Tuberculosis guidelines and payments

To: Social Services Appropriations Committee

From: Janae Duncan, Population Health Division Director
Jeffrey Eason, Office of Communicable Diseases Director
Rachel Ashby, Refugee Health and TB Control Program Manager

Subject: DHHS Response to Legislative Intent Language Items Regarding Tuberculosis Guidelines and Bed Reservations

Purpose

This report responds to the following intent language from the Utah State Legislature:

Intent language #1:

"The Legislature intends that the Department of Health and Human Services provide potential options to change latent tuberculosis treatment guidelines issued by the Department of Health and Human Services for individuals identified via employment and school screening to have the private healthcare system be responsible for treatment to the Social Services Appropriations Subcommittee by June 1, 2026."

Intent language #2:

"The Legislature intends that the Department of Health and Human Services report to the Social Services Appropriations Subcommittee by June 1, 2026 on possible alternatives to the $81,000 annual payment to reserve two beds for non-compliant active tuberculosis patients and feasibility of serving compliant active tuberculosis patients with other providers."

Executive summary

DHHS has developed a framework to transition latent TB care to private providers while maintaining safety nets for uninsured individuals. Key actions include launching a provider toolkit and recommending policy changes to Medicaid eligibility.

The department has also evaluated the multi-year contract with the University of Utah for active tuberculosis isolation services. Following direct consultation with hospital leadership, the issuance of a public request for information (RFI), and a survey of local health departments (LHDs), DHHS has modeled three strategic options. The department presents these findings along with a formal recommendation to secure carryover, non-lapsing authority for the total $320,000 allocation to safeguard against sudden high-acuity surges or complex court-ordered cases.

Potential legislative action

To optimize public health outcomes and fiscal efficiency, DHHS recommends the following legislative options:

- **Establish local funding carve-outs**: Allocate dedicated funding pathways to ensure local health departments (LHDs) are properly reimbursed for managing and treating uninsured individuals who fall outside traditional coverage.
- **Approve contract rate modification**: Reduce the University of Utah contract's annual reservation fee to $40,500 to secure a single dedicated isolation bed, reallocating the remaining $40,500 in surplus funds to lower-cost settings such as local hotel accommodations and a mobile housing unit for statewide deployment.
- **Grant non-lapsing authority**: Provide explicit non-lapsing authority for the $320,000 total tuberculosis allocation, allowing cost savings from low-volume years to serve as a vital contingency reserve for future resource-intensive surge events.

Primary report

Section 1: Latent tuberculosis infection (LTBI) treatment transition (Intent language #1)

DHHS established a specialized TB Workgroup to rigorously evaluate the policy shift toward making the private healthcare system responsible for treating individuals with LTBI identified via school and employment screenings. This initiative was formally presented to LHD leadership to ensure multi-jurisdictional alignment. While LHD leadership emphasized that a complete transition of LTBI care to the private sector poses significant barrier concerns for uninsured populations, a general consensus was achieved that private healthcare systems should assume greater management responsibility, provided provider capacity is expanded through professional education.

DHHS developed and distributed a comprehensive provider guidance toolkit shared with LHDs for localized distribution to actively support private networks through this transition. The guidance package includes:

- A **"Dear Colleague Letter"** outlining the critical role community providers must assume in state LTBI eradication efforts.
- A **one-page quick reference guide** delivering direct links to standardized testing protocols, treatment regimens, and trusted clinical resources.
- A **"TB and Medicaid" guide** detailing TB-related Medicaid eligibility requirements, specialized application processes, and a comprehensive formulary of covered medications.

Analysis reveals that the TB-specific Medicaid program remains underutilized because its income eligibility ceiling is only marginally higher than that of traditional Medicaid. To address this, the TB Workgroup proposes two primary policy solutions: increasing the income eligibility ceiling to expand the patient base and establishing dedicated TB funding carve-outs to ensure LHDs are reimbursed for treating uninsured individuals who fall outside traditional coverage limits. DHHS will review the feasibility of increasing the income eligibility ceiling as recommended by the TB Workgroup.

Section 2: Active tuberculosis contract alternatives and feasibility analysis (Intent language #2)

DHHS evaluated alternatives to the University of Utah (U of U) contract through three research tracks:

1. **University of Utah consultation:** DHHS consulted directly with the U of U Chief Financial Officer to explore moving from a fixed annual reservation fee to a pay-per-use structure. The University indicated that the current contract is already insufficient to meet actual operational overhead, concluding that a reduced fee setup could jeopardize the long-term partnership.
2. **Request for information (RFI):** A formal RFI was publicly published on the official e-procurement and bidding platform used by the State of Utah and distributed to major regional healthcare systems—including U of U, HCA, Intermountain, and CommonSpirit and behavioral health providers—including Odyssey House, First Step House, and Valley Behavioral Health. This RFI sought comprehensive facility capacity and pricing data to identify alternate systems capable of managing infectious, uninsured, or court-mandated TB patients. The RFI period closed with zero responses returned.
3. **LHD lower-acuity survey:** The department surveyed LHDs to identify existing lower-acuity isolation facilities for compliant patients who do not require acute hospital-level care, looking

to systematically lower reliance on high-cost clinical contracts. Some results include:

- Negative air pressure rooms at a county behavioral health group home
- Agreements with the local mental health authority to use apartments when available or use their receiving center
- Methods to pay for an individual to stay at a local hotel/motel

DHHS modeled three strategic options:

- **Option 1: Maintain status quo.** Maintain the current contract with the University of Utah under existing terms through its scheduled expiration on June 30, 2030.
- **Option 2: Increase contract rate.** Maintain the U of U contract but increase reimbursement rates to align with current provider costs and ensure service sustainability.
- **Option 3: Reduce reservation fee.** Cut the annual reservation fee to $40,500 to secure a single dedicated bed. The remaining $40,500 in surplus funds would be reallocated to alternate lower-cost settings, such as reimbursing localized hotel accommodations and purchasing a mobile housing unit for statewide deployment.

Regardless of the selected model, DHHS recommends establishing non-lapsing carryover authority for the $320,000 total tuberculosis allocation. Historical data demonstrates that overpayments caused by complex, long-term court-ordered patients (such as in SFY 2023) must be absorbed through alternative funds when allocation boundaries are rigid. Non-lapsing status ensures cost savings from low-volume years are preserved as a critical contingency buffer for resource-intensive surge periods.

Historical contract usage data (SFY 2022 – SFY 2026):

SFY	# Days used	# Patients	Paid by DHHS	Remaining balance	Operational notes
2022	53	1	$140,357.82	$179,642.18	Baseline operational year.
2023	272	3	$403,760.29	$(83,760.29)	Included a 6-month court-ordered isolation patient on an expensive medication regimen. Overpayment covered by OCD funds.

SFY	# Days used	# Patients	Paid by DHHS	Remaining balance	Operational notes
2024	125	4	$258,455.03	$61,544.97	Stable intermediate utilization.
2025	87	3	$201,179.45	$118,820.55	Moderate volume year.
2026	30	4	$150,000.00	$170,000.00	Amounts are approximate and year-to-date.

* Balance sheets and paid amounts are derived from historical Office of Communicable Diseases financial trackers.