on the lowest of four calculations. These four calculations result in annual increases to the reimbursement rates paid to this provider group.

The Department of Health uses the Medicaid Management Information System to reimburse providers. This claims system had a General Fund cost between $2,026,000 to $3,376,000 during years FY 2012 to FY 2016.

Category ($ in Millions)	Total Funds	Federal Funds	State Funds	Provider Contributions	Local Gov. Funds	Client Contributions	Other Funds
	FY 2012						
Medicaid Total Spending	$2,062	$1,425	$477	$ 128	$ 16	$ 14	$ 3
Minus Medicaid Administration	$ (98)	$ (53)	$ (44)	$ (1)	$ (0)	$ (0)	$ (0)
Medicaid Services Spending	**$1,964**	**$1,371**	**$433**	**$ 127**	**$ 16**	**$ 14**	**$ 3**
	FY 2013						
Medicaid Total Spending	$2,195	$1,497	$494	$ 154	$ 30	$ 15	$ 4
Minus Medicaid Administration	$ (100)	$ (56)	$ (43)	$ (1)	$ (0)	$ (0)	$ (0)
Medicaid Services Spending	**$2,095**	**$1,441**	**$451**	**$ 154**	**$ 30**	**$ 15**	**$ 4**
	FY 2014						
Medicaid Total Spending	$2,378	$1,654	$528	$ 147	$ 26	$ 21	$ 2
Minus Medicaid Administration	$ (116)	$ (75)	$ (40)	$ (0)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,262**	**$1,579**	**$488**	**$ 147**	**$ 25**	**$ 21**	**$ 2**
	FY 2015						
Medicaid Total Spending	$2,438	$1,687	$546	$ 166	$ 23	$ 17	$ 0
Minus Medicaid Administration	$ (118)	$ (75)	$ (42)	$ (1)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,320**	**$1,612**	**$504**	**$ 165**	**$ 22**	**$ 17**	**$ 0**
	FY 2016						
Medicaid Total Spending	$2,548	$1,755	$580	$ 169	$ 27	$ 16	$ 1
Minus Medicaid Administration	$ (126)	$ (79)	$ (46)	$ (1)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,422**	**$1,676**	**$535**	**$ 168**	**$ 26**	**$ 16**	**$ 1**
Sources:							
Issue Brief - 2017 General Session - Medicaid Spending Statewide							
2016 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2016 Interim - Medicaid Spending Statewide							
2015 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2015 Interim - Medicaid Spending Statewide							
2014 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2014 General Session - Medicaid Spending Statewide							
2013 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2013 General Session - Medicaid Spending Statewide							
2012 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2016 Interim - Medicaid Collections, What is the Bang for our Buck?							

What Are we Buying and How Are we Paying for it?

The State of Utah spent $2.0 billion total funds in FY 2012 and $2.4 billion total funds in FY 2016 on reimbursement for Medicaid services. The sources from FY 2012 through FY 2016 for funding Medicaid provider reimbursement are listed in the table on the previous page. Additionally, there is a brief discussion of each funding type and if the funding type could be increased.

Are there any options to increase federal funds? Yes

The federal government pays a percentage changed annually each October of all the State's medical claim costs for Utah. This percentage is known as Federal Medical Assistance Percentage (FMAP) and in Utah has normally been around 70 percent from FY 2013 through FY 2018. The federal government utilizes a formula to determine its annual percent of FMAP based on a rolling three-year average of per capita income levels compared to the national average. Below is a discussion of some options to increase federal funds:

1. **Utah's per capita income levels** - If Utah's per capita income levels went down compared to the national average, then the federal government would pay a higher percentage of medical claim costs.
2. **Move claims to higher federal match rate categories** - The only other way to increase federal participation is to move medical claims into category types that receive a higher federal match rate. The federal government pays 100 percent of the costs for American Indian and Alaskan Native Medicaid clients using Indian Health Services. The federal government would also pay 100 percent for outside services referred by Indian Health Services providers if the State submitted State Plan Amendment and there is a care coordination agreement with the outside provider. Based on FY 2015 spending levels, if all outside services referred by Indian Health Services providers were moved to 100 percent paid by the federal government, this would save the State approximately $1.6 million ongoing General Fund. Health indicates: "[Health] does not consider this to be a viable budget reduction. Medicaid recipient participation is voluntary for [Indian Health Services]/Tribal Facilities and there is no incentive for them to participate, since it is the State that receives the enhanced rate… In addition, there is a significant administrative impact to the State to properly identify and track all care-coordination agreements, as well as to try to link the agreements to the claims as they are submitted to ensure that we can draw down the enhanced federal match. More recent guidance has introduced the option for tribal facilities to enroll as FQHC 'look alike', which would provide an opportunity to draw down the enhanced federal match for American Indians and Alaskan Natives receiving services as these facilities. Because of the impact of care coordination agreements and the lack of geographic access to these Tribal facilities, the approximate savings of $1.6 million is significantly overstated."
    a. *The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee requests the Department of Health to provide an update on the status of moving more Medicaid claims from American Indian and Alaskan Native Medicaid clients to a higher match rate by June 1, 2018. The update shall an include a best guess on the outlook of potential savings.*
        i. **Agency Response:** Support - "The Department of Health is supportive of this request and can provide information on how many, if any, tribal facilities have enrolled as an FQHC 'look alike' provider and whether enrollment of these identified facilities has increased the Department's ability to claim additional enhanced federal matching funds."

Public School Enrollment, by School District, Utah			
School District	FY 2017	Medicaid Enrollment	Estimated Medicaid Enrollment
Alpine	77,343	464	
Beaver	1,519	4	
Box Elder	11,572	128	
Cache	17,536	254	
Canyons	34,017	403	
Carbon	3,348	57	
Daggett	183	#N/A	2
Davis	71,021	706	
Duchesne	5,009	-	
Emery	2,174	#N/A	20
Garfield	904	4	
Grand	1,483	5	
Granite	67,177	559	
Iron	9,074	#N/A	83
Jordan	52,507	367	
Juab	2,513	-	
Kane	1,256	0	
Logan	5,719	118	
Millard	2,840	18	
Morgan	2,994	6	
Murray	6,494	60	
Nebo	32,437	425	
North Sanpete	2,360	10	
North Summit	1,042	#N/A	9
Ogden	12,192	193	
Park City	4,891	#N/A	45
Piute	280	#N/A	3
Provo	17,840	234	
Rich	497	#N/A	5
Salt Lake	23,047	251	
San Juan	2,940	28	
Sevier	4,513	-	
South Sanpete	3,221	74	
South Summit	1,574	#N/A	14
Tintic	244	#N/A	2
Tooele	14,332	115	
Uintah	7,034	58	
Wasatch	6,605	27	
Washington	29,355	238	
Wayne	450	-	
Weber	31,445	229	
District Total	572,982	5,033	182
# School Districts	41	32	9
% Medicaid Eligible		1%	
Total Medical Claims		$ 28,282,400	$ 1,000,000
Total Seed		$ 7,716,100	$ 300,000

3. **Full Adult Medicaid Expansion** - The Department of Health suggests the following as options to increase federal funds – "If the State were to implement a full adult expansion, the state would be able to draw an enhanced federal match rate, which would result in a significant increase in federal funds. To the extent that the State is willing to provide additional funding to increase provider rates, the federal government will match those increases at Federal Medical Assistance Percentage (FMAP)."
4. The Department of Human Services provided the following option to increase federal funds:
    a. "Further extend the current Medicaid extension from 0% to X% FPL with qualifying [mental health/substance use disorder] condition. Only full expansion allows [Division of Substance Abuse and Mental Health] to return state funds as there would continue to be a large uninsured population with partial expansion scenarios."
        i. **Agency Response:** Support - "[Division of Substance Abuse and Mental Health] appreciates the Legislature's efforts to meet the treatment need of people in extreme poverty with mental health and substance use disorders. Further expansion provides people with a defined benefit vs safety net status which encourages prevention, treatment and recovery support. Federal participation in this scenario only gives the state a 70/30 match rate for the population to be covered. Without full expansion funds continue to be needed to meet existing need for the safety net population."
5. **School Districts** – in FY 2017 32 of 41 school districts submitted claims for providing Medicaid medical services at school for 1 percent of its students who were eligible for school-based services. If that same 1 percent Medicaid eligibility for school-based services applied to the enrollment of the remaining nine school districts who did not participate in FY 2017, those nine school districts might be able to receive $1,000,000 total funds from Medicaid at a cost of providing $300,000 match. Stated another way for $1,000,000 in medical costs coming from local funds before, the school districts might be able to pay $300,000 and receive $700,000 federal funds to help cover the same expenses. For more information please see the table on the previous page.
6. **Charter Schools** – in FY 2017 2 of 108 charter schools submitted claims for providing Medicaid medical services at school for 3 percent of its students who were eligible for school-based services. Since there were only two participating charter schools, there is no enough data to estimate Medicaid eligible students and claims among the non-participating charter schools. For more information please see the table in Appendix D.
    a. *The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee intends that the Department of Health work with the Utah State Office of Education to encourage school districts and charter schools with large student populations to bill Medicaid for eligible medical services provided at school. The Department of Health shall work with the Utah State Office of Education to provide a report on the status of and financial impact to newly participating school districts and charter schools to the Office of the Legislative fiscal analyst by June 1, 2018.*
        i. **Agency Response (Health):** Neutral - "While the Department can work with the Utah State Board of Education, we cannot mandate that a school district or charter school participate in the program. School districts may face significant costs to implement the administrative tracking and it may not be cost effective for them to do so. In addition, the school districts and charter schools provide the state match to fund this program. The

state match provided by the schools are subject to 42 CFR 433 Subpart B which requires that state matching funds are voluntary and are not being required through statute, rule, or otherwise. Additionally, the Department of Health cannot mandate that Medicaid eligible students participate in the program. Pursuant to 34 CFR 300.154(d) parental consent is required to bill Medicaid or any other insurer and a parent may withhold their consent to bill."

If the Legislature wanted to increase federal funds via full adult Medicaid expansion or increasing the income eligibility level for Utah's Medicaid extension, then the Legislature would want to open a bill file(s) or pursue other legislative action.

Are there any options to increase state funds? Yes

The vast majority of these funds are from discretionary legislative appropriations from the General Fund with a little bit from the Education Fund. There are also some dedicated credits. The table below details the sources for non-General Fund sources from FY 2012 through FY 2016 and if there any options to increase each revenue source:

Non-General Fund State Fund Sources for Medicaid Services ($ in Millions)	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	Option to Increase?
Office of Recovery Services	$ 8	$ 10	$ 8	$ 10	$ 10	Yes
Recovery Audit Contractors	$ 2	$ 3	$ 5	$ 2	$ 1	No
Attorney General's Medicaid Fraud Control Unit	$ 4	$ 12	$ 20	$ 5	$ 7	Yes
Office of Inspector General	$ 1	$ 2	$ 0	$ 1	$ 2	Yes
Education Fund	$ 5	$ 7	$ 8	$ 7	$ 7	Yes
UTA seed money	$ 0.3	$ 0.3	$ 0.4	$ 0.5	$ 0.6	No
Total	**$ 21**	**$ 34**	**$ 42**	**$ 26**	**$ 28**	
% of all Medicaid Services Non-Federal Funds	**4%**	**5%**	**6%**	**4%**	**4%**	
Clients	289,950	296,260	304,658	325,410	335,888	

Below is a discussion of some options to increase state funds:

1. **Increasing collections** – there are four entities involved in collections for Medicaid - Department of Human Services' Office of Recovery Services, Attorney General's Medicaid Fraud Control Unit, Recovery Audit Contractors, and Office of Inspector General. Below is a discussion of each entity and options for that entity to increase its collections.
    a. Department of Human Services' Office of Recovery Services (ORS) – pursue third parties with financial responsibilities for a Medicaid client's medical costs. The department recovered for the State $4.6 million in FY 2016 in estate recoveries for clients who used long term care services in Medicaid. The department believes the following changes may help to increase estate collections but cannot quantify a specific impact. Some changes would require a statutory change to implement.
        i. **Surviving Spouse, Waiver vs. Deferral** – *The fiscal analyst recommends that Social Services Appropriations Subcommittee consider passing the following motion: The Social Services Appropriations Subcommittee directs the Department of Health to amend the State plan to pursue estate collections for Medicaid clients using long term care services after a*

surviving spouse has died. The Department of Health is to end the practice of waiving state claims to estates because there is a surviving spouse by December 31, 2017.

1. Currently, the State of Utah waives its claim to an estate of a Medicaid client using long term care services if there is a surviving spouse. The department recommends the state just defer its claim until the surviving spouse passes away, rather than waive it.
2. **Agency Response (Health):** Support - "The Department of Health is supportive of this recommendation and would submit the required SPA if the Legislature makes the direction to do so. However, eliminating the referenced waiver is contingent upon [Centers for Medicare and Medicaid Services] approval of the SPA, which may not be received by the December 31, 2017 date"

ii. **TEFRA (Tax Equity and Fiscal Responsibility Act) Liens** – *The Legislature may want to open a bill file to allow the department to place a lien against a client's estate once the client enters into permanent long-term care paid for by Medicaid.*

1. Currently, the department may only place a lien once a client has passed away, which makes collections on estates more difficult.

iii. **Require Probate to Notify ORS of All Actions** – *The Legislature may want to open a bill file to require all parties to notify the state of any probate actions. This action may help improve estate collections by the State for Medicaid long term care expenses incurred.*

1. This change may help the department to place liens on more property before it is sold or transferred to pay for a client's use of Medicaid long term care services.

iv. **Agency Response:** Support - "The Office of Recovery Services supports the three suggestions above. Each suggested change represents increased opportunities to recover funds for Medicaid by closing some existing loopholes that currently make recovery either impossible or difficult."

v. For the full response by the Office of Recovery Services on options for increasing collections, please see Appendix A.

b. Attorney General's Medicaid Fraud Control Unit – criminal prosecution of fraud, waste, and abuse in the Medicaid program. This entity recommends the following to potentially increase collections:

i. **Adopt a Comprehensive False Claims Act** – such an act allows private citizens to bring lawsuits against violating corporations. Some of the collections would be shared with the private citizens who instigated lawsuits. The federal government would allow the state of Utah to increase its share of recoveries by 10 percent. The unit may need additional staff to handle complex health care litigation.

1. *The Legislature may want to consider opening a bill file to enact a comprehensive false claims act.*
2. **Agency Response:** Neutral - "The Attorney General's Office is neutral on policy matters which reside in the discretion of the Utah legislature."

ii. For the full response by the Medicaid Fraud Control Unit on options for increasing collections, please see Appendix B.

c. Office of Inspector General – recovery of overpayments to medical providers. This entity recommends the following two options to increase its collections:
   i. **Use of Extrapolation** – "The Office would support a change to this law that allows extrapolation. We can currently meet all of the requirements as outlined in the code except for the $200,000 threshold. We would like to see that reduced to $25,000. This change could potentially produce an additional $1 million in recoveries annually."
      1. *The Legislature may want to consider opening a bill file to lower the extrapolation threshold from $200,000 to $25,000.*
         a. **Agency Response:** Support - "The Office would support a change to this law that allows extrapolation."
   ii. **Updated Data Analysis Tools** - "If the Office is permitted the one time funds to acquire a data analysis tool…It is not possible to adequately quantify how much recovery improved data analytics capability could have on recoveries, but…recoveries may increase by as much as $1.5 million annually."
      1. *When the Office of Inspector General proposes funding for a new data analysis tool, the Legislature may want to consider granting that request.*
         a. **Agency Response:** Support - "We believe it will increase recoveries based on our ability to more effectively and efficiently perform those tasks associated with recovery of inappropriately billed/paid funds."
   iii. For the full response by the Office of Inspector General on options for increasing collections, please see Appendix C.

d. Recovery Audit Contractors – contractors historically paid on a contingency fee basis to recoup overpayments to providers. S.B. 61, *Medicaid Audit Amendments*, required these types of contracts to be paid a flat fee. The Department of Health submitted the following on August 21, 2017 in response to a request for options to increase collections: "The Department of Health (Department) is focused on efforts to increase collections while minimizing duplication of collection efforts among the different agencies performing Medicaid collections. The Department is currently working to finalize a new contract with the vendor selected as the Recovery Audit Contractor (RAC). Throughout this process, the Department evaluated and modified contract language in an effort to potentially increase collections made by the RAC. In the previous contract, the RAC was not permitted to collect Third Party Liability (TPL) for at least 1 year after payment. The new contract allows the RAC to pursue collection on TPL claims under $100 immediately, to pursue collection on TPL claims not flagged by ORS after 1 year, and to pursue collection on any claims with uncollected TPL after 2 years. The Department believes this will increase the collections made by the RAC, however, without experience data, it is not yet possible to quantify the projected impact to the RAC collections." The current contract with the Recovery Audit Contractor is effective as of September 1, 2017.

2. **Utah Transit Authority seed money** – In FY 2016 the Utah Transit Authority transferred $642,400 seed money "to Division of Services for People with Disabilities, which is used to draw Medicaid for transportation services"
3. **Education Fund** – please see the discussion for school districts and charters schools in the "Are there any options to increase federal funds? Yes" section.

Are there any options to increase provider contributions? Yes

The federal government limits the maximum amount available from provider assessments in two primary ways:

1) Each assessment may not exceed 6 percent of revenues for that service provider category.
2) Assessments may not be used for more than 25 percent of a State's match used for Medicaid. For FY 2016 Utah the Department of Health indicates that it had 15.6 percent of its state match from provider assessments; however, the funds from intergovernmental transfers are excluded which changes the percentage to 8.8 percent.

Assessments are assessed on providers uniformly and used to increase that provide group's reimbursement. The table below details the sources for provider contributions from FY 2012 through FY 2016 and if there any options to increase each revenue source:

Provider Contribution Sources for Medicaid Services ($ in Millions)	Source	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	Option to Increase?
Hospital Assessment	companies	$ 42	$ 48	$ 49	$ 47	$ 47	Yes
Pharmacy Rebates	companies	$ 26	$ 28	$ 26	$ 40	$ 40	No
Nursing Home Assessment	companies	$ 21	$ 23	$ 23	$ 24	$ 27	Yes
Inpatient Payment Seeds	U Hospital	$ 19	$ 29	$ 25	$ 27	$ 19	No
Physician Enhancement	U Hospital	$ 9	$ 17	$ 13	$ 11	$ 14	No
Outpatient Hospital Upper Payment Limit	U Hospital	$ -	$ -	$ 3	$ 6	$ 8	No
Disproportionate Share Hospital	U Hospital	$ 7	$ 7	$ 6	$ 5	$ 7	No
Ambulance Assessment	companies	$ -	$ -	$ -	$ -	$ 3	Yes
Healthy U Health Plan	Healthy U	$ 3	$ 3	$ 3	$ 5	$ 3	No
Total		**$ 127**	**$ 154**	**$ 147**	**$ 165**	**$ 168**	
% of all Medicaid Services Non-Federal Funds		**21%**	**24%**	**22%**	**23%**	**23%**	
Clients		289,950	296,260	304,658	325,410	335,888	

1. The list below explains where each assessment is at relative to the 6 percent cap and how much more could be assessed if the assessment were taken to 6 percent based on FY 2017 revenue as well as FY 2017 preliminary closing fund balances as of September 9, 2017.
    a. Hospital Assessment – recently at 1.8 percent, an additional $105 million could be charged. Fund balance is $4,877,900. This assessment has not been changed since implementation. H.B. 437, *Health Care Revisions*, from the 2016 General Session approved a new hospital assessment, but the assessment has not started yet.
    b. Nursing Home Assessment - Fund balance is $0.
        i. Nursing Facility – recently at 5.6 percent, an additional $1.8 million could be charged. With the budget actions from the 2017 General Session, the nursing facility assessment has reached it maximum cap.
        ii. Intermediate Care Facilities for individuals with Intellectual disability – recently at 4.9 percent, an additional $0.4 million could be charged. The Legislature last changed this assessment in FY 2014.

c. Ambulance Assessment – recently at 3.5 percent, an additional $2.2 million could be charged. This assessment has not been changed since implementation; however, the assessment is based on the need to fund an increased ground ambulance transportation rate which has increased each year since implementation of the assessment. Fund balance is $500.

2. Pharmacy Rebates - the Department of Health states: "The Department has fully implemented a [preferred drug list] that has targeted all significant drug classes. The Department will continue to analyze the [preferred drug list] on a regular basis to maximize the savings. These savings come in part from increased supplemental rebates or from market shifts that decrease costs."

If the Legislature wanted to increase Medicaid funds from current provider contributions, then it may want to consider raising one or all four current provider assessments via opening a bill file(s) or other legislative action.

Agency Response: Neutral - "The Department of Health is neutral on this recommendation; however, the State could not increase any assessment beyond the federal maximum of 6% of a provider groups' total revenues."

Are there any options to increase local government funds? Yes

The table below details the sources for local government funds from FY 2012 through FY 2016 and if there are any options to increase each revenue source:

Local Government Funds for Medicaid Services ($ in Millions)	Source	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	Option to Increase?
Capitated Mental Health	counties	$ 9	$ 21	$ 12	$ 8	$ 10	Yes
Nursing Facility Upper Payment Limit	local gov.	$ -	$ -	$ 3	$ 6	$ 8	No
School Districts and Charter Schools	schools	$ 5	$ 6	$ 8	$ 7	$ 6	No
Disproportionate Share Hospital	local gov.	$ 1	$ 2	$ 2	$ 1	$ 1	No
Substance Abuse	counties	$ 0	$ 1	$ 1	$ 1	$ 1	Yes
Total		**$ 16**	**$ 30**	**$ 25**	**$ 22**	**$ 26**	
% of all Medicaid Services Non-Federal Funds		**3%**	**5%**	**4%**	**3%**	**3%**	
Clients		289,950	296,260	304,658	325,410	335,888	

1. The Department of Human Services provided the following options to increase funds:
   a. "Full Medicaid expansion."
      i. **Agency Response:** Support - "Full Medicaid Expansion is the best case scenario for [Division of Substance Abuse and Mental Health] as Federal participation is currently at 90/10 match rate for this population. In this scenario [Division of Substance Abuse and Mental Health] can give [state General Fund] to support the cost of expansion on the [substance use disorder] side due to the low numbers of Medicaid enrollees due to current eligibility requirements."
   b. "Revisit 80/20 partnership between Counties and State."

i. **Agency Response:** Support - "The current partnership arrangement between the State and Counties for the provision of mental health and substance use disorder, prevention, treatment and recovery support services was established in Code in the 1980's and revisited briefly through Medicaid Capitation in the 1990's when Medicaid Mental Health Capitation first began. The Federal Medicaid rules and regulations governing revenue, profit and administration of services as well as interpretation by [Centers for Medicare and Medicaid Services] Region IX office has changed over the years creating a different playing field than existed when the initial agreements were entered into in the 80's and 90's. Without an automatic increase built into base rates or increasing Medicaid Eligibles, County's had to prioritize Medicaid contracted services over safety net services and for some Local Authorities all of their State funds had to be diverted to keep up with the needs of the Medicaid population. Health Homes, [accountable care organization]'s (Capitation on the Physical Health side of Medicaid), [Medicare Access and CHIP Reauthorization Act], Value-Based Payments and other developments may be important elements to include in these types of discussions. In addition, connections with other critical social services ([Division of Child and Family Services], [Division of Juvenile Justice Services], [Division of Services for People With Disabilities], [Department of Workforce Services], etc.) safety net services (Affordable Housing, Homelessness, Employment, Transportation, Food Pantries, etc.) and criminal justice services are increasingly important and demanding for Local Mental Health and Substance Abuse Authorities to meet for the success of people receiving services. Revisiting the partnership, including the County's obligation to match certain State funding at 20% with County General Fund would be beneficial for all parties."

If the Legislature wanted to increase Medicaid funds from local governments, then it may want to consider full adult Medicaid expansion and/or revisit the 80/20 state/local county partnership.

Are there any options to increase client contributions for categories that had more than $100,000 in revenue for FY 2016? Yes

1. **Prescription Drugs** – Utah will soon charge the highest copay for all drug classes like Oklahoma at $4. The copay will change from $3 to $4 effective October 1, 2017.
2. **Inpatient Hospital Stay** – The Department of Health changed this copayment from a $220 copay to $75 per visit effective July 1, 2017.
3. **Non-Preventive Physician Visit** –The Department of Health will change this copayment from $3 to $4 effective October 1, 2017.
4. **Outpatient Hospital Services**
    a. **Non-Emergency Use of the Emergency Room** – The Department of Health will change this copayment from $6 to $8 effective October 1, 2017. South Dakota charges its clients the full cost, which it does this by excluding non-emergency use of the emergency room as a covered service. On August 15, 2017, the Department of Health submitted a request to the federal government to raise the copay to $25 for parents.
    b. **Outpatient Hospital Services** –The Department of Health will change this copayment from $3 to $4 effective October 1, 2017.

5. For a list of each states' copay levels please see Appendix E.

If the Legislature wanted to exclude non-emergency use of the emergency room as a covered service in Medicaid as is done in South Dakota, then the Legislature would want to open a bill file.

Agency Response: Neutral - "South Dakota implements its no pay policy in conjunction with a health home model and a 24/7 nurse hotline. Fee for service Utah Medicaid does not have these additional services today and the State would have to invest in these services to support a no pay model. In addition, in other areas, [accountable care organization]'s would need to provide these type of supportive services."

Are there any options to increase other funds? Yes

The largest other fund revenue source is the revenue collected by the State's three medical clinics (Health Clinics of Utah) and two dental clinics (Family Dental Plan, which includes the Community Partnered Mobile Dental Services). The Department of Health suggested the three options below as options to increase other funds:

1. "The Department of Health believes that actions to increase medical service agreements with health insurance companies, enhance integrated mental/behavioral health services, and increase services provided to other state agencies could result in an approximately $15,000 or 10% increase in related revenues for clinics annually. The Health Clinics of Utah currently have service agreements with health insurance companies such as Molina and SelectHealth to provide annual comprehensive exams, assist restricted Medicaid patients, and serve PEHP patients at discounted rates. Existing mental/behavioral health services (including VOA Cornerstone and on-site therapy) can be further developed to increase grant funding, along with reimbursement for implementation of the new OARS drug abuse screening tool, and more robust referral networking with Weber Human Services. Beyond the agreements that the Health Clinics of Utah already has with state agencies (including Dept. of Corrections, Juvenile Justice, Highway Patrol, Child & Family Services, and Refugee Program). Increasing services to these agencies by 10% (through new or expanded agreements with state agencies) is projected to potentially increase revenues by approximately $12,000 annually. With the recent implementation of dental coverage to the disabled and blind population on Medicaid, the Family Dental Plan has experienced an increase in new patients requesting appointments. This new demand has increased wait times for dental appointments from two weeks to five weeks. Family Dental Plan has equipped two operatories with wheelchair lifts to accommodate patients with disabilities."
2. "The last major change in this area came with the state policy establishing the Health Clinics of Utah and Family Dental Plan as PEHP "value clinics" (where state employees could receive health care services at a discounted rate), the recent expansion of dental services to Medicaid members who are blind or disabled, and a newly approved TASC grant that will pay Health Clinics of Utah to provide laboratory testing and primary care exams for parolees."
3. "The Department of Health also lists additional options to increase other fund revenue such as the Family Dental Plan's new School Based Sealant program which provides dental services to Title I schools in Salt Lake County. The Health Clinics of Utah is also initiating an agreement to provide annual exams for military veterans, which is anticipated to bring in additional revenue. Besides the critical issue of increasing revenue, our clinics have also been extremely conscientious in implementing new tracking and reporting practices in order to monitor expenditures and evaluate expense trends in order to maximize our operational cost efficiency."

What Non-governmental Sources Are Involved?

The federal government in 42 CFR 431.10 requires a single state agency to be responsible for the supervision of the Medicaid program. In Utah the single state agency for Medicaid is the Department of Health. States have the option to delegate the administration of Medicaid and delivery of services to other government or private entities. Below is a list of some of the functions performed in Utah Medicaid by non-governmental sources:

1) Provision of medical and dental services done by over 7,900 mostly non-governmental providers in 2016
2) Actuarial certification of managed care rates includes work by contracted actuaries and CPA firms.
3) Point of Sale and Drug Rebate Management System run by Change Healthcare

The Department of Health runs three medical and two dental clinics. These clinics have brought in less revenue than expenditures, with the average annual deficit over the past five years being $2.29 million. Revenue has increased after the state passed discounts for PEHP members to use the state's clinics, and the ability to serve more commercial insurance members (such as PEHP) will continue to increase revenue and offset uninsured and Medicaid patients. The clinics' free volunteer medical services are a direct cost avoidance for the state. The clinics contribute to systemic cost savings by providing accessible care that diverts patients from the emergency room. The clinics have also been shown to be more cost effective to the State compared to Federally Qualified Health Centers because the clinics accept the lower Medicaid reimbursement rates and are exempt to end of year cost settlement adjustments.

The make up of clients using the State's dental clinics has changed from 44 percent from Medicaid, 15.2 percent PCN & CHIP, and 27 percent private pay/uninsured in FY 2013 to 66 percent Medicaid, 7 percent PCN & CHIP, and 9 percent private pay/uninsured. The make up of clients using the State's medical clinics has changed in the last five years from 56 percent from Medicaid & Medicare, 9 percent from PCN & CHIP, and 13 percent from private pay/uninsured in FY 2013 to 54 percent from Medicaid & Medicare, 14 percent from PCN & CHIP, and 16 percent in FY 2017. The state clinics are in provider networks with all Medicaid accountable care organizations.

Is it time to shut down the state's medical and dental clinics? Are they still serving an appropriate purpose?

Agency Response: Oppose - "The Department of Health opposes shutting down the state's medical and dental clinics. Our clinics (including our mobile clinics) are critical access points for underserved and uninsured populations throughout the state and constitute a medical and dental home for thousands of Medicaid, PCN, and CHIP patients. Our clinics are an asset to the State as a system that saves costs in the form of volunteer medical care, emergency room diversion, avoidance of cost-based reimbursement and annual cost settlements required by FQHCs, and providing primary care and preventive services for patients who might otherwise overburden the system with late-stage diagnoses requiring more expensive therapies. Not only are the State's clinics serving an appropriate purpose, they are filling a critical service gap for thousands of patients whose options for accessible, affordable care are becoming more and more elusive."

What are Other States Doing for Medicaid Reimbursement Rates?

What is the Current State of the States for Use of Medicaid Provider Assessments?

According to the Kaiser Commission on Medicaid and the Uninsured Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates in October 2016, as of FY 2016 all 50 states except for Alaska had at least one Medicaid provider assessment. Utah is one of 11 states with four Medicaid provider assessments. Six states have more provider assessments than Utah, with a total of five assessments (Kentucky, Missouri, New Jersey, New York, Pennsylvania, and West Virginia). Thirty-three states have less provider assessments than Utah ranging from three to zero. For a list of each states' Medicaid provider assessments please see Appendix I.

Other states have the following provider assessments that are not currently used in Utah:

1. Managed care – used by 10 states
2. Ambulatory surgical centers – used by 5 states (Connecticut, Massachusetts, New Jersey, West Virginia, and Wisconsin)
3. Home health – used by 3 states (Kentucky, New York, and Vermont)
4. Prescription drugs - used by 3 states (Alabama, Louisiana, and Missouri)
5. Service provider tax – used by 2 states (Maine and Minnesota)
6. Personal care – used by 1 state (New York)
7. Independent laboratory or X-ray services – used by 1 state (West Virginia)
8. Psychiatric residential treatment facilities – used by 1 state (Mississippi)

If the Legislature wanted to increase provider rates for specific provider groups and/or increase funding resources for Medicaid, then the Legislature may want to consider implementing one of the eight provider assessments used in other states or explore an entirely new provider assessment.

Agency Response: Neutral - "The topic of provider assessments merits an indepth review and could be a suitable subject for a future deep dive review."

What are Some Examples of States with Strict Policies for Medicaid Provider Reimbursement?

The following three states have a reimbursement rate system that may be of interest to Utah. Staff from the National Conference of State Legislatures suggested these three states as "states that have strict policies for Medicaid provider reimbursement."

1. Missouri – withholds five percent of payments to its managed care health plans and pays that out up to one percent based on the plan's performance in each of the following areas (please see "Managed Care Contract effective May 1, 2017" at http://dss.mo.gov/business-processes/managed-care/ for more information):
    a. Accuracy of submitted encounter data (98 percent or more)
    b. Primary care providers and psychiatrists
        i. accuracy rate for online listing or participating providers (90 percent or more)
        ii. providers accepting new members (80 percent or more)
    c. Well-child visits for children ages 0 to 6 (80 percent or more)
    d. Care management

i. Complete initial assessment of pregnant women within 15 business days (80 percent or more or 10 percentage points improvement)
ii. Timeliness for children with elevated lead levels (80 percent or more)

e. Medicaid reform and transformation activities
i. Client participation in approved incentive program (15 percent or more)
ii. Provider participation in approved incentive program (10 percent or more)
iii. Client participation in Local Community Care Coordination Program (20 percent or more)

2. Alabama –Alabama previously was working towards having two or more non-profit regional care organizations in each of five regions covering the entire state providing many medical and behavioral services to about 2/3 of its Medicaid clients in exchange for a fixed payment. These organizations were to be governed by local boards. Please see http://medicaid.alabama.gov/documents/5.0_Managed_Care/5.1_RCOs/5.1.1_RCO_Basics/5.1.1_RCO_Fact_Sheet_2-9-16.pdf for additional information. The State of Alabama decided to abandon these proposed changes effective July 27, 2017.
a. What are some of the services that are excluded? "Excluded services include home and community-based waiver services (HCBS), targeted case management, nursing home care, pharmacy services, dental care and school-based services."
b. What are some of the populations that are excluded? "Foster children, people who have both Medicare and Medicaid, and those recipients who reside in a 2/9/16 nursing facility or receive long-term care services and supports such as HCBS waiver services, will continue to receive care via the current fee-for-service system."

3. Mississippi – "Dr. Dzielak (our Medicaid Director) has repeatedly stated that we are one of the most codified Medicaid agencies in the country. Most of our Medicaid reimbursement methodologies are included in the…code section (§ 43-13-117), including inpatient (APR-DRG) and outpatient (APC) hospital, nursing facility (case mix adjusted per diem), and physician payments (90% of Medicare). Our Division of Medicaid staff also note they are limited in what they can modify without authorizing legislation by § 43-13-117 (D). There are also several restrictions placed on the managed care program in § 43-13-117 (H). For example, the managed care companies are required to pay providers at a rate no less than Medicaid fee-for-service. According to our Division of Medicaid staff, this is uncommon and that most states with managed care programs allow the managed care companies to negotiate rates with providers" (8/30/2017 email from analyst in the Mississippi Joint Legislative PEER Committee).

If the Legislature wanted to pursue any changes in Utah like those in Missouri or Mississippi, then a bill file(s) would need to be opened.

Agency Response: Neutral - "The Department is supportive of value based payment methodologies and is working to increase value based payment methodologies in its ACO contracts. However, it is unclear how codifying payment methodologies will increase savings. As part of its process, the Department is considering the option to withhold a portion the ACOs' payment contingent upon meeting certain outcome measures. The Department will continue to work with ACOs to develop its quality improvement process. Of note, Alabama abandoned its above referenced plan."

What is the Current State of the States for Managed Care Participation?

As of July 1, 2014, the Kaiser Family Foundation, see http://www.kff.org/state-category/medicaid-chip/medicaid-managed-care-trend-data/ (accessed July 31, 2017), 47 of 50 states have at least some clients served by some level of managed care program. The Foundation reports Utah's percentage of clients served by managed care organizations at 98 percent or sixth highest in the nation. The median of clients served by capitated payment rate of arrangements nationwide is 80 percent. The participation rate ranges from a low of 0 percent in three states (Alaska, Connecticut, and Wyoming) to a high of 100 percent in four states (Idaho, North Carolina, Tennessee, and Washington). For a full list of each state's client participation rates in managed care, please see Appendix F.

What is the Current State of the States for Medicaid Physician Reimbursement as Compared to Medicare?

According to Kaiser's "Medicaid-to-Medicare fee index" for 2016, see http://www.kff.org/state-category/medicaid-chip/medicaid-physician-fees/ (accessed August 16, 2017), Utah paid 86 percent of Medicare rates for physician fee-for-service rates, which is 5th highest of Utah and its six neighboring states, whose rates range from 80 percent in Arizona to 98 percent in Wyoming (see table below), and tied for 13th highest of 49 states with fee-for-service programs (Tennessee does not have a fee-for service program). The range paid by 49 states ranges from 38 percent in Rhode Island to 126 percent in Alaska. Two states, Alaska and Montana, pay higher rates than Medicare in their Medicaid fee-for-service programs. For a full list of each state's "Medicaid-to-Medicare fee index," please see Appendix G.

2016 Medicaid-to-Medicare Physician Fee Index by the Henry J. Kaiser Family Foundation		
State	All Services	Rank (High)
Wyoming	98%	1
Idaho	95%	2
Nevada	95%	2
New Mexico	89%	4
Utah	86%	5
Colorado	80%	6
Arizona	80%	6

What is the Current State of the States for Pharmacy Reimbursement?

The Average Wholesale Price used by Utah prior to April 1, 2017 is the second most common pharmacy reimbursement system used by states. According to www.medicaid.gov (accessed August 2017) as of March 2017, 24 of 50 states used Average Wholesale Price in their reimbursement of pharmacy drugs. The most common pharmacy reimbursement methodology is Wholesale Acquisition Cost, which is used by 34 of 50 states. Wholesale Acquisition Cost is the reported price from manufacturers to wholesalers. Utah began using this pricing methodology effective April 1, 2017. The Department of Health indicates: "New, high-cost drugs that have recently come to market and are coming in the future make controlling costs in these areas difficult due to current federal regulations mandating Medicaid cover drugs whose manufacturer enters into a rebate agreement with [Centers for Medicare and Medicaid Services]. Should federal law (42 USC 1396r-8(d)(2)) be modified to allow states to not cover drugs that have been shown to be safe, but not effective, regardless of their approval pathway or status by the United States Food and

Drug Administration, then the Department could opt to not cover drugs with unproven efficacy." For a list of pharmacy reimbursement system by state please see Appendix H.

The fiscal analyst recommends that the Legislature open a bill for a resolution to request that the federal government allow Medicaid to not cover drugs approved by the Food and Drug Administration with unproven efficacy.

Agency Response: Oppose - "The Department of Health opposes this recommendation as currently proposed. A Medicaid formulary could potentially impact the health of needy Utahns, particularly in the rural and frontier areas of the state. The topic of a Medicaid formulary merits an indepth review and could be a suitable subject for a future deep dive review. The Legislature should involve representatives from all impacted provider groups, local government, consumers, DOH, DHS and others."

What is the Current State of the States for Client Cost-sharing Requirements?

As of January 1, 2017, the Kaiser Family Foundation, see http://www.kff.org/state-category/medicaid-chip/premium-cost-sharing-requirements/ (accessed August 14, 2017), thirty-nine or 78 percent of states have some cost sharing requirements for their Medicaid adults eligible via section 1931 of the Social Securities Act. For a list of each states' copay levels please see Appendix E. Below is a summary of how Utah compares to other states with different types of cost sharing requirements as of January 1, 2017:

1. Non-Preventive Physician Visit – the twenty-seven states with cost sharing in this area, charged between $1 (California, Missouri, and Virginia) and $10 (Alaska). Utah was tied with eight other states at 10th highest with a $3 copay.
2. Non-Emergency Use of the Emergency Room – the twenty states with cost sharing in this area, charged between $3 (seven states) and the full amount (South Dakota). Utah was 7th highest with a $6 copay.
3. Inpatient Hospital Visit – there were the twenty-six states with cost sharing in this area, but the data from Kaiser for eight states cannot be calculated into a maximum charge based on the information provided. For the remaining eighteen states the charge ranged between $3 (seven states) and $220 (Utah).
4. Prescription Drugs – Utah did not have a tiered pharmacy copay. Some states charged differing copays in the following categories of prescription drugs: generic, preferred brand name, non-preferred brand name. Some states also charged a range of copays within each prescription drug category. Five states had a range that includes $0 in the range of possible copays. There were thirty-four states with prescription drug copays ranging from $0 (five states) to $20 (Kansas). Utah was tied with 22 other states at 12th highest potential copay with a $3 copay for prescription drugs.

How Much do all 50 States Spend on Each Medicaid Client?

For FY 2014, the Kaiser Family Foundation, see http://www.kff.org/state-category/medicaid-chip/medicaid-spending-per-enrollee/ (accessed August 16, 2017), report Utah as the 10th lowest of the 50 reporting states for Medicaid spending per full-benefit enrollee. Utah is 5th lowest in spending per senior client on Medicaid amongst the 49 reporting states (no data for New Mexico). Compared to the other 50 reporting states for Medicaid spending per full-benefit enrollee, Utah is 28th lowest for individual with disabilities, 19th lowest for adults, and 18th lowest for children. For a list of each states' spending per full-

benefit enrollee see Appendix J. The table below compares Utah spending per full-benefit enrollee on Medicaid to its six neighboring states:

FY 2014 Medicaid Spending Per Full-Benefit Enrollee by The Henry J. Kaiser Family Foundation									
State (Utah and Its Neighbors)	Total	Seniors	Rank (Low)	Individuals with Disabilities	Rank (Low)	Adults	Rank (Low)	Children	Rank (Low)
Nevada	$4,003	$16,589	5	$15,589	1	$2,323	1	$1,520	1
Colorado	$4,898	$12,532	3	$16,252	2	$2,915	2	$2,026	2
Utah	$5,326	$11,638	1	$19,510	5	$4,201	5	$2,483	5
Idaho	$5,452	$15,096	4	$18,215	3	$4,036	4	$2,204	3
Arizona	$5,801	$12,232	2	$19,313	4	$4,521	7	$2,972	6
New Mexico	$6,026	N/A	N/A	$19,675	6	$3,564	3	$5,137	7
Wyoming	$6,602	$29,268	6	$25,242	7	$4,382	6	$2,292	4
Average	**$5,444**	**$16,226**		**$19,114**		**$3,706**		**$2,662**	
Minimum	**$4,003**	**$11,638**		**$15,589**		**$2,323**		**$1,520**	
Maximum	**$6,602**	**$29,268**		**$25,242**		**$4,521**		**$5,137**	

ADDITIONAL INFORMATION

1. "Medicaid Providers A Snapshot" 2013 Interim Issue Brief, see https://le.utah.gov/interim/2013/pdf/00002603.pdf
    - "This issue brief provides a snapshot of how many Medicaid providers (physicians, dentists, and pharmacies) participated in the Medicaid fee-for-service program from FY 2008 through FY 2012 and how many clients they served. In general the data indicates that participation for physicians in the fee-for-service Medicaid program is decreasing, while dentist participation is increasing, and pharmacy participation has remained relatively constant. The fee-for-service program for physician services served about 60% of all Medicaid clients from FY 2008 through FY 2012. The fee-for-service program for dental and pharmacy services serves 100% of Medicaid clients. Participation in the Medicaid program by providers is optional and qualifying providers can start or stop serving clients at will."
2. https://medicaid.utah.gov/Documents/pdfs/Utah_Access_Monitoring_Review_Plan.pdf
3. Medicaid Provider Rates - Michael Hales - February 11, 2014 presentation to the Social Services Appropriations Subcommittee, see http://le.utah.gov/interim/2014/pdf/00002258.pdf
4. http://kff.org/state-category/medicaid-chip/
5. http://legislature.vermont.gov/assets/Documents/2016/WorkGroups/House%20Ways%20and%20Means/Miscellaneous%20Tax%20Bill/W~Nolan%20Langweil~Provider%20Taxes%20Overview%20updated%20Jan%2029%202016~1-29-2016.pdf
6. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/downloads/xxxreimbursement-chart-current-qtr.pdf
7. "Medicaid Spending Statewide" 2017 General Session Issue Brief, see https://le.utah.gov/interim/2017/pdf/00001073.pdf

8. "Utah Annual Report of Medicaid & CHIP", see https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/Medica idAnnualReport_2016.pdf
9. Overview information on some of the types of reimbursement rates in Medicaid, see https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/understand-the-reimbursement-process.html
10. https://www.medicaid.gov/medicaid/financing-and-reimbursement/
11. http://www.ncsl.org/documents/health/MedicaidFundingVoluntarydonations-LA.pdf
12. Issue Brief - 2017 Interim - ORS Medical Collections Report Summary, see https://le.utah.gov/interim/2017/pdf/00003281.pdf
13. FY 2011 Issue Brief - HHS - DOH - Medicaid Review, see https://le.utah.gov/interim/2010/pdf/00000295.pdf
    - Issue Brief - 2011 Interim - SS - Medicaid Review; Status of Recommendations, see https://le.utah.gov/interim/2011/pdf/00002029.pdf
14. 2012 Medicaid Survey Responses From Public, see http://www.le.utah.gov/lfa/reports/BBIB/APPSOC_1-26-12_2.pdf
15. 2012 Medicaid Survey Responses From Agencies, see http://www.le.utah.gov/lfa/reports/BBIB/APPSOC_1-26-12_1.pdf
16. Medicaid Waivers Summary, see https://le.utah.gov/interim/2013/pdf/00002622.pdf
17. http://www.health.utah.gov/medicaid/stplan/index.htm

APPENDIX A - DEPARTMENT OF HUMAN SERVICES' OFFICE OF RECOVERY SERVICES AUGUST 17, 2017 SUBMISSION - REQUEST FOR OPTIONS TO INCREASE MEDICAID COLLECTIONS

The request from the LFA included TEFRA liens and requiring medical insurers to share coverage data with ORS as possible options. ORS has added additional suggestions. All would be helpful to the Medicaid third-party liability recovery efforts; however, ORS is unable to commit to or estimate specific dollar amounts for increased collections or cost avoidance that could result from the implementation of either suggestion. The benefits and complications for each are explained below.

TEFRA liens: The advantage of TEFRA liens is that they remove the restriction that the Office of Recovery Services is unable to place a lien against a Medicaid recipient's property until the Medicaid recipient has died. A TEFRA lien would allow ORS to place a lien against the Medicaid recipient's property upon the recipient's entry into a final, permanent care institution such as a nursing home. TEFRA liens will help reduce the number of cases in which the Medicaid recipient (or his/her family) sell or transfer the home without paying the Medicaid lien. TEFRA liens would give the Medicaid lien greater priority over other liens against the property. TEFRA liens would help ORS more easily meet statutes of limitations. TEFRA liens would give all parties involved (the patient, other lienholders, the patient's family members) better notice of the Medicaid lien, resulting in more funds being available to reimburse Medicaid and reducing litigation at the time of probate. It is not possible to determine the number of times that the above issues have impacted Medicaid collections, and every probate case involves different time periods, amounts of Medicaid paid, and values of estates; therefore, it is not possible to assign a monetary value of increased future collections to this change.

Requiring medical insurers to share coverage data with ORS: This is already a requirement of the Deficit Reduction Act (DRA) and ORS has worked to implement this practice; however, the reality is that this has proven to be very difficult to put into practice. Because of the number of insurance companies involved and the volume of policy holders, automation of the process is critical. In order for this to be successful, each company must 1) be able to connect to the state's mainframe, and 2) be able to and agree to receive and send information in a required file format. After years of attempting to set up automation with insurance companies, only three are exchanging information in an automated format now: PEHP, Deseret Mutual Benefit Administrators, and Select Health. Even those three companies have enough trouble matching their policy holder information with the Medicaid Eligible population at a high enough confidence level that we receive "exception reports," generally over 900 pages in a month, requiring manual review and entry of the policies. At this time, BMC is not currently staffed at a level that we can keep up with the manual entry of just those "exception reports." At one time, the All Payer Claims Database appeared to have potential to assist with this goal; however, with the Supreme Court decision striking down the requirement for insurance companies to report to such databases, that possibility no longer exists.

Surviving Spouse, Waiver vs. Deferral: At this time, the current practice is if a Medicaid recipient passes away, leaving assets which can normally be attached during the estate recovery process, but the individual leaves a surviving spouse, the State waives its claim to those assets, not even collecting once the second spouse is deceased. Many other states defer this claim and collect against the assets after the second spouse is deceased. It is not possible to determine the number of times that the above issues have impacted Medicaid collections, and every probate case involves different time periods, amounts of Medicaid paid, and values of estates; therefore, it is not possible to assign a monetary value of increased future collections to this change.

Require probate to notify ORS of all actions: Several other states require all parties to notify the state of any probate actions. If Utah required all parties to notify the state of all probate proceedings, ORS could ensure that

it was able to place a lien on the property before the property was sold or transferred and ensure that no probate was completed for the estate of a Medicaid recipient unless the Medicaid claim had been satisfied. It is not possible to determine the number of times that the above issues have impacted Medicaid collections, and every probate case involves different time periods, amounts of Medicaid paid, and values of estates; therefore, it is not possible to assign a monetary value of increased future collections to this change.

APPENDIX B – MEDICAID FRAUD CONTROL UNIT AUGUST 18, 2017 SUBMISSION - REQUEST FOR OPTIONS TO INCREASE MEDICAID COLLECTIONS

Utah Attorney General's Office

Memorandum

To: Russel Frandsen
Legislative fiscal analyst

From: Robert E. Steed
Director Medicaid Fraud Control Unit

Subject: Increasing Medicaid Collections

Mr. Frandsen,

Note: The contents of this memorandum are the personal opinions of the Director of the Medicaid Fraud Control Unit and does not constitute the opinion or recommendations of the Attorney General.

This is response to your request asking the Medicaid Fraud Control Unit for recommendations on how we might increase our collections to the Medicaid program annually. There is no simple answer to that question. I will discuss some of the dynamics of this issue and address a potential solution that will require legislative action and input from various stakeholders including the Attorney General.

MFCU Background

The MFCU is a health oversight/law enforcement agency within the Attorney General's Office. We independent from the Department of Health which administers the Medicaid program. Our mission is to investigate and when appropriate. prosecute fraud in the provision of health care services under the Medicaid program. The MFCU also has an additional mission that is no less vital to the State than pursuing fraud. The MFCU investigates the abuse, neglect or exploitation of individuals residing in board and care facilities. We devote considerable time, effort and resources to each focus area and seek to achieve a proper case mix which address both fraud prevention as well as protecting some of Utah's most vulnerable citizens. Our unit is responsive to all credible referrals whether they report fraud relating to Medicaid dollars, or the abuse, neglect and exploitation of individuals in board and care facilities.

Utah's MFCU is certified annually by the Secretary of the United States Department of Health and Human Services. The MFCU is not measured and evaluated based on benchmarks for financial recoveries but on the 12 performance standards contained in the Code of Federal Regulations.[1] The United States Office of Inspector General for the Department of Health and Human Services "HHS-OIG" provides oversight of the MFCU and its compliance with federal standards.

Your inquiry about increasing the amount of recoveries raises some complex issues. The MFCU is committed to doing all we can to stop and prevent fraud and hold accountable providers who engage in fraud. We are actively engaged in a variety of cases that involve fraud. While it is important to recover losses sustained by the program due to fraud, there is a real concern when a law enforcement agency sets benchmarks for recovering money. Our goal is to investigate all credible allegations of fraud. When we prevail on a case, we

[1] https://oig.hhs.gov/authorities/docs/2012/performancestandardsfinal060112.pdf

always seek to obtain restitution to the Medicaid program. In many cases the greatest benefit to the State is the fact that future fraud is prevented and the offending provider is removed or "excluded" from being able to provide services to any federal health care program. [2]

However, if a law enforcement agency sets a benchmark on collection numbers, it would compromise our objectivity or the appearance of our objectivity with the public. The cases we investigate and prosecute should not be determined based on achieving a certain benchmark. We cannot overlook an obvious fraud case because it offers less potential for recovery and set our legal machinery in motion to target a suspect based on "deep pockets." We administer justice according to the merits of each case. I know of no other prosecuting agency that sets financial goals as a measure of their effectiveness. Moreover. it is problematic to make assumptions about what would be an appropriate benchmark to establish. Health care fraud is a complex area of the law and each case is unique in terms of the time it takes to investigate, prosecute or to seek administrative or civil collections efforts. We do not have consistent pattern of referrals or results to use as a guide in making collection projections.

In recent years, the MFCU was able to offer limited projections on civil recoveries due to the continuous case flow of pharmaceutical cases that were occurring nationally through global case resolutions. We also have had more lawsuits generated by our Unit in this area as a result of certain factors that were prevalent in the past when violations by large pharmaceutical cases started receiving national attention. Based on the relative size of the Utah MFCU , Utah was among the leaders in the nation in recovering Medicaid funds from various cases we pursued using outside law firms. However, the trend in this type of litigation has been declining sharply nationwide due to a variety of factors. While we continue to have as many national drug cases and investigations now as we had in the past, those cases tend to be for much smaller dollar amounts due to changes occurring in how states manage Medicaid services (ACO, Managed Care, etc.). Also changes to the pharmaceutical industry and the implementation of Medicare Part D benefits which have resulted in much greater share of the cost of drug benefits being paid through the Medicare system. We also have witnessed changes to how pharmaceutical companies operate and document their business activities.

Notwithstanding, these challenges, the MFCU is still engaged in three civil suits including a case against Merck, for issues relating to the drug Vioxx. This case has been in litigation for over a decade. However, it has the potential to realize a considerable recovery to the Medicaid program. We also have two remaining cases involving average wholesale price litigation which we hope to resolve in the short term.

Potential Solutions

The State may recover more money due to fraud, waste and abuse by enacting a federally certified False Claims Act with its attendant qui tam and penalty provisions and by devoting additional resources to its enforcement.[3]

If the State of Utah wants to consider ways to increase fraud prevention including the recovery of more resources lost to fraud, it may consider the following recommendation:

I. **Adopt a Comprehensive False Claims Act[4]** patterned after the Federal False Claims with its attendant qui tam (whistleblower) provisions. The substance of a more robust False Claims Act would provide the following means of increasing recoveries to the State.

[2] https://oig.hhs.gov/faqs/exclusions-faq.asp

[3] The MFCU is not proposing the adoption of a comprehensive False Claims Act, but merely raise it as an option for purposes of this inquiry. The idea has raised in prior legislative sessions without much success by various members of the legislative branch.

[4] http://www.modernhealthcare.com/article/20150725/MAGAZINE/307259960

1. The Act would allow private citizens to bring qui tam lawsuits against corporations that violate the act.
2. The Act would allow the State MFCU to intervene or decline intervention in the suit based on assessment of the merits of the litigation.
3. The Act would provide remuneration to the "relator" (whistleblower) based on a variety of factors including the value of their assistance, whether the relator is the "original source" of the information, etc.
4. The Act if adopted in conformity with the Federal False Claims Act and receives approval from the Secretary of the United Sates Department of Health and Human Services and the United States Department of Justice, the State would be able to retain a greater share of recovery by 10 percent.
5. The Act would require the State to pay the whistleblower a percentage of the recovery obtained from a successful resolution of the case.
6. The Attorney General's Office would be given sufficient budget to hire attorneys and staff qualified to handle the complex litigation involved in health care cases.

The idea of passing a comprehensive False Claims Act has been discussed in prior years with various legislatures. There are plusses and minuses to this proposal including the cost of creating a civil fraud unit who can handle the complex nature of health care fraud cases without compromising parallel criminal investigations and proceedings.

I would be happy to discuss the issues raised in this memorandum with you at your convenience. However, such a discussion would necessarily require the approval of the Attorney General and collaboration from other stakeholders.

APPENDIX C – UTAH OFFICE OF INSPECTOR GENERAL AUGUST 18, 2017 SUBMISSION - REQUEST FOR OPTIONS TO INCREASE MEDICAID COLLECTIONS

Utah Office of
Inspector General

Gene Cottrell
Inspector General

August 18, 2017

RE: Response to LFA Questions regarding UOIG Recoveries

Dear Russell Frandsen,

The Utah Office of Inspector General of Medicaid Services submits the following paper in response to questions posed by the Legislative Fiscal Analyst's Office. On August 1, 2017 the Inspector General received an email request for information wherein the analyst, Russell Frandsen, asked the following questions.

1. Are there any options for the Legislature to make to help increase your agency's Medicaid's (sic) collections?

2. For each option does your agency have a position (support, neutral, etc.) on the recommendation and a rough estimate of the impact to potential collections?

The Office's management team has a number of recommendations that may help increase recoveries. However, it is important to first point out that dollars recovered should not be the only performance measure by which state elected officials measure the success of the Office of Inspector General.

The Office fulfills a critical role within the Medicaid program. The Office is given authority by the Utah State Legislature to fulfill Program Integrity responsibilities that are federally mandated. The federal tasks that the Office performs are primarily outlined in 42 CFR sections 455 and 456. In order to fulfill that role the Office entered into a Memorandum of Understanding with the Utah Department of Health, which is designated as the "Single State Agency" responsible for administration of the Medicaid program within the State of Utah.

A 2007 Kaiser Commission report on Medicaid and the Uninsured titled, "The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid" outlines the challenges that Program Integrity units nationwide face. It points out that Program Integrity is a holistic approach to ensuring the Medicaid Program is managed effectively and efficiently and helps ensure taxpayers' return on investment is maximized. The report further points out that a narrow view of Program Integrity focuses only on fraud and abuse but misses the much more holistic and broader intent of ensuring Medicaid is effective. The report states, "A narrow focus that exclusively defines program integrity as issues related to "fraud and abuse" misses the much larger picture of managing a program to ensure that care is provided in an appropriate and efficient manner and in a way that prevents quality care and public funds from being placed at risk. In this larger picture, preventing violations of program integrity and avoiding inappropriate costs is at least as important as addressing cases of fraud and abuse, **even if the monetary effects of these efforts are hard to quantify"** (Wachino 2007).

It is my belief, as the Inspector General, that taking a more holistic approach to Program Integrity, as outlined in the Kaiser Commission report, will aide legislators, management, and other key stakeholders in setting realistic goals for the program and for the Office of Inspector General. Return on Investment and dollar amounts collected are by-products of the Office's work. In fact, the Office, in the course of its medical records reviews, frequently finds cases where the provider was under-paid which results in a negative ROI to the program. In those cases letters are sent to the providers instructing them to rebill the claim so that they are paid appropriately.

Wachino, Victoria. Wachino Health Policy Consulting. "Kaiser Commission on Medicaid and the Uninsured: The New Medicaid Integrity Program: Issues and Challenges in Ensuring Program Integrity in Medicaid." https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7650.pdf. Accessed 16 Aug 2017.

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Gene Cottrell
Inspector General

The Office is asked, every year, to estimate the amount of recoveries for the upcoming year. This practice puts in jeopardy the Office's objectivity by giving the appearance that our sole concern is making money for the state rather than ensuring programs are managed appropriately throughout the Medicaid system.

Open lines of communication need to be established between the Legislative and the Executive branches of the Utah State Government and the Office of Inspector General. The opening of these lines is critical to understanding the scope of the work the Office undertakes and will help establish clearly defined performance measures, beyond simple return on investment.

FUNDING THE OIG

Since the OIG fulfills the federally mandated requirement of Program Integrity, in close correlation with Medicaid, the Office's expenses were 70.24% covered by Federal funds during SFY 2017. That amount will be closer to 72% during SFY 2018.

For SFY 2017 the state portion of funding for the OIG was $1,139,781.88 and the federal portion paid was $2,689,993.26 with recoveries totaling about $6.2 million. Final reconciliation of rebill amounts is ongoing.

ANSWER TO LFA'S QUESTION

In answering Russell's question, there are a number of recommendations the Office management team would make.

Use of Extrapolation

The use of extrapolation is essential to some reviews and we would recommend that the restrictions placed upon its use by S.B. 61 during the 2015 Legislative Session be loosened. Currently the law only allows extrapolation for the use of a particular service code over a period of three years if the value of claims for the provider, in aggregate, exceeds $200,000 in reimbursement for a particular service code on an annual basis, only after documented education intervention has failed to correct the level of payment error.

Example:
Evaluation and Management (E/M) Coding: E/M coding is the process by which physician-patient encounters are translated into five digit CPT codes to facilitate billing. CPT stands for "current procedural terminology." These are the numeric codes which are submitted to insurers for payment. There are 5 E/M codes a physician normally bills. We would expect to see a standard bell curve when we analyze E/M codes for any given physician. However, there are providers who bill exclusively the 4th and higher paid code, regardless of the service performed. This is an example of upcoding and those funds should be recovered but since we can't use extrapolation and have to review each encounter separately we can never meet the criteria as it is currently codified.

The Office would support a change to this law that allows extrapolation. We can currently meet all of the requirements as outlined in the code except for the $200,000 threshold. We would like to see that reduced to $25,000. This change could potentially produce an additional $1 million in recoveries annually.

Updated Data Analysis Tools

Data Analysis is critical to identifying irregularities in billing and payment made by and to Medicaid providers. The Office currently uses COGNOS to pull data from the data warehouse but would like to research open market solutions designed for analysis of Medicaid data. OIG Management recently reviewed a number of these programs at the National Association of Medicaid Program Integrity (NAMPI) annual conference. The management team is

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Gene Cottrell
Inspector General

currently researching a few of these programs to determine which ones would best fit the needs of the Office. There are currently federal funds available that pay 90% of costs for acquisition and implementation of such programs.

The Office will continue to investigate these tools and request demonstrations to determine rather or not they can aid in the identification of fraud, waste and abuse in Utah. If the Office is permitted the one time funds to acquire a data analysis tool we believe it will increase recoveries based on our ability to more effectively and efficiently perform those tasks associated with recovery of inappropriately billed/paid funds. It is not possible to adequately quantify how much recovery improved data analytics capability could have on recoveries, but if the right product is identified and incorporated into the program integrity operation the recoveries may increase by as much as $1.5 million annually.

CONCLUSION

The Utah Office of Inspector General fulfills an important role within the Utah Medicaid Program. A holistic approach to Program Integrity, by all stake holders, is critical to identifying meaningful performance measures beyond simple return on investment. If granted the correct tools to perform the Program Integrity function, under both Federal and State guidelines, recoveries will improve, but more importantly the entire Medicaid program will benefit through improved effectiveness and efficiency.

Sincerely,

Gene D Cottrell
Inspector General
Utah Office of Inspector General

Cc Wayne Niederhauser, President, Utah State Senate
Gregory H. Hughes, Speaker, Utah House of Representatives
Justin Harding, Chief of Staff, Utah Governor's Office
Ric Cantrell, Chief of Staff, Utah State Senate
Greg Hartley, Chief of Staff, Utah House of Representatives
Dr. Joseph Miner, Director, Utah Department of Health
Dr. Marc Babitz, Deputy Director, Utah Department of Health
Nathan Checketts, Deputy Director, Utah Department of Health
Jonathan Ball, Director, Legislative Fiscal Analyst

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APPENDIX D - PUBLIC SCHOOL ENROLLMENT, BY CHARTER SCHOOL, UTAH (AND MEDICAID ENROLLMENT)

Public School Enrollment, by Charter School, Utah			
Charter School	FY 2017	Medicaid Enrollment	Estimated Medicaid Enrollment
American Academy of Innovation	214	#N/A	2
American International	1,322	#N/A	12
American Leadership	1,728	#N/A	16
American Prep	4,272	#N/A	39
AMES	479	#N/A	4
Aristotle Academy	113	#N/A	1
Ascent Academies	1,891	#N/A	17
Athenian eAcdemy	575	#N/A	5
Athlos Academy	838	#N/A	8
Bear River	168	#N/A	2
Beehive Science & Technology	297	#N/A	3
C.S. Lewis Academy	296	#N/A	3
Canyon Grove Academy	613	#N/A	6
Canyon Rim	530	#N/A	5
Center for Science Education	398	#N/A	4
Channing Hall	628	#N/A	6
City Academy	137	#N/A	1
DaVinci Academy	1,168	#N/A	11
Dixie Montesorri Academy	426	#N/A	4
Dual Immersion Academy	481	#N/A	4
East Hollywood High	351	#N/A	3
Edith Bowen	304	#N/A	3
Endeavor Hall	542	#N/A	5
Entheos Academy	1,038	1	
Esperanza Elementary	508	#N/A	5
Excelsior Academy	731	#N/A	7
Fast Forward	219	#N/A	2
Franklin Discovery Academy	500	#N/A	5
Freedom Academy	1,306	#N/A	12
Gateway Preparatory	675	#N/A	6
George Washington	1,000	#N/A	9
Good Foundations	487	#N/A	4
Greenwood	378	#N/A	3
Guadalupe Schools	296	#N/A	3

Public School Enrollment, by Charter School, Utah			
Charter School	FY 2017	Medicaid Enrollment	Estimated Medicaid Enrollment
Hawthorn Academy	1,527	#N/A	14
HighMark	685	#N/A	6
InTech Collegiate High	193	#N/A	2
Itineris	386	#N/A	4
Jefferson Academy	570	#N/A	5
John Hancock	199	#N/A	2
Kairos Academy	93	#N/A	1
Karl G. Maeser	627	#N/A	6
Lakeview	1,018	#N/A	9
Leadership Learning	533	#N/A	5
Legacy Preparatory	1,110	#N/A	10
Lincoln Academy	866	#N/A	8
Lumen Scholar Institute	503	#N/A	5
Mana Academy	400	#N/A	4
Maria Montessori	655	#N/A	6
Merit College Preparatory	320	#N/A	3
Moab Charter	120	#N/A	1
Monticello	763	#N/A	7
Mountain Heights Academy	525	#N/A	5
Mountain West Montessori	491	#N/A	4
Mountainville	759	#N/A	7
Navigator Pointe	512	#N/A	5
Noah Webster	583	#N/A	5
North Davis Prep	1,017	#N/A	9
North Star Academy	530	#N/A	5
NUAMES	765	#N/A	7
Odyssey	480	#N/A	4
Ogden Prep	1,102	#N/A	10
Open Classroom	374	#N/A	3
Pacific Heritage Academy	430	#N/A	4
Paradigm High	557	#N/A	5
Pinnacle Canyon	459	#N/A	4
Pioneer High School	131	#N/A	1
Promontory School	457	#N/A	4

Public School Enrollment, by Charter School, Utah			
Charter School	FY 2017	Medicaid Enrollment	Estimated Medicaid Enrollment
Providence Hall	2,149	#N/A	20
Quest Academy	947	#N/A	9
Ranches Academy	364	#N/A	3
Reagan Academy	675	#N/A	6
Renaissance	721	#N/A	7
Rockwell High	433	#N/A	4
Roots Charter School	166	#N/A	2
Salt Lake Arts	392	#N/A	4
Salt Lake SPA	294	#N/A	3
Scholar Academy	550	#N/A	5
Soldier Hollow	266	#N/A	2
Spectrum	1,106	68	
SUCCESS Academy	429	#N/A	4
Summit Academy	2,411	#N/A	22
Summit Academy High	542	#N/A	5
Syracuse Arts	1,739	#N/A	16
Terra Academy	616	#N/A	6
The Early Light Academy	1,003	#N/A	9
Thomas Edison - North	1,360	#N/A	12
Timpanogos Academy	472	#N/A	4
Tuacahn High	388	#N/A	4
UCAS	395	#N/A	4
Uintah River High	76	#N/A	1
UT International Charter	215	#N/A	2
Utah Career Path High	155	#N/A	1
Utah Connections	953	#N/A	9
Utah Military Academy	503	#N/A	5
Utah Virtual Academy	2,028	#N/A	18
Valley Academy	295	#N/A	3
Vanguard Academy	383	#N/A	3
Venture	776	#N/A	7
Vista at Entrada	877	#N/A	8
Voyage Academy	533	#N/A	5
Walden School	416	#N/A	4

Public School Enrollment, by Charter School, Utah			
Charter School	**FY 2017**	**Medicaid Enrollment**	**Estimated Medicaid Enrollment**
Wallace Stegner Academy	**509**	**#N/A**	5
Wasatch Peak	**417**	**#N/A**	4
Wasatch Waldorf Academy	**536**	**#N/A**	5
Weilenmann School	**605**	**#N/A**	6
Winter Sports School	**113**	**#N/A**	1
WSU Charter School	**37**	**#N/A**	0
Charter Total	**71,494**	70	631
# Charter Schools	108	2	106
% Medicaid Eligible (Charters)		3%	
% Medicaid Eligible (Districts)		1%	

APPENDIX E – 2017 COST-SHARING REQUIREMENTS FOR SELECTED MEDICAID SERVICES FOR SECTION 1931 PARENTS BY THE KAISER FAMILY FOUNDATION

2017 Cost-Sharing Requirements for Selected Medicaid Services for Section 1931 Parents by the Henry J. Kaiser Family Foundation							
State	Cost Sharing?	Non-Preventive Physician Visit (Max)	Non-Emergency Use of ER (max)	Inpatient Hospital Visit (Max)	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Alabama	Yes	$3.90	$4	$50	$0.65-$3.90	$0.65-$3.90	$0.65-$3.90
Alaska	Yes	$10	$0	$50/day	$3	$3	$3
Arizona	Yes	$3.40	$0	$0	$2.30	$2.30	$2.30
Arkansas	Yes	$0	$0	10% cost of first day	$0.50-$3.90	$0.50-$3.90	$0.50-$3.90
California	Yes	$1	$5	$0	$1	$1	1
Colorado	Yes	$2	$3	$10/day	$1	$3	3
Connecticut	No	N/A	N/A	N/A	N/A	N/A	N/A
Delaware	Yes	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Florida	Yes	$2	$15	$3	$0	$0	$0
Georgia	Yes	$0	$0	$13	$0.50-$3	$0.50-$3	$0.50-$3
Hawaii	No	N/A	N/A	N/A	N/A	N/A	N/A
Idaho	No	N/A	N/A	N/A	N/A	N/A	N/A
Illinois	Yes	$3.90	$4	$3.90/ day	$2	$3.90	$3.90
Indiana	Yes	$4	$8	$75	$4	$4	$8
Iowa	Yes	$3	$3	$0	$1	$1	$2-$3
Kansas	No	N/A	N/A	N/A	N/A	N/A	N/A
Kentucky	Yes	$3	$8	$50	$1	$4	5% cost ($8 min/ $20 max)
Louisiana	Yes	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Maine	Yes	$0	$3	up to $3 per day	$3	$3	$3
Maryland	Yes	$0	$0	$0	$1-$3	$1-$3	$1-$3
Massachusetts	Yes	$0	$0	$3	$4	$4	$4
Michigan	Yes	$0	$0	$0	$1	$1	$1
Minnesota	Yes	$3	$4	$0	$1	$3	$3
Mississippi	Yes	$3	$0	$10	$3	$3	$3
Missouri	Yes	$1	$3	$10	$0.50-$2	$0.50-$2	$0.50-$2
Montana	Yes	$4	$8	$75	$0	$4	$8
Nebraska	Yes	$2	$0	$15	$2	$2	$3

2017 Cost-Sharing Requirements for Selected Medicaid Services for Section 1931 Parents by the Henry J. Kaiser Family Foundation							
State	Cost Sharing?	Non-Preventive Physician Visit (Max)	Non-Emergency Use of ER (max)	Inpatient Hospital Visit (Max)	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Nevada	No	N/A	N/A	N/A	N/A	N/A	N/A
New Hampshire	Yes	$0	$0	$0	$0	$1	$2
New Jersey	No	N/A	N/A	N/A	N/A	N/A	N/A
New Mexico	No	N/A	N/A	N/A	N/A	N/A	N/A
New York	Yes	$0	$3	$25/ discharge	$1	$3	$3
North Carolina	Yes	$3	$0	$3/day	$3	$3	$3
North Dakota	Yes	$2	$0	$75	$0	$3	$3
Ohio	Yes	$0	$3	$0	$0	$2	$3
Oklahoma	Yes	$4	$4	$90	$4	$4	$4
Oregon	No	N/A	N/A	N/A	N/A	N/A	N/A
Pennsylvania	Yes	$3.80	$3	$3/day	$1	$3	$3
Rhode Island	No	N/A	N/A	N/A	N/A	N/A	N/A
South Carolina	Yes	$2.30	$0	$25	$3.40	$3.40	$3.40
South Dakota	Yes	$3	Full amount	$50	$1	$3.30	N/C
Tennessee	Yes	$0	$0	$0	$1.50	$3	$3
Texas	No	N/A	N/A	N/A	N/A	N/A	N/A
Utah	Yes	$3	$6	$220	$3	$3	$3
Vermont	Yes	$3	$0	$0	$1-$3	$1-$3	$1-$3
Virginia	Yes	$1	$0	$100	$1	$3	$3
Washington	No	N/A	N/A	N/A	N/A	N/A	N/A
West Virginia	Yes	$4	$8	$75	$0-$3	$0-$3	$0-$3
Wisconsin	Yes	$3	$0	$3	$1	$3	$3
Wyoming	Yes	$2	$4	$0	$0.65	$3.65	$3.65
Total States	**39**	**27**	**20**	**26**	**34**	**38**	**37**

APPENDIX F - 2014 TOTAL MEDICAID MANAGED CARE ENROLLMENT BY THE KAISER FAMILY FOUNDATION

2014 Total Medicaid Managed Care Enrollment by the Henry J. Kaiser Family Foundation			
States	Total Medicaid Managed Care Enrollment	Percent of State Medicaid Enrollment	Rank (High)
Idaho	266,172	100%	1
North Carolina	1,717,658	100%	1
Tennessee	1,288,631	100%	1
Washington	1,245,322	100%	1
Hawaii	318,200	99%	5
Utah	282,844	98%	6
Michigan	3,774,727	98%	7
Missouri	797,512	97%	8
Colorado	1,029,950	95%	9
Nebraska	229,661	95%	10
Oregon	971,104	92%	11
New Jersey	1,418,074	92%	12
Pennsylvania	1,978,894	92%	13
Iowa	533,403	90%	14
Kentucky	1,081,673	89%	15
Kansas	356,630	89%	16
Oklahoma	736,785	89%	17
Nevada	464,054	87%	18
Arkansas	515,111	87%	19
Delaware	196,065	86%	20
Arizona	1,317,463	85%	21
New Hampshire	121,161	85%	21
Rhode Island	223,749	85%	23
Maryland	1,084,437	83%	24
Louisiana	1,044,899	80%	25
New Mexico	580,224	80%	26
Texas	3,232,307	78%	27
Florida	2,684,181	76%	28
New York	4,412,837	76%	29
South Dakota	91,289	75%	30
Virginia	707,926	74%	31
Ohio	2,028,249	73%	32
Minnesota	791,004	71%	33
Georgia	1,352,544	69%	34
Montana	91,071	69%	34

2014 Total Medicaid Managed Care Enrollment by the Henry J. Kaiser Family Foundation			
States	Total Medicaid Managed Care Enrollment	Percent of State Medicaid Enrollment	Rank (High)
California	7,840,879	68%	36
Illinois	2,163,351	67%	37
South Carolina	720,925	66%	38
Indiana	773,757	66%	39
Maine	161,367	62%	40
Alabama	641,217	61%	41
Massachusetts	1,110,277	59%	42
Wisconsin	701,290	59%	43
North Dakota	46,154	58%	44
Vermont	79,735	42%	45
West Virginia	203,288	42%	46
Mississippi	155,124	22%	47
Wyoming	57	0%	48
Alaska	-	0%	49
Connecticut	-	0%	49
Median	**714,426**	**80%**	
Minimum	**-**	**0%**	
Maximum	**7,840,879**	**100%**	

APPENDIX G – 2016 MEDICAID-TO-MEDICARE FEE INDEX, BY THE KAISER FAMILY FOUNDATION

2016 Medicaid-to-Medicare Physician Fee Index by the Henry J. Kaiser Family Foundation		
States	All Services	Rank
Alaska	126%	1
Montana	109%	2
North Dakota	98%	3
Wyoming	98%	3
Delaware	96%	5
Idaho	95%	6
Nevada	95%	6
Nebraska	92%	8
Virginia	92%	8
Mississippi	89%	10
New Mexico	89%	10
Maryland	88%	12
Oklahoma	86%	13
Utah	86%	13
South Dakota	84%	15
Iowa	82%	16
Oregon	81%	17
West Virginia	81%	17
Arizona	80%	19
Arkansas	80%	19
Colorado	80%	19
Vermont	80%	19
Massachusetts	79%	23
South Carolina	79%	23
Kansas	78%	25
North Carolina	78%	25
Georgia	77%	27
Indiana	77%	27
Kentucky	77%	27
Connecticut	76%	30
Alabama	75%	31
Minnesota	75%	31
Washington	71%	33
Louisiana	70%	34
Pennsylvania	69%	35
Michigan	65%	36
Texas	65%	36

2016 Medicaid-to-Medicare Physician Fee Index by the Henry J. Kaiser Family Foundation		
States	**All Services**	**Rank**
Maine	64%	38
Ohio	63%	39
Hawaii	62%	40
Wisconsin	62%	40
Illinois	61%	42
Missouri	60%	43
New Hampshire	58%	44
Florida	56%	45
New York	56%	45
California	52%	47
New Jersey	42%	48
Rhode Island	38%	49
Tennessee	N/A	
Median	**78%**	
Minimum	**38%**	
Maximum	**126%**	
N/A: Not applicable because Tennessee does not have a Medicaid fee-for-service program.		

APPENDIX H – MEDICAID COVERED OUTPATIENT PRESCRIPTION DRUG REIMBURSEMENT INFORMATION BY STATE, QUARTER ENDING MARCH 2017

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State, Quarter Ending March 2017			
State	**Ingredient Cost**	**Dispensing Fee**	**State MAC**
Alabama	Ingredient cost is AAC or if not available WAC, or U/C; ASP +6% (blood clotting factors)	Dispensing fee is $10.64	Yes
Alaska	Ingredient cost is NADAC or if not available WAC plus 1%	Dispensing fee is $13.36 (pharmacy located on the road system); $16.58 (mediset pharmacy); $21.28 (pharmacy not located on the road system); $10.76 (out-of-state pharmacy)	Yes
Arizona	Ingredient cost is AWP minus 15%; FQHCs and FQHC Look-alikes at the lesser of billed charges or the 340B ceiling price	Dispensing fee is $2.00 (FFS only); $8.75 (FQHCs and FQHC Look-alikes)	No
Arkansas	Lower of NADAC; or state AAC; or FUL; or state AAC	Dispensing fee is $9.00 for brand and non-preferred brands; $10.50 for preferred brand and generics	Yes
California	Ingredient cost is AWP minus 17%; ASP plus 6% (physician administered drugs)	Dispensing fee is $7.25; $8.00 (legend drugs dispensed to residents in skilled nursing facilities or intermediate care facilities)	Yes
Colorado	Ingredient cost for all drugs for retail pharmacies, 340B pharmacies, institutional pharmacies, government pharmacies, and mail order pharmacies shall be based upon the lower of: (1) The usual and customary charge to the public minus the client's copayment; or (2) The allowed ingredient cost, The allowed ingredient cost is the lesser of AAC or submitted ingredient cost. If AAC is not available the allowed ingredient cost is the lesser of WAC or the submitted drug ingredient cost. Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the 340B Drug Pricing Program, the submitted ingredient cost means the 340B purchase price. Ingredient cost for designated rural pharmacies: The allowed ingredient cost shall be AAC. If AAC is not available, the allowed ingredient cost shall be WAC	The dispensing fees for retail pharmacies, 340B pharmacies, institutional pharmacies, and mail order pharmacies shall be tiered based upon annual total prescription volume. The dispensing fees shall be tiered at: (1) Less than 60,000 total prescriptions filled per year = $13.40, (2) Between 60,000 and 90,000 total prescriptions filled per year = $11.49, (3) Between 90,000 and 110,000 total prescriptions filled per year = $10.25, and (4) Greater than 110,000 total prescriptions filled per year = $9.31 Dispensing fee is $14.41 (rural pharmacies); no dispensing fee (government pharmacies)	No
Connecticut	Ingredient cost is AWP minus 72% to step down tiers through AWP minus 20 percent based on meeting specific invoice pricing criteria (selected multi-source brand and generic); AWP minus 16% (brand)	Dispensing fee is $1.70*	Yes
Delaware	Ingredient cost is NADAC	Dispensing fee is $10.00	Yes
Florida	Ingredient cost is lower FUL, WAC plus 1.5%, SMAC, provider's U&C, AAC (for 340B covered entities, and FQHC or their contract agents)	Dispensing fee is $3.73 (for non-340B billed drugs); $7.50 (340B billed drugs)	Yes
Georgia	Ingredient cost is AWP minus 11%; Select Specialty Pharmacy Rate for certain disease states that are rare and/or complex with a reimbursement methodology determined by wholesaler/ manufacturer data, a comparison to other State agencies' reimbursement information, and publicly available drug prices from other payers; Maximum allowable reimbursement for an injectable drug administered by a provider or their designee in an outpatient setting is ASP plus 6% as determined on January 1st of the applicable year; Most Favored Nations rate submitted by the provider and accepted by the State	Dispensing fee is $4.63 (for-profit pharmacy); $4.33 (not-for-profit)	Yes
Hawaii	Ingredient cost is WAC	Dispensing fee is $5.00	Yes
Idaho	Ingredient cost is AAC, or where there is no AAC reimbursement is WAC	Tiered dispensing fees: (1) Less than 39,999 claims a year = $15.11, (2) Between 40,000 and 69,999 claims per year = $12.35, and (3) 70,000 or more claims per year = $11.51	Yes

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State, Quarter Ending March 2017			
State	**Ingredient Cost**	**Dispensing Fee**	**State MAC**
Illinois	Ingredient cost is WAC plus 1% (multiple source legend); WAC plus 1% (single source legend); WAC plus 25% (over-the-counter drugs); AAC for implantable contraceptive devices purchased under the 340B Drug Pricing Program via FQHC or rural health centers	Dispensing fee is $5.50 (multiple source); $2.40 (single source); $12.00 for both single source and multiple source drugs purchased through the 340B Drug Pricing Program (May 1, 2015-June 30, 2015 only - Dispensing fee is $4.50 (multiple source); $1.40 (single source); $11.00 for both single source and multiple source drugs purchased through the 340B Drug Pricing Program)	Yes
Indiana	Ingredient cost is AWP minus 16% (brand); AWP minus 20% (generic); Reimbursement for physician administered drugs is WAC plus 5% or ASP plus 6% for those drugs without a published WAC	Dispensing fee is $3.90	Yes
Iowa	Ingredient cost is AAC as determined from surveys or where there is no AAC reimbursement is WAC	Dispensing fee is $10.02	Yes
Kansas	Ingredient cost is WAC minus 8.6% (generic); WAC plus 4.6% (brand); Invoice pricing for drugs without WAC or SMAC	Dispensing fee is $3.40	Yes
Kentucky	Ingredient cost is WAC plus 3.2% (generic); WAC plus 2%; or if WAC is not available, the provider will be required to contact the manufacturer for WAC or produce an invoice price	Dispensing fee is $5.00 (generic); $4.50 (brand)	Yes
Louisiana	Ingredient cost is AAC of the drug dispensed or where there is no AAC reimbursement is WAC Reimbursement for Cost of the Influenza Vaccine at: $17. 37 for intramuscular injected influenza vaccine - preservative free, $13.22 for intramuscular injected influenza vaccine, and $22.03 for intranasal influenza vaccine or billed charges, whichever is the lesser amount	Dispensing fee is $10.51 includes State provider fee; $10.51 for drugs obtain through the 340B Drug Pricing Program which includes the State provider fee	Yes
Maine	Ingredient cost is AWP minus 16% (brand); AWP minus 13% (generic); AWP minus 17% (specialty pharmacy); AWP minus 20% (mail order brand); AWP minus 60% (mail order generic)	Dispensing fee is $3.35; $2.50 (mail order brand & generic); $4.35 and $5.35 (compounding); $12.50 (filling insulin syringe)	Yes
Maryland	Ingredient cost is lower of AWP minus 12%, WAC plus 8%, direct price plus 8% or distributor price when available	Dispensing fee is $3.51 (generic); $2.56 (brand); $4.46 (generic to NH); $3.51 (brand to NH); $6.89 (home IV therapy)	Yes
Massachusetts	Ingredient cost is WAC plus 5% (all drugs except 340B billed drugs); actual acquisition cost (340B billed drugs)	Dispensing fee is $3.00 (all drugs except 340B billed drugs); $10 (340B billed drugs)	Yes
Michigan	Ingredient cost is AWP minus 13.5 % or WAC plus 3.80 % (independent pharmacy (and chain pharmacies fewer than 5 stores); AWP minus 15.1% or WAC plus 1.88% (chain pharmacies and pharmacies serving nursing facilities)	Dispensing fee is $3.00 (long term care); $2.75 all other providers; $6.00 (cream, emulsion, nasal drops, ointments or optic drugs); $10.00 (compounded capsules, powders or suppositories)	Yes
Minnesota	Ingredient cost is WAC plus 2%; WAC plus 4% (independently owned pharmacies located in a small rural or isolated rural location); WAC minus 40% (340B billed drugs)	Dispensing fee is $3.65 (plus $0.30 for legend unit dose drugs); Dispensing fee for over-the-counter drugs in a nursing facility through the use of an automated dispensing system is $1.31 when the amount dispensed is less than the amount contained in the manufacturer's original packaging.	Yes
Mississippi	Ingredient cost is lower of AWP minus 12% or WAC plus 9% (brand); AWP minus 25% (generic); ASP plus 6% (chemotherapy drugs and concomitant non- chemotherapy drugs administered during the chemotherapy treatment and billed on the same claim as the chemotherapy treatment)	Dispensing fee is $3.91 (brand); $4.91 (generic)	No
Missouri	Ingredient cost is lower of AWP minus 10.43% or WAC plus 10%	Dispensing fee is $4.09	Yes

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State, Quarter Ending March 2017			
State	**Ingredient Cost**	**Dispensing Fee**	**State MAC**
Montana	Ingredient cost is WAC plus 2%	Dispensing fee is $6.78; $12.50 to $22.50 (compounding)	Yes
Nebraska	Ingredient cost is AWP (Nebraska Point of Purchase – NE-POP) minus 11% or WAC plus 6.8%	Dispensing fee is $4.45	Yes
Nevada	Ingredient cost is NADAC	Dispensing fee is $9.47	No
New Hampshire	Ingredient cost is AWP minus 16% or WAC plus 0.8%	Dispensing fee is $1.75; Compound dispensing fee is $1.75	Yes
New Jersey	Ingredient cost is WAC minus 1%	Dispensing fee is $3.73 up to $3.99 (twenty-four hour emergency service and impact area location)*	Yes
New Mexico	Ingredient cost is lower of AWP minus 14%; WAC as submitted to State; manufacturer price as submitted to State; pharmacy invoice price as obtained through audits	Dispensing fee is $3.65	Yes
New York	Ingredient cost is AWP minus 17% (brand); AWP minus 25% (generic)	Dispensing fee is $3.50 (generic); $3.50 (brand)	Yes
North Carolina	Ingredient cost is NADAC. If NADAC pricing is not available, AAC will be WAC + 0%. Physician administered drugs ASP plus 6% or AWP minus 10%; for the contraceptive drugs (Implanon and Mirena) WAC plus 6%	Tiered professional dispensing fee: $13.00 when 85% or more of claims per quarter are for generic or preferred brand drugs $7.88 when less than 85% of claims per quarter are for generic or preferred brand drugs and $3.98 for non-preferred brand drugs.	Yes
North Dakota	Ingredient cost is the lower of NADAC, WAC, MAC, U/C (legend, non-legend, specialty drugs, long-term care, physician administered drugs, clotting factor); the lower of logic also includes AAC (340B, 340B physician administered drugs, FSS, Nominal Price); 340B contract pharmacies not covered; invoice pricing (investigational drugs).	Professional dispensing fee is $12.46; plus $0.15 per pill (pill splitting)	Yes
Ohio	Ingredient cost is WAC plus 7%; AWP minus 14.4% (if WAC cannot be determined)	Dispensing fee is $1.80	Yes
Oklahoma	Ingredient cost is lower of AWP minus 12%; WAC + 5.6% (if AWP is not available); ASP +6% (injectable drugs)	Dispensing fee is $4.02	Yes
Oregon	Ingredient cost for single source and multiple source drugs is AAC	Dispensing fee varies by claims volume; less than 30,000 claims a year is $14.01; between 30,000 and 49,999 claims per year is $10.14; 50,000 or more claims per year is $9.68	No
Pennsylvania	Ingredient cost WAC plus 3.2% (brand) and WAC (generic)	Dispensing fee is $2.00; $3.00 (compounding)	Yes
Rhode Island	Ingredient cost is WAC	Dispensing fee is $3.40 (outpatient); $2.85 (long term care)	No
South Carolina	Ingredient cost is lower of AWP minus 16% or WAC plus 0.8%	Dispensing fee is $3.00 (independent pharmacy); $3.00 (institutional pharmacies)	Yes
South Dakota	Ingredient cost is Consolidated Price (WAC multiplied by 1.2) for the drug less 13%; If no WAC, then Direct Price multiplied by 1.2	Dispensing fee is $4.40 plus an additional $.80 for unit dose dispensing	Yes
Tennessee	Ingredient cost AWP minus 13% for generic drugs; AWP minus 15% for brand name drugs, MAC or FUL (whichever is lower) for TennCare Pharmacy Network; Specialty Pharmacy Rates are set separately	Dispensing fee for TennCare Pharmacy Network is $2.50 (brand); $3.00 (generic); $5.00 (brand nursing home) $6.00 (generic nursing home); Compounded prescriptions$10 (requiring 0-15 minutes to compound), $15 (requiring 16-30 minutes), $25 (requiring 31 or minutes)	Yes
Texas	Ingredient costs of legend and nonlegend drugs: Retail = NADAC; Long term care (LTC) = (NADAC - 2.4%) Specialty = (NADAC - 1.7%); If NADAC is not available for a specific drug: Retail = (WAC - 2%), LTC = (WAC - 3.4%) Specialty = (WAC - 8%); 340B is based on state's estimate of the 340B ceiling price	Professional Dispensing fee is (((Acquisition Cost + Fixed Component) divided by (1 – the percentage used to calculate the Variable Component)) - Acquisition Cost) + Delivery Incentive + Preferred Generic Incentive	Yes

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State, Quarter Ending March 2017			
State	**Ingredient Cost**	**Dispensing Fee**	**State MAC**
Utah	Ingredient cost is the lesser of AWP minus 17.4%, FUL, Utah Maximum Allowable Cost, or the ingredient cost submitted; Ingredient cost for 340B drugs is no more than the 340B ceiling price	Dispensing fee is $3.90 (urban); $4.40 (rural) Dispensing fee is $12.39 for 340B billed drugs	Yes
Vermont	Ingredient cost is AWP minus 14.2% (multiple and single source); AWP minus 16.5% (large volume out- of-state mail order specialty pharmacies); 93% of Medicare's ASP plus 6% (physician administered drugs)	Dispensing fee $4.75 (In-State); $2.50 (Out-of-State); $19.75 (compound drug fee in-state); $17.50 (compound drug fee out-of-state)	Yes
Virginia	Ingredient cost is the lower of NADAC, WAC, FUL, U/C (legend, non-legend, specialty drugs, long-term care); Lower of NADAC, WAC, U/C (clotting factor); AAC (340B, 340B physician administered drugs, FSS, Nominal Price); ASP plus 6% (physician administered drugs); 340B contract pharmacies not covered; investigational drugs not covered	Professional dispensing fee is $10.65	No
Washington	Ingredient cost is AWP minus 16% (single source drugs); AWP minus 16% (multi-source drugs with four or fewer manufacturers/labelers); AWP minus 50% (multi-source drugs with five or more manufacturers/labelers and no MAC or FUL); ASP plus 6% (physician administered drugs)	Dispensing fee is $4.24 to $5.25 (based on 3-tiered pharmacy volume)	Yes
West Virginia	Ingredient cost is AWP minus 15% (brand); AWP minus 30% (generic)	Dispensing fee is $2.50 (brand); $5.30 (generic); $8.25 (340B billed drugs)	Yes
Wisconsin	Ingredient cost is WAC plus 2% (single source drugs); WAC minus 3.8% (multi-source drugs)	Dispensing fee is $3.44 (brand); $3.94 (generic); $0.015 per unit (for repackaging); $9.45 to $22.16 (compound drug fee); $9.45 to $40.11 (pharmaceutical care dispensing fee)	Yes
Wyoming	Ingredient cost is AWP minus 11%	Dispensing fee is $5.00	No
340B=prices charged to covered entities under the Public Health Services Act, AAC=actual acquisition cost, ASP=average sale price,			
AWP=average wholesale price, DP=Direct Price, FFS=fee for service, FUL=Federal upper limit, NADAC= National Averaged Drug Acquisition			
Cost, State MAC=State Maximum Allowance Cost, U/C=Usual and Customary, WAC=wholesaler acquisition cost			
FQHC=Federally Qualified Health Centers, NH=nursing home			
*CMS Approved State Plans or State Source			
Source = www.medicaid.gov, (accessed August 2017) Revised – 3/31/17			

APPENDIX I - FY 2016 PROVIDER TAXES AND FEES IN PLACE, BY PROVIDER TYPE BY THE KAISER FAMILY FOUNDATION

Provider Taxes and Fees in Place in FY 2016, by Provider Type							
State	Nursing Facilities	ICF/ID*	Hospitals	Other Taxes	Other Taxes	Other Taxes	Total # Taxes
KY	Yes	Yes	Yes	home health	managed care		5
MO	Yes	Yes	Yes	prescription drugs	ambulance		5
NJ	Yes	Yes	Yes	ambulatory surgical centers	managed care		5
NY	Yes	Yes	Yes	home health	personal care		5
PA	Yes	Yes	Yes	Philadelphia	managed care		5
WV	Yes	Yes	Yes	ambulatory surgical centers	independent laboratory or X-ray services		5
VT	Yes	Yes	Yes	home health	ambulance		5
CA	Yes	Yes	Yes	managed care			4
CT	Yes	Yes	Yes	ambulatory surgical centers			4
MD	Yes	Yes	Yes	managed care			4
ME	Yes	Yes	Yes	service provider tax			4
MN	Yes	Yes	Yes	service provider tax			4
MS	Yes	Yes	Yes	psychiatric residential treatment facilities			4
OH	Yes	Yes	Yes	managed care			4
TN	Yes	Yes	Yes	managed care			4
UT	Yes	Yes	Yes	ambulance			4
WI	Yes	Yes	Yes	ambulatory surgical centers			4

Provider Taxes and Fees in Place in FY 2016, by Provider Type							
State	Nursing Facilities	ICF/ID*	Hospitals	Other Taxes	Other Taxes	Other Taxes	Total # Taxes
AL	Yes	–	Yes	prescription drugs			3
AR	Yes	Yes	Yes				3
CO	Yes	Yes	Yes				3
FL	Yes	Yes	Yes				3
IA	Yes	Yes	Yes				3
ID	Yes	Yes	Yes				3
IL	Yes	Yes	Yes				3
IN	Yes	Yes	Yes				3
LA	Yes	Yes	–	prescription drugs			3
MA	Yes	–	Yes	ambulatory surgical centers			3
MT	Yes	Yes	Yes				3
NC	Yes	Yes	Yes				3
NM	–	–	–	managed care	managed care	managed care	3
OK	Yes	Yes	Yes				3
RI	Yes	–	Yes	managed care			3
WA	Yes	Yes	Yes				3
AZ	Yes	–	Yes				2
GA	Yes	–	Yes				2
HI	Yes	–	Yes				2
KS	Yes	–	Yes				2
MI	Yes	–	Yes				2
NE	Yes	Yes	–				2
NH	Yes	–	Yes				2
OR	Yes	–	Yes				2
SC	–	Yes	Yes				2
TX	–	Yes	–	managed care			2
DE	Yes	–	–				1
ND	–	Yes	–				1
NV	Yes	–	–				1
SD	–	Yes	–				1
VA	–	Yes	–				1
WY	Yes	–	–				1
AK	–	–	–				0
Total	**43**	**35**	**39**	**23**	**8**	**1**	**149**
*ICF/ID = Intermediate Care Facilities for Individuals with Intellectual Disability							

APPENDIX J – FY 2014 MEDICAID SPENDING PER FULL-BENEFIT ENROLLEE BY THE HENRY J. KAISER FAMILY FOUNDATION

FY 2014 Medicaid Spending Per Full-Benefit Enrollee by the Henry J. Kaiser Family Foundation										
Location	Total	Rank (Low)	Seniors	Rank (Low)	Individuals with Disabilities	Rank (Low)	Adults	Rank (Low)	Children	Rank (Low)
Nevada	$4,003	1	$16,589	17	$15,589	12	$2,323	2	$1,520	1
South Carolina	$4,169	2	$8,623	1	$10,340	2	$4,292	23	$1,945	5
Florida	$4,788	3	$13,356	9	$14,779	6	$2,866	4	$1,816	3
Alabama	$4,827	4	$18,927	24	$9,448	1	$4,263	21	$2,083	8
Georgia	$4,838	5	$12,670	8	$11,008	3	$5,305	41	$2,825	29
Colorado	$4,898	6	$12,532	7	$16,252	17	$2,915	6	$2,026	7
New Jersey	$4,969	7	$9,085	2	$16,906	20	$3,768	12	$2,484	19
Illinois	$5,301	8	$13,539	10	$17,313	22	$3,350	9	$2,108	9
California	$5,318	9	$10,976	3	$20,672	32	$2,672	3	$2,500	20
Utah	$5,326	10	$11,638	5	$19,510	28	$4,201	19	$2,483	18
Idaho	$5,452	11	$15,096	12	$18,215	25	$4,036	17	$2,204	12
Washington	$5,510	12	$15,590	13	$15,891	14	$6,238	46	$1,994	6
North Carolina	$5,573	13	$11,178	4	$15,238	9	$4,495	28	$2,349	16
Oklahoma	$5,608	14	$15,924	14	$16,309	18	$3,912	16	$2,734	27
Louisiana	$5,740	15	$19,148	25	$15,501	11	$3,904	14	$1,930	4
Arizona	$5,801	16	$12,232	6	$19,313	27	$4,521	30	$2,972	33
Wisconsin	$5,828	17	$14,266	11	$13,923	4	$3,600	11	$1,807	2
West Virginia	$5,854	18	$24,997	36	$14,957	7	$3,222	8	$2,538	21
South Dakota	$5,988	19	$18,678	23	$20,107	30	$4,223	20	$2,336	15
New Mexico	$6,026	20	N/A	N/A	$19,675	29	$3,564	10	$5,137	50
Hawaii	$6,084	21	$18,098	20	$21,915	35	$4,268	22	$2,577	23
Arkansas	$6,109	22	$21,342	28	$16,799	19	$1,657	1	$3,372	42
Iowa	$6,223	23	$24,317	34	$21,341	33	$3,183	7	$2,217	13
Michigan	$6,411	24	$16,174	16	$16,972	21	$4,719	32	$2,405	17
Nebraska	$6,455	25	$16,743	18	$17,612	24	$4,990	35	$2,163	11
Texas	$6,495	26	$18,078	19	$23,485	38	$3,854	13	$2,962	32
Kentucky	$6,572	27	$18,465	22	$15,929	15	$4,837	33	$3,123	36
Wyoming	$6,602	28	$29,268	45	$25,242	41	$4,382	25	$2,292	14
Oregon	$6,604	29	$21,416	29	$20,544	31	$5,667	43	$2,783	28
Kansas	$6,670	30	$22,928	33	$15,754	13	$5,300	40	$2,662	26
Tennessee	$6,718	31	$18,302	21	$16,187	16	$6,048	44	$3,145	38
Montana	$6,733	32	$21,581	30	$14,575	5	$9,135	50	$3,132	37
Mississippi	$6,780	33	$21,087	27	$15,063	8	$4,473	26	$2,568	22
Ohio	$7,010	34	$26,219	39	$22,993	37	$4,498	29	$2,591	24
New Hampshire	$7,472	35	$25,455	37	$29,780	46	$4,361	24	$2,984	34
Maine	$7,507	36	$15,929	15	$17,387	23	$3,906	15	$3,164	39
Virginia	$7,678	37	$20,070	26	$21,370	34	$6,137	45	$2,840	30

FY 2014 Medicaid Spending Per Full-Benefit Enrollee by the Henry J. Kaiser Family Foundation										
Location	Total	Rank (Low)	Seniors	Rank (Low)	Individuals with Disabilities	Rank (Low)	Adults	Rank (Low)	Children	Rank (Low)
Indiana	$7,777	38	$30,276	46	$25,092	40	$4,917	34	$2,158	10
Maryland	$8,118	39	$26,971	42	$28,402	44	$5,027	36	$3,082	35
Rhode Island	$8,315	40	$22,832	32	$27,192	42	$5,479	42	$3,297	41
Connecticut	$8,446	41	$33,824	48	$33,435	49	$5,237	38	$3,377	43
Missouri	$8,501	42	$21,856	31	$22,781	36	$4,481	27	$3,187	40
New York	$8,618	43	$28,227	44	$28,382	43	$4,709	31	$2,653	25
Massachusetts	$8,620	44	$24,689	35	$15,410	10	$2,913	5	$3,508	44
Vermont	$8,787	45	$26,524	40	$24,082	39	$5,289	39	$4,612	48
Minnesota	$8,973	46	$26,970	41	$30,925	48	$5,132	37	$3,569	45
Delaware	$9,041	47	$44,752	49	$29,827	47	$6,723	48	$3,835	46
Pennsylvania	$9,638	48	$25,625	38	$18,310	26	$4,139	18	$2,889	31
Alaska	$10,001	49	$27,020	43	$28,756	45	$6,890	49	$5,133	49
North Dakota	$10,721	50	$31,970	47	$38,442	50	$6,377	47	$4,366	47
Median	**$6,475**		**$19,148**		**$18,263**		**$4,428**		**$2,658**	
Minimum	**$4,003**		**$8,623**		**$9,448**		**$1,657**		**$1,520**	
Maximum	**$10,721**		**$44,752**		**$38,442**		**$9,135**		**$5,137**	

APPENDIX K – UTAH DEPARTMENT OF HEALTH MEDICAID REIMBURSEMENT RATES BUDGET DEEP DIVE

Utah Department of Health
Medicaid Reimbursement Rates for Medical, Pharmacy, and Dental Providers
Budget Deep-dive

What We Are Attempting to Accomplish

1. What authorizes Delivery/provision of function (statute, intent, rule)?

The Division of Medicaid and Health Financing (DMHF) administers the Medicaid program which provides a variety of health care services to low income individuals in the state. DMHF reimburses medical, dental, pharmacy and behavioral health providers using approved rates for the various services performed either through fee for service (FFS) or managed care arrangements.

Federal regulations that provide guidance for states on implementing Medicaid state plan payment rates can be found at 42 CFR 447 for FFS and 42 CFR 438 for managed care.

State statute also provides some guidance on rates as well. Utah Code Annotated Title 26 Chapter 35a Section 107 addresses the adjustment to nursing care facility reimbursement rates as a result of the assessment. Utah Code Annotated Title 26 Chapter 36b Section 209 requires the department to include a requirement in the ACO contracts to reimburse hospitals no less than the Medicaid fee-for-service rate. Utah Code Annotated Title 26 Chapter 36a Section 205 addresses the adjustment to the accountable care organization rates related to the hospital assessment. Utah Code Annotated Title 26 Chapter 37a Section 105 addresses the adjustment to fee-for-service rates up to the Emergency Medical Services Ambulance Rates adopted annually by the department.

In addition, all rate methodologies are included in the State Plan or the applicable waiver. All amendments made to the State Plan or to a waiver must be approved by the Centers for Medicare and Medicaid Services (CMS) and must also be reported to the Social Services Appropriations Subcommittee (SSAS).

2. What other activities are undertaken without explicit authority?

CMS must approve rate setting activities for medical, dental or pharmacy providers that increase/decrease costs. As discussed in the response to #1, CMS must approve changes to rate methodologies and DMHF reports those changes to SSAS through its quarterly report.

The Utah Legislature authorizes changes to rates by making discreet changes to the Medicaid services budget through bills, appropriations, or intent language. DMHF

implements approved rate setting activities to target legislatively authorized appropriations. From time to time, DMHF rebases rates in order to effectively distribute appropriated dollars; however, this is done on a budget neutral basis.

3. What alternative government and non-government resources exist to achieve these outcomes? Why is state involved?

For the purpose of determining managed care rates, we use contracted actuaries to determine the rate ranges and a contracted CPA firm to audit cost reports used in the rate setting process. In addition, managed care rates are submitted to CMS Office of the Actuary for review and certification. For FFS medical, dental and pharmacy provider rates internal staff work to set rates according to federal regulations and within the appropriated budget. All rate setting methodologies are approved by CMS as part of the State Plan or as part of a Waiver approval.

As requested by the Legislative Fiscal Analyst, the Utah Department of Health (Department) is also submitting information regarding the Health Clinics of Utah and the Family Dental Plan (Clinics) in this section.

Originally, counties provided medical care for indigent residents. About 30 years ago, the State created the Clinics to provide care for this population. The Clinics then transitioned to Utah Medical Assistance Program (UMAP) clinics. In 2002, the UMAP program transitioned to the Primary Care Network (PCN) program to increase care for up to 18,000 individuals rather than up to 8,000 individuals under UMAP.

The Clinics seek to serve underserved individuals. Many physicians in other clinics don't serve PCN patients even though they take Medicaid patients. Many patients seen in the clinics have severe and persistent mental illness and have a difficult time fitting in or being accepted in regular clinic settings. In addition, the clinics are located near or in large State offices and serve as episodic clinics for the convenience of State employees so they don't have to miss as much work. The Provo clinic has long provided work fitness examinations for prospective Department Of Corrections and Public Safety Highway Patrol employees statewide as well as medical services for children at the Slate Canyon Juvenile Justice facility. These are cost-effective services provided in support of these State agencies. It is important for the Department as a state health agency to retain a measure of clinical health services to address different needs of other state agencies and special populations.

Below are the revenues and costs associated with operating the Clinics:

Sum of Amount	Fiscal Year					
Clinics Revenue Sources	2012	2013	2014	2015	2016	Grand Total
2802 Contracts For Services	$ 9,504.00					$ 9,504.00
2944 Support Collections	$ 1,051,288.96	$ 1,066,074.32	$ 1,487,295.64	$ 1,772,542.76	$ 1,959,534.70	$ 7,336,736.38
2985 Non-sufficient Funds Checks Clearing Account	$ (1,851.80)	$ 1,969.97	$ 525.24	$ 3,546.84	$ 4,820.18	$ 9,010.43
2997 Cash Over & Short					$ 0.01	$ 0.01
3252 Fed DOH Title XIX Medicaid	$ 411,789.95	$ 380,116.49	$ 415,182.94	$ 413,057.57	$ 389,849.28	$ 2,009,996.23
4737 Transfer From Other Agencies	$ 21,581.14	$ 66,141.57	$ 53,650.74	$ 56,712.95	$ 60,109.02	$ 258,195.42
4738 Transfer Within An Agency	$ 1,876,789.04	$ 1,742,554.62	$ 1,413,510.06	$ 1,263,512.95	$ 1,015,860.34	$ 7,312,227.01
4742 Transfer Federal Revenue Within An Agency	$ 212,500.00	$ 184,500.00	$ 18,000.00			$ 415,000.00
Grand Total	**$ 3,581,601.29**	**$ 3,441,356.97**	**$ 3,388,164.62**	**$ 3,509,373.07**	**$ 3,430,173.53**	**$ 17,350,669.48**

Sum of Amount	Fiscal Year					
Clinics Expenditure Categories	2012	2013	2014	2015	2016	Grand Total
AA Personnel Services	$ 3,964,363.61	$ 3,795,009.07	$ 4,035,320.73	$ 4,112,669.91	$ 4,334,900.93	$ 20,242,264.25
BB Travel/In State	$ 30,567.00	$ 26,748.48	$ 31,662.35	$ 36,350.71	$ 37,457.32	$ 162,785.86
CC Travel/Out of State	$ 1,538.12	$ 2,391.49	$ 3,685.71	$ 2,596.87	$ 4,679.40	$ 14,891.59
DD Current Expense	$ 894,783.58	$ 746,182.50	$ 922,314.63	$ 928,122.80	$ 1,014,805.48	$ 4,506,208.99
EE Data Processing Current Expense	$ 146,859.55	$ 65,876.90	$ 128,943.70	$ 127,915.85	$ 97,423.13	$ 567,019.13
FF Data Processing Capital Expenditure				$ -		$ -
GG Capital Expenditure	$ 71,954.40	$ 22,421.88	$ 86,066.21	$ -		$ 180,442.49
HH Other Charges/Pass Through	$ 531,583.55	$ 415,896.72	$ 757,418.26	$ 810,387.66	$ 641,764.71	$ 3,157,050.90
Grand Total	**$ 5,641,649.81**	**$ 5,074,527.04**	**$ 5,965,411.59**	**$ 6,018,043.80**	**$ 6,131,030.97**	**$ 28,830,663.21**

How We Are Organized

4. What organizations are associated with this function?

Bureau of Authorization and Community Based Services
Bureau of Coverage and Reimbursement Policy
Bureau of Eligibility Policy
Bureau of Financial Services
Bureau of Managed Health Care
Bureau of Medicaid Operations
Carver, Florek, and James CPAs
Milliman (actuarial services)
Centers for Medicare and Medicaid Services

5. What are the missions of the organizations associated with that function?

DMHF Mission - We provide access to quality, cost-effective health care for eligible Utahns.

6. What outcomes are achieved by the organization associated with this function?

The primary outcomes are meaningful rates that are consistent with federal regulations, that don't impede access to care, and that reasonably reimburse providers for their services. For information on the number of providers participating in FFS by category of service, see Table 17 in the 2016 Annual Report of CHIP and Medicaid (pages 33-34).

7. **What data is collected/reported to document/demonstrate progress toward the outcomes?**

DMHF collects, reviews and reports data on access to care and on quality of care performance measures.

For Health Effectiveness Data and Information Set (HEDIS) measures, see http://stats.health.utah.gov/reports/hedis/index.php?year=2016&doc=result&doc=result&mytabsmenu=3&cat=2

For Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of patient experience with healthcare, see https://health.utah.gov/myhealthcare/reports/cahps/2016/?page=medicaidMember#1

For access to care data, see https://medicaid.utah.gov/Documents/pdfs/Utah_Access_Monitoring_Review_Plan.pdf

The State is also required to perform an external quality review (EQR) of its contracted managed care organizations. The state contracts with an external quality review organization (EQRO) that performs an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the managed care organizations provide to Medicaid members.

8. **How are appropriations structured to accomplish this function?**

In the 2017 General Session, the Legislature approved a new line item to track Medicaid funding. The programs/appropriation units within this new line item are structured to track the largest expenditure groups for the Medicaid program. They are:
LIA – Accountable Care Organizations
LIB – Dental
LIC – Expenditure Offsets from Collections
LID – Home & Community Based Waivers
LIE – Home Health & Hospice
LIF – Inpatient Hospital
LIG – Intermediate Care Facilities for the Intellectually Disabled
LIH – Medical Transportation
LII – Medicare Buy-In
LIJ – Medicare Part D Clawback Payments
LIK – Mental Health and Substance Abuse

LIL – Nursing Home
LIM – Other Services
LIN – Outpatient Hospital
LIO – Pharmacy
LIP – Physician and Osteopath
LIQ – Provider Reimbursement Information System for Medicaid
LIR – School Based Skills Development
LIS – Medicaid Expansion 2017

9. **In what units of measure are outputs reported, how and why have those outputs changed over time?**

   DMHF measures the effectiveness of medical, dental, and pharmacy rates using the following measures:

   For Health Effectiveness Data and Information Set (HEDIS) measures of the quality of care, see http://stats.health.utah.gov/reports/hedis/index.php?year=2016&doc=result&doc=result&mytabsmenu=3&cat=2

   For Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of patient experience with healthcare, see https://health.utah.gov/myhealthcare/reports/cahps/2016/?page=medicaidMember#1

   For access to care data, see https://medicaid.utah.gov/Documents/pdfs/Utah_Access_Monitoring_Review_Plan.pdf

10. **Are performance measures meaningful and how is management assuring such?**

    DMHF considers the performance measures to be meaningful measures of the program's performance. In addition, the categories that are measured are based on national standards.

11. **What kind of external variables impact the organization/function and what is the current status of those variables?**

    There are several variables that impact the rate setting process. They can include, but are not limited to the following:

- Consumer Price Index changes – Inflationary factors are considered in the Consensus process for appropriation. Average annual percentage growth of Medical Care CPI between 2012 and 2016 was 2.82%.
- FDA approval of new pharmaceuticals - FDA approval of new high cost pharmaceuticals impacts the costs for pharmacy benefits for fee for service and impacts the rates paid to the Accountable Care Organizations. These impacts are considered in the Consensus process for appropriation.
- New federal regulations – Federal regulation changes can increase providers' costs of performing services, which can also impact the rates. For example, new federal regulations related to face-to-face requirements for DME will increase the administrative burden for home health and personal care service providers. In addition, changes to federal labor laws have increased personnel costs for home health and hospice providers. Future federal regulation changes, such as the Electronic Visit and Verification regulations will also increase provider costs.
- The CMS Office of the Actuary can impact both the rate and the timeline for the approval of the rate. The CMS Office of the Actuary make the final determination as to whether the managed care rates are actuarially sound. If proposed rates are not actuarially sound, the CMS Office of the Actuary will not approve the rates. The analysis and final approval of proposed rates performed by the CMS Office of the Actuary typically takes from 6 months to a year. This can significantly delay the implementation of new rates.
- The status of the economy – Economic factors can influence enrollment in the Medicaid program. While these factors may not necessarily impact rates, they do impact total costs of services provided in the Medicaid program. Typically, Medicaid enrollment decreases in periods of economic growth and has historically increased in periods of economic decline. In state fiscal year 2017, total Medicaid enrollment decreased. This was largely the result of decreases in the Children, Pregnant Women, and Adult populations.
- Results of the dispensing fee survey – Federal regulations require the state to periodically perform a dispensing rate survey. When the survey is complete, it can result in modifications to the dispensing fees.

12. Are there standards (industry, national, other states, etc.) for output or output per unit of input? How do they compare to this?

The following represent standards of performance:

For Health Effectiveness Data and Information Set (HEDIS) measures of the quality of care, see

http://stats.health.utah.gov/reports/hedis/index.php?year=2016&doc=result&doc=result&mytabsmenu=3&cat=2

For Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of patient experience with healthcare, see https://health.utah.gov/myhealthcare/reports/cahps/2016/?page=medicaidMember#1

For access to care data, see https://medicaid.utah.gov/Documents/pdfs/Utah_Access_Monitoring_Review_Plan.pdf

13. To whom is performance data reported?

Data related to medical, dental and pharmacy rates is reported in the Annual Report of Medicaid and CHIP, which is posted on the Medicaid website. DMHF also reports expenditure and related statistical data to CMS quarterly via the CMS-64 report and the Transformed Medicaid Statistical Information System (T-MSIS) report. In addition, various other stakeholders monitor DMHF performance, such as, the Governor's Office of Management and Budget, the Legislature, the Medical Care Advisory Committee, and the community.

14. What decisions are based on reporting data?

DMHF uses data from Milliman reports, information from dispensing surveys, encounter data for managed care, and acuity of residents in nursing facilities to determine whether or not rates need to be adjusted. In addition, DMHF receives recommendations from the Medical Care Advisory Committee on funding request to pursue annually, which typically include various provider rate increases. If DMHF determines that rates need to be adjusted, we will submit a building block to the Governor's Office of Management and Budget.

Specifically with regards to managed care, rates for ACOs, PMHPs, Medicaid Dental plans, CHIP Managed Care and Dental plans, and the H.O.M.E. program are determined through Milliman analysis of encounter data and other financial reports from the plans to determine actuarially sound rate ranges and rates. Rates are targeted to available funding. If the actual encounter experience, trended forward plus reasonable costs of administration exceed available funding, Milliman cannot certify the rates. In turn DMHF is unable to submit approvable actuarially certified rates to CMS. This places the state in a possible disallowance situation. If this scenario occurs, DMHF will need to request a building block to increase funding for managed care rates or make a

recommendation to terminate managed care contracts and move back to fee for service reimbursement.

15. How might you recommend the authorization, mission, or performance measurement change?

DMHF would recommend that states be allowed more flexibility in calculating rates and more timely approval of rates. Currently, all managed care rates must be reviewed and approved by the CMS Office of the Actuary and the CMCS Division of Managed Care Plans. This process is very prescriptive and can take a significant amount to time. Historically, rate review and approval has taken 6 months to 1 year. DMHF cannot pay new managed care rates until they have been approved. Delays in the approval process result in DMHF paying the previously approved rates until the new rate is approved. At which point, all capitation payments made to the managed care organization between the effective date of the rate through the point of certification are recouped and replaced. This presents challenges in terms of budgeting and financial reporting for both DMHF and the managed care organizations.

What We Are Buying

16. What is the largest category of expenditure for an organization and how big is it?

Managed care expenditures represent the largest category of expenditure in the organization. See Figure 15 in the 2016 Annual Report of CHIP and Medicaid (page 38) for managed care expenditures between fiscal years 2012 and 2016.

Inpatient Hospital Services represent the largest category of expenditure for fee for service. See Table 17 in the 2016 Annual Report of CHIP and Medicaid (pages 35-36) for fee for service expenditures by category of service between fiscal years 2012 and 2016.

As requested by the Legislative Fiscal Analyst, DMHF is also reporting here the costs to operate the Medicaid Management Information System that is used to pay the claims. The administrative costs associated with operating MMIS between 2012 and 2016 are included below:

	2012	2013	2014	2015	2016	2017
Total Funds	$8,105,394.72	$10,631,051.99	$10,581,674.02	$13,507,173.94	$12,854,173.26	$12,039,410.89
State's Share	$2,026,348.68	$2,657,763.00	$2,645,418.51	$3,376,793.49	$3,213,543.32	$3,009,852.72

17. How does this expenditure support the above justification/authorization?

Reimbursement rates paid to Medicaid providers support providing medical, dental and behavioral health services to Medicaid members.

18. What is that category of expenditure buying (how many/cost per unit)?

Utilization and related expenditures for both fee for service and managed care are reported in the 2016 Annual Report of CHIP and Medicaid (pages 41-49).

19. How does the above relate to units of output?

The number of providers participating in FFS by category of service is reported in Table 17 in the 2016 Annual Report of CHIP and Medicaid (pages 33-34).

20. How has the expenditure changed over five years relative to the units of output?

The following represent cost per claim data related to the largest fee for service expenditure categories. Because DMHF pays capitation payments to managed care organizations that is a monthly amount per member to provide health care to Medicaid members, the same type of analysis cannot be performed. The source of the following information is the 2016 Annual Report of CHIP and Medicaid (pages 41-46).

Fee for Servie					
	Hospital Care				
	2012	2013	2014	2015	2016
Claims	332,850	279,222	205,534	215,837	134,528
Expenditures	$ 618,520,000	$ 490,730,000	$ 325,260,000	$ 314,890,000	$ 282,720,000
Average Cost Per Claim	$ 1,858	$ 1,757	$ 1,583	$ 1,459	$ 2,102
	Physician Services				
	2012	2013	2014	2015	2016
Claims	1,187,870	951,840	683,837	705,961	444,287
Expenditures	$ 109,600,000	$ 98,470,000	$ 76,490,000	$ 89,200,000	$ 65,550,000
Average Cost Per Claim	$ 92	$ 103	$ 112	$ 126	$ 148
	Pharmacy Services				
	2012	2013	2014	2015	2016
Claims	2,680,493	2,037,675	1,416,388	1,481,552	1,247,833
Expenditures	$ 182,870,000	$ 136,930,000	$ 115,780,000	$ 139,640,000	$ 126,110,000
Average Cost Per Claim	$ 68	$ 67	$ 82	$ 94	$ 101
	Other Services				
	2012	2013	2014	2015	2016
Claims	3,396,191	3,563,903	3,501,559	3,773,085	3,855,872
Expenditures	$ 210,930,000	$ 233,000,000	$ 203,620,000	$ 224,670,000	$ 253,560,000
Average Cost Per Claim	$ 62	$ 65	$ 58	$ 60	$ 66
	Long-Term Care				
	2012	2013	2014	2015	2016
Claims	468,643	477,165	537,539	569,387	536,301
Expenditures	$ 419,800,000	$ 435,300,000	$ 465,500,000	$ 500,400,000	$ 541,400,000
Average Cost Per Claim	$ 896	$ 912	$ 866	$ 879	$ 1,010

Note: The decreases between state fiscal year 2012 and state fiscal year 2013 relate to the implementation of ACOs in the 4 counties. The decreases between state fiscal year 2015 and state fiscal year 2016 relate to expansion of ACOs into 9 additional counties.

21. Are there any outliers/anomalies in current or budgeted spending in this category?

Although there are many variable that impact the provider rates, one of the most impactful variables relates to new to market high cost drugs. Some examples include:

- Spinal Muscular Atrophy (SMA)
  - Spinraza (nusinersen) was approved by the FDA in December 2016. The cost is about $25,000 per treatment for this intrathecal drug injection with a lumber puncture procedure. Estimated 1st year cost is $750,000 and subsequent annual treatments to cost $375,000 per year per patient.
- Mucopolysaccharidosis (MPS)
  - Vimizim was approved by the FDA for MPS IVA in 2014 to be administered by a provider intravenous infusion. Estimated cost is $380,000 per year.
  - UX-003 (rhGUS) by Ultragenyx is an intravenous drug that is anticipated to receive approval during 4q2017 for the treatment of MPS VII. Cost is unknown.
- Hyperammonemia
  - Carbaglu (carglumic acid) oral tablets was approved by the FDA for both acute and chronic treatment in pediatric and adult patients in 2010. Estimated annual cost for treatment is more than $105,000.

22. Does the amount of expenditure for a category change significantly in accounting period 12 or 13? Why?

There is typically no correlation between rates paid to providers nor the related utilization and the state's fiscal year end. The most significant changes that occur at fiscal yearend relate to accounting accruals performed for the state's financial statements. These yearend entries include deferral of capitation payments made in June that relate to July; accrual of a pharmacy rebate accounts receivable to recognize pharmacy rebates that have been or will be billed to drug manufacturers for periods prior to accounting period 12 that have not yet been paid; and accrual of anticipated effects of rate changes that are effective for periods prior to accounting period 12, but that have not yet been certified and paid.

23. How might you recommend this expenditure category change based on the above?

DMHF has no recommendations for change to the referenced expenditure categories.

<u>How We Are Paying For It</u>

24. What is the largest fund or account from which resources are drawn to support the above expenditures and how big is it?

Medical, Dental, Pharmacy and Behavioral Health reimbursement rates are funded primarily with federal Title XIX funds, General Fund appropriations, Assessment Collections, Intergovernmental Transfers, and Pharmacy Rebates.

25. What are the revenue sources for that fund or account and what are their relative shares?

The revenue sources for provider rates are primarily the federal government, state General Fund, assessments charged to providers, intergovernmental transfers from non-state government owned facilities and pharmacy rebates collected from drug manufacturers.

26. Is the source one-time or ongoing and do ongoing sources match or exceed ongoing expenditures?

The sources of funding for provider rates are typically ongoing and generally the funding sources are sufficient to cover established provider reimbursement rates. However, enrollment and utilization are significant variables in the final costs associated with reimbursement rates and significant changes in either variable could result in expenditures exceeding appropriated funding sources.

27. How has the source changed over time relative to expenditures and units of output?

Category ($ in Millions)	Total Funds	Federal Funds	State Funds	Provider Contributions	Local Gov. Funds	Client Contributions	Other Funds
	FY 2012						
Medicaid Total Spending	$2,062	$1,425	$477	$ 128	$ 16	$ 14	$ 3
Minus Medicaid Administration	$ (98)	$ (53)	$ (44)	$ (1)	$ (0)	$ (0)	$ (0)
Medicaid Services Spending	**$1,964**	**$1,371**	**$433**	**$ 127**	**$ 16**	**$ 14**	**$ 3**
	FY 2013						
Medicaid Total Spending	$2,195	$1,497	$494	$ 154	$ 30	$ 15	$ 4
Minus Medicaid Administration	$ (100)	$ (56)	$ (43)	$ (1)	$ (0)	$ (0)	$ (0)
Medicaid Services Spending	**$2,095**	**$1,441**	**$451**	**$ 154**	**$ 30**	**$ 15**	**$ 4**
	FY 2014						
Medicaid Total Spending	$2,378	$1,654	$528	$ 147	$ 26	$ 21	$ 2
Minus Medicaid Administration	$ (116)	$ (75)	$ (40)	$ (0)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,262**	**$1,579**	**$488**	**$ 147**	**$ 25**	**$ 21**	**$ 2**
	FY 2015						
Medicaid Total Spending	$2,438	$1,687	$546	$ 166	$ 23	$ 17	$ 0
Minus Medicaid Administration	$ (118)	$ (75)	$ (42)	$ (1)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,320**	**$1,612**	**$504**	**$ 165**	**$ 22**	**$ 17**	**$ 0**
	FY 2016						
Medicaid Total Spending	$2,548	$1,755	$580	$ 169	$ 27	$ 16	$ 1
Minus Medicaid Administration	$ (126)	$ (79)	$ (46)	$ (1)	$ (1)	$ (0)	$ (0)
Medicaid Services Spending	**$2,422**	**$1,676**	**$535**	**$ 168**	**$ 26**	**$ 16**	**$ 1**
Sources:							
Issue Brief - 2017 General Session - Medicaid Spending Statewide							
2016 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2016 Interim - Medicaid Spending Statewide							
2015 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2015 Interim - Medicaid Spending Statewide							
2014 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2014 General Session - Medicaid Spending Statewide							
2013 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2013 General Session - Medicaid Spending Statewide							
2012 Utah Annual Report of Medicaid & CHIP							
Issue Brief - 2016 Interim - Medicaid Collections, What is the Bang for our Buck?							

28. Are there any outliers/anomalies in current or budgeted periods for this source?

There are a few significant variables that exist in the revenue sources related to provider rates. They are:

Pharmacy Rebates – Pharmacy rebates are the most significant collections used to offset costs in the Medicaid program. They are a function of the units dispensed and the

negotiated rebate per unit and due to adjustments, timing of collections, and disputes they are very difficult to forecast.

Collections – There are various entities that perform Medicaid Collections. The primary sources of collections are:

Office of Recovery Services (ORS)– DMHF contracts with ORS to perform the following collections on its behalf: TORT, Estate Recovery, Third Party Liability (TPL), and credit balance write-off collections.

Medicaid Office of Inspector General (OIG) – OIG recovers inappropriately paid Medicaid funds.

Medicaid Fraud Control Unit (MFCU) – MFCU recovers Medicaid funds lost to fraud, waste, or abuse.

Recovery Audit Contractor (RAC)– DMHF contracts with a RAC to perform work as defined in federal regulations as well as to perform TPL recoveries that are not subject to collection by ORS.

Collections among the various entities that recover for Medicaid can vary significantly from year to year and are extremely difficult to anticipate for budgeting purposes.

29. Does source have unencumbered balances that relate directly to this function/organization? How have those balances changed over time?

The Legislature has established 4 separate assessments for specific provider groups to fund the state's share of portions of the related rates. They are as follows:

Ambulance Service Provider Assessment – The funds collected are required be used to support fee-for-service rates for ambulance service providers. This assessment was new in state fiscal year 2016.

Fiscal Year	Ending Balance
2016	$ 500.99
2017	$ 500.99

Hospital Provider Assessment – The funds collected are required to be used to make inpatient hospital access payments. The ending balance amounts listed below are the result of years where the collections exceeded the appropriation from the fund. In years that collections exceeded appropriations, General Fund was used to ensure hospitals

received the amount established in statute. In fiscal year 2016, DMHF paid $1,222,701 of the balance in the fund to providers as required by intent language.

Fiscal Year	Ending Balance
2012	$ 3,438,700.00
2013	$ 4,248,329.00
2014	$ 6,100,636.00
2015	$ 6,100,636.00
2016	$ 4,877,935.00
2017	$ 4,877,935.00

Nursing Care Facility Assessment – The funds collected are required to be used to increase the rates paid to nursing care facilities. The collections from this assessment have historically been required to be recorded in a restricted fund. The ending balance amounts listed below are the result of years where the collections exceeded the appropriation from the fund. In the 2017 General Session, the Legislature approved moving the collections from a restricted fund to a special revenue fund.

Fiscal Year	Ending Balance
2012	$ 123,708.00
2013	$ 287,797.00
2014	$ 287,797.00
2015	$ 287,797.00
2016	$ (1.00)
2017	$ -

Medicaid Expansion Fund – This fund was created to record various funding sources that are required to be used to pay the costs of the health coverage improvement Medicaid waiver defined in UCA 26-18-411 and the outpatient UPL in UCA 26-36b-210. The funding sources recorded in this fund are:

1) Assessments collected as authorized in the related statute
2) Intergovernmental Transfers
3) Savings attributable to the health coverage improvement program
4) Savings attributable to the inclusion of psychotropic drugs on the preferred drug list
5) Savings attributable to the services provided by PEHP
6) Gifts, grants, donations or any other conveyance of money from private sources
7) Appropriations

Fiscal Year	Ending Balance
2017	$ 735,564.00

30. What is a reasonable balance and Why?

UCA 26-36a-207 governs the creation of and expenditures from the Hospital Provider Assessment Fund; UCA26-35a-106 governs the creation of and expenditures from the Nursing Care Facilities Account; UCA 26-36a-107 governs the creation of and expenditures from the Ambulance Service Provider Assessment Fund. The related statutes do not provide direction on a reasonable balance for these funds.

The existing balance in the Medicaid Expansion Fund relates to remaining General Fund appropriations and PDL savings in excess of amounts estimated in original appropriations. This balance will be used only for purposes authorized in statute.

31. Is the availability of sources (grants or previous "building blocks"), rather than mission or objective, driving expenditures?

DMHF works to accomplish our mission within the constraints of the appropriated budget.

32. Are other sources available to support the same expenditure?

There are federal limitations on the sources that are available to be included as the state's share of Medicaid expenditures. 42 CFR 433.51 states that "Public funds may be considered as the State's share in claiming FFP (federal financial participation) if they meet the conditions specified in paragraphs (b) and (c) of this section. (b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section. (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to math other Federal funds." In addition to the items stated above, the state may also include permissible provider-related donations and health care-related taxes as the state's share of Medicaid expenditures. Permissible provider–related donations are defined in 42 CFR 433.66. Permissible health care-related taxes are defined in 42 CFR 433.68 and are limited to 6 percent or less of the revenues received by the taxpayer.

33. How might you recommend this revenue category change based on the above?

DMHF has no recommendations for change to the referenced revenue categories.

Do We Balance?

34. What are total expenditures and total sources? Do they equal one another?

	Medicaid Mandatory Services	Medicaid Optional Services
2012		
Total Sources	$ 1,071,255,409	$ 925,640,732
Total Expenditures	$ 1,055,908,229	$ 913,494,708
Unexpended	$ 15,347,180	$ 12,146,024
Non-Lapsing	$ 15,266,669	$ 12,146,024
2013		
Total Sources	$ 1,184,003,090	$ 939,503,502
Total Expenditures	$ 1,160,053,523	$ 925,450,245
Unexpended	$ 23,949,567	$ 14,053,257
Non-Lapsing	$ 23,949,567	$ 14,053,258
2014		
Total Sources	$ 1,386,803,838	$ 900,281,376
Total Expenditures	$ 1,367,054,380	$ 897,518,755
Unexpended	$ 19,749,458	$ 2,762,621
Non-Lapsing	$ -	$ -
2015		
Total Sources	$ 1,409,882,852	$ 927,707,016
Total Expenditures	$ 1,396,154,032	$ 927,167,557
Unexpended	$ 13,728,820	$ 539,459
Non-Lapsing	$ 3,500,000	$ -
2016		
Total Sources	$ 1,494,303,288	$ 966,685,036
Total Expenditures	$ 1,468,789,542	$ 956,050,197
Unexpended	$ 25,513,746	$ 10,634,839
Non-Lapsing	$ 8,800,000	$ 2,959,675

35. Have all appropriated or authorized sources been expended at year-end?

See table above.

36. How have non-lapsing appropriation balances (if any) changed over time?

In fiscal years 2012 and 2013, DMHF had non-lapsing authority for all unspent appropriations. In fiscal year 2014, DMHF had no non-lapsing authority. In fiscal years 2015-2016, DMHF had non-lapsing authority for the PRISM project and for the Medically Complex Children's Waiver program.

37. Are fees or taxes supporting a function and are those fees or taxes reasonable?

Taxes supporting provider rates are reasonable and within the federal limitations.

38. Are there significant risk associated with this organization/function, if so, are there proper controls in place?

There is significant oversight over the development of Medicaid reimbursement rates. All rate methodologies are included in the State Plan or the applicable waiver. All amendments made to the State Plan or to a waiver must be approved by the CMS and must also be reported to the Social Services Appropriations Subcommittee. In addition, all managed care rates are required to be approved by CMS. Finally, DMHF has controls in place to ensure that rates are properly entered into the Medicaid Management Information System.