

**MINUTES OF THE
SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE**

Room 30 House Building, State Capitol Complex

Monday, January 30, 2012

MEMBERS PRESENT: Sen. Allen M. Christensen, Co-Chair
Rep. Bill Wright, Co-Chair
Rep. Bradley G. Last, House Vice Chair
Sen. Patricia W. Jones
Sen. Peter C. Knudson
Sen. Wayne L. Niederhauser
Sen. Luz Robles
Sen. Todd Weiler
Rep. Jim Bird
Rep. Rebecca Chavez-Houck
Rep. John Dougall
Rep. David Litvack
Rep. Daniel McCay
Rep. Ronda Rudd Menlove
Rep. Kraig Powell
Rep. Evan Vickers
Rep. Larry B. Wiley

MEMBERS EXCUSED: Sen. Margaret Dayton

STAFF PRESENT: Mr. Russell Frandsen, Fiscal Analyst
Mr. Stephen Jardine, Fiscal Analyst
Mr. Gary Ricks, Fiscal Analyst
Mrs. Diane Pope, Secretary

Note: A copy of related materials and an audio recording of the meeting can be found at www.le.utah.gov
A list of visitors and a copy of handouts are filed with the committee minutes.

2. Introduction

Co-Chair Christensen called the meeting to order at 8:12 am.

1. Approval of Minutes

None.

3. Ideas from Iowa Medicaid Provider

Mr. Bill Applegate, Executive Director, Iowa Chronic Care Consortium, spoke with the Subcommittee via telephone. He has been working with different states in developing Medicaid programs to build their capacity to work with chronic care patients. He believes that Legislators have a powerful responsibility to take a look at what happens in Medicaid. He asks: "What matters? Why bother? Who cares?" He believes that the Subcommittee has a pivotal role in answering these questions. In terms of what matters; what kind of quality, what amount of cost, what kind of access and what kind of services does Utah expect. Why bother? There are access issues, total cost issues, and lives to be covered issues. Because Medicaid is consuming a great deal of the resources of many states and it looks like there will be more demand placed on the

states in the future. In terms of who cares, we have lots of departments involved in Medicaid programs but there is no stronger steward than state government. The state departments guide the programs with Legislators making decisions about where they go.

There have been some old school fixes in terms of focusing on cost. These have dealt with prices, what are you paying for any particular service; menu, the list of services covered; and access, reducing access to curb costs. The prices are already very low so it's not a great way to reduce costs. Once a service gets on the menu, it's very difficult to take it away. Changing access has to be done very thoughtfully especially since there is an increasing population eligible for Medicaid. Mr. Applegate explained what he calls new school cost strategies. To manage Medicaid better there has been an increase in managed care. One of the reasons states are moving to managed care is to shift some of the risk to health plans and have that health plan manage the patients. It's also been well received by Medicaid participants. Managed care companies have gotten better, they've gotten smarter, and focused on the experiences of the individual. Health and wellness plans are good if they are evidence based. If the State looks at the three questions listed above, they want to have a shared vision or collective decision. There is a push for home based care and managing chronic conditions differently. There is a lot of value in working with patients with chronic conditions is because states spend 70 to 80 percent of their Medicaid budget on the 10 percent of patients with chronic conditions. Eighty percent of the cost of health care in general goes to chronic disease. Eighty percent of that cost comes from ER visits and hospital stays. If you can take hospital stays out of the equation, you can have a dramatic effect on costs. States are looking at managing chronic conditions by looking at behaviors in the home.

Four years ago, Iowa focused on a heart failure program because those patients were the highest cost group at \$24,000 per patient; now in excess of \$30,000. They had 266 participants in their program. They had daily contact in care management with these individuals, they leveraged technology heavily, and avoided hospitalizations. The savings in the treatment group was in excess of \$3 million at a cost of about \$350,000 to operate. By smart planning of chronic care there will be some savings. Mr. Applegate referred to the handout, "Heart Failure Care Management."

Mr. Applegate continued with "the state of reality." For an example, there is a state with an operating budget of \$5.4 billion per year, of which \$1 billion goes to Medicaid. So the total state operating budget for everything other than Medicaid is \$4.4 billion. There was a federal match of \$1.2 billion for Medicaid. Medicare costs for Medicaid, what the Medicare for their beneficiaries was \$1.6 billion for a total of \$4.7 billion in Medicaid costs. In a study of ten states, one half of states were spending more on Medicaid than on their total operating budget, based on this model. This is worth paying attention to.

Mr. Applegate explained that the Iowa Chronic Care Consortium is a population health non-profit organization with ten years of progressive experience in population chronic condition improvement, five years in clinical health coach training, and six years of active experience in Medicaid. They build the capacity for a state to make changes, they don't do their job for them.

Sen. Jones thanked Mr. Applegate for his presentation. She wanted a couple of examples of how prevention is bringing in significant returns on their investment.

Mr. Applegate used pap smears as an example. In commercial health plans, the level of

participation is about 70 to 80 percent. In Medicaid populations, participation is much lower at about 50 percent. A lot of states are in the 14 to 15 percent range. Utah needs to look at the Medicaid population to see if they're using this preventative test. Another example is paying for well physicals. Is there an action plan developed by the doctor to help the patient maintain or improve their health? Are the measures actually being taken by the patient? A look into inoculations and shots might be of value as well.

Sen. Jones asked if there are any measures being presented with return on investment in dealing with prevention of obesity.

Mr. Applegate indicated that Iowa wanted to see if weights were being recorded at visits and found they weren't for a lot of Medicaid beneficiaries, making it hard to draw conclusions, so they started looking to find data. Along with well physicals, is there a risk assessment or personal health assessment? Are individuals in the Medicaid program ready to make a change? Many states spend millions in Medicaid programs on smoking cessation, but they don't know what population they should target. There needs to be an established profile of the state in terms of health status and risk.

4. Required report from HB 174 from the 2011 General Session

Dr. David Patton, Executive Director, Department of Health (DOH), presented a report on the potential for privatization of eligibility for Medicaid. They contracted with two professors, Dr. Roberta Herzberg, Associate Professor and Department Head, Department of Political Science, Utah State University, and Dr. Ryan Yonk, Assistant Professor of Political Science, Southern Utah University, to conduct a study from an objective point of view. Dr. Herzberg indicated that she has been involved in health policy issues for a long time. The study will be finished shortly for presentation to the Legislature. The current status of Medicaid eligibility process is across multiple agencies which makes it a pretty complex issue. They defined efficiency as monetized costs and other forms of costs and benefits non-monetized, i.e. convenience to consumers, ability to evaluate processes and one-stop shopping. During the period of 2006 to 2009, authority was granted to consolidate eligibility, create the one-stop shop and make it easier to find efficiencies. When there is a period of change such as this, it would be anticipated that during the transition phase there would be increased costs and this was true. There are steep learning curves, new federal regulations, increased links between agencies, and other changes that increase costs, especially found at Workforce Services (WFS). Then the recession started and demands increased. There was an increase in errors, especially negative errors, denying someone benefits that they are entitled to. Policy is also in flux during this period. There are also changes in federal government requirements which add cost.

The second period, from 2010 to present, is difficult to examine in terms of data from outside sources because the data isn't yet available so they had to rely on data provided by the agencies. A different picture develops. Utah is trending in a good direction and is starting to see cost savings across overall budgets even during a recession, a good sign of efficiency increases. The cost of administration in medical assistance programs is high for Utah historically and is high in relation to national averages. Higher administrative costs in Utah are in correlation to lower service costs. Unified eligibility does seem to have substantial efficiency gains in terms of state and federal dollars and is more convenient for recipients. This convenience is a very big positive. Utah is already addressing some of the issues coming with new federal mandates. Workforce Services is conducting an internal audit and is finding meaningful improvements in

reducing error rate since last October.

Dr. Ryan Yonk spoke directly to the process of privatization. They found a current market that exists for privatizing eligibility and that federal and state regulations are open to at least some pieces of privatization. Because Utah has a unified system, and because it views that system as a large efficiency gain, Utah has to operate under the federal government's most restrictive rules across all programs. This includes food stamps, or SNAP program, as the most restrictive program and no part of it will allow for privatization, which essentially eliminates any possibility of eligibility privatization. Therefore, Dr. Herzberg and Dr. Yonk see no efficiency gains in trying to privatize eligibility unless Utah wants to disentangle the eligibility process thereby losing those efficiencies already recognized.

Dr. Herzberg and Dr. Yonk identified five areas of recommendation for the Subcommittee and the agencies as Utah moves into the future. At the top of the list, they see a need for increased cooperative governance of the eligibility process between DOH and WFS. Because of the way the programs are governed, widespread cooperation between the two agencies is fundamental for an ongoing process to making efficiency gains. DOH remains the responsible party for large sections of the program. They view this as being achieved with a more formalized process with oversight in each agency where decisions are made cooperatively, not in an informal arrangement. Their second observation is that through this oversight the agencies should design a set of benchmarks that both meet the needs of each agency in terms of eligibility as well as the federal rules, and with the best interest of the recipients and taxpayers of the state of Utah in mind. That communicative process should lead to common standards for error and cost savings, etc. The third area concerns ongoing oversight both internally and through the Legislature. Observation will help with continued efficiency. Both agencies are interested in internal oversight but that is not a substitute for Legislative oversight. They suggest the Subcommittee come back to look at the trends in the near future. Fourth, there may be small pieces, as they go forward, that can be contracted. The shared governance may identify pieces where it is relatively easy to capture efficiency gains from contracting opportunities. For example, there has been a movement to use call centers and increasing technology. These won't be big gains but small ones that together will impact the budget. Their last recommendation is that the institutional arrangement needs to continue to be reviewed by oversight.

Co-Chair Christensen said that since the unification, the departments are working together better. He gives a lot of credit to the current leaders. His recommendation is that this Subcommittee leave things in place with the new changes. He suggests that the Subcommittee give the departments at least another year before worrying about privatization and let them realize more savings and efficiencies.

5. Findings From the Annual Financial Audit of the Department of Health

Mr. Van Christensen, Audit Director, with Mr. Jason Allen, Auditor, reported on the findings from the audit of DOH. Their department does an audit of DOH annually. They select grants to test based on a risk assessment. Medicaid is selected every year. All tests are based on compliance requirements as regulated by the federal government. They determined nine findings and recommendations for DOH this past year, five of which are repeat findings, problems that existed in the previous year at least. They are reported in the order of significance. Mr. Christensen indicated that he would report on the first three findings.

A. The interest from the past has been focused on benefits, whether someone is eligible or not. Many of the processes or internal controls are designed to prevent an error before it is made. The documentation errors that they identify shouldn't be discounted. There has been a decline of projected errors over the last five years. In 2011 the projected errors totaled \$31 million. The impact to the State was about \$6.6 million. These errors are all from allowing ineligible individuals to receive benefits. The scope of this report doesn't cover negative errors.

B. Sometimes a Medicaid recipient has some other type of insurance available, or third party liability. In 2011, about 3.3 percent of cases had other insurance that was not used in payment. Medicaid is an insurance of last resort. There could have been some money recovered from third party companies.

C. The third finding pertains to CHIP errors. Errors were found in 24 percent of cases processed with 11 percent determined to be ineligible over the five year period.

Co-Chair Christensen asked if there were any specific areas that were particularly glaring with errors.

Mr. Christensen indicated that Utah is seeing some improvement in error prevention. Eligibility for Medicaid and CHIP are now determined by Workforce Services.

Rep. Litvack asked if they have identified any correlation between policy changes or shifts and impact on programs, either positive or negative.

Mr. Christensen stated that as auditors, there were not able to say conclusively. From an auditors perspective, they get to see what is happening from one department to another. They can see where errors are consistently made. They would like to see more accountability.

6. Medicaid Follow up - Legislative Auditor General

Mr. Kade Minchey, Audit Supervisor, and Mr. Tim Osterstock, Audit Manager, passed out "Medicaid Implementation of Audit Recommendations." Mr. Minchey indicated that this year's in-depth Medicaid report provides the status of their recommendations from four previous Medicaid reports. The first report was in August 2009 and showed a need for better controls to combat fraud, waste and abuse. It estimated about \$20 million in potential savings. The second report was released in January 2010 and recommended stronger financial oversight of the Utah Medicaid managed care system. This report estimated \$13 million to \$19 million in potential savings with implementation of the auditor's recommendations. The third report, released in December 2010, provided several examples of fraud, waste and abuse. It also showed potential areas for savings in the pharmacy program. Lastly, it recommended the Office of Inspector General independently review the Medicaid program for integrity. The fourth report, also released in December 2010, followed up on recommendations from the first two Medicaid reports. It found that more work was needed to gain full implementation of recommendations.

This year's report found that most recommendations have been implemented or are in the process of being implemented. They found that management over the Medicaid program has made several programmatic and administrative improvements that have resulted in increased oversight and cost savings. They also found that the newly created Office of Inspector General is well-positioned to increase collections and to reduce fraud, waste and abuse. The cost savings

from all the recommendations is estimated to be between \$39.5 million and \$45.5 million with a savings of \$500 million over ten years. In addition to this savings, about \$400,000 has been recovered by a cost recovery contractor, hired in conjunction with a past audit. The contractor has identified an additional \$23 million in possible funds to recover, with the actual amount to be determined through a hearing process.

The status on recommendations from the first report shows improvements made with 15 recommendations that have been implemented and ten that are in process. One of these was an improved prior authorization program that has been put into place. Also, improved provider enrollment oversight controls are in place. Increased attention to cost recovery is in place, with a report of \$11.1 million being recovered in FY 2011. The status of recommendations for the managed care report includes 18 items that have been implemented and 9 recommendations are in process. Some improvements to note include the utilization and update of the risk adjusted relative cost study. This study pushes providers to the lowest cost and best services to their peers. Also, quality care oversight has improved. In the provider cost control audit, there were nine recommendations, six are implemented and three are in process. Training about frequently abused billing codes now occurs. Pharmacy savings have improved. Two important pieces of legislation were passed last year. HB 84 created the Office of Inspector General which is up and running. Also there was HB 358 which gave broader access to the controlled substance database to auditors to review the Medicaid program. In the final report, two recommendations were made. Those recommendations dealt with automating provider dis-enrollment and using statistical extrapolation in audits. Both recommendations have been implemented.

Mr. Tim Osterstock said they are very encouraged by the changes that have been made in Medicaid. It was pretty rocky when they began the audits. The Inspector General office has been a good addition.

Co-Chair Christensen congratulated the auditors on their recommendations. He also congratulated Mr. Lee Wycoff for his efforts as the Inspector General.

7. Report on the Transition of CHIP to Full Capitation

Mr. Michael Hales, Deputy Director, DOH, indicated there were three contractors at the inception of CHIP in the 1990's--PEHP, Molina Healthcare and United Healthcare. United Healthcare exited the market, leaving two main providers for CHIP. Although they were trying to handle things as a managed care facility, PEHP could not handle any of the risk. PEHP was also the only dental provider for CHIP. In 2008 legislation required that there be managed care contracts for CHIP with full capitation. In 2008, Molina Healthcare received a contract. In 2009, Select Health was also issued a contract after some changes were made to HB 370. Now there are two healthcare contractors under a full managed care model, who manage their own risk. In 2010, DOH began looking at the dental program and awarded two different contracts to replace PEHP.

Rep. Vickers asked what agency handles the eligibility for which plan each child is placed on and how do they handle the confusion. He's found now there is more confusion with lost or outdated cards and wanted to know what agency to call.

Mr. Hales indicated that eligibility is determined by Workforce Services and the individual providers would issue insurance cards for each child. Based on eligibility, two children from the

same home might be in two different programs. Mr. Hales would have a provider call one of the healthcare program representatives that help enroll clients once they are determined eligible.

Rep. Litvack asked what the impact has been on the provider community during this shift and are there any access problems. He wanted to know if they have lost providers or have CHIP patients been dropped by providers. He also wanted to know if there had been any cost savings with the change.

Mr. Hales said they haven't seen much of an impact on the medical community. There have been more notable problems within the dental program. There are pressure points in managed care as they try to contain costs and providers try to keep services to a minimum. They have come up with a limited claims period. Providers want to be paid within 60 days. They are currently asking for bids for the Medicaid dental system. DOH has tried to implement changes from feedback given on the CHIP RFP contract. They have lost some providers. Mr. Hales didn't have all the information on denials at this time, but he indicated that if DOH feels there is an access problem, they will intervene. DOH has found the cost savings to be neutral under the new program.

Co-Chair Christensen asked if there has there been any positive feedback from providers.

Ms. Emma Chacon, Division Director, Div. of Health Financing, indicated they generally do not get positive feedback. They have had some struggles with dental plans and eye care.

Vice Chair Last asked if these contracts are bid every year. He stated there needs to be motivation on the part of the contractor to help change the behavior of recipients so longer contracts would be best.

Ms. Chacon said the contracts are 3-year contracts with two optional years. They will be asking for bids again in 2013.

Sen. Christensen is aware of providers having a problem. The insurers have met with the dental providers and made several concessions to improve things.

Sen. Jones asked if chronic conditions such as obesity are being addressed during well physicals and whether we can we do better to address those needs. Sen. Jones didn't want this issue to get lost with the Subcommittee. She wanted them to look at incentives and better prevention.

Mr. Hales indicated that they could definitely do better. Historically, it has been difficult to coordinate client care because there were two different sides, the administrative and the program side. With some of the changes they have made, they are hoping through administration they will be able to address more disease prevention. DOH already has a good hemophilia program in place. They are continuing to explore prevention and chronic care management as they move into the Accountable Care Organizations.

Mr. Frandsen asked Mr. Hales if there was a specific proposal from DOH to bring before this Subcommittee concerning a program for prevention through a transfer of funds.

Mr. Hales said they did not have a proposal but would be willing to put one together this week.

Rep. Litvack asked that as the Subcommittee looked at capitation, what outcome measures would they would be tracking; what are the desired effects of capitation in the Medicaid program.

Mr. Hales indicated the new proposal under ACO's would be to move away from billable events to providing quality care where the individual's health is assessed to prevent disease, encouraging them to be healthy. The CAHPS measures are in place to look at quality of care. There is also an external organization that reviews their quality measures and provides benchmarks. They intend to convene quality work groups that would include providers and users to develop even more robust quality measures.

Sen. Jones would like to propose that staff draft some documentation with possible options for the Subcommittee to address preventative health and disease management in Medicaid.

8. Contingency Plans for Federal Fund Reductions - Department of Health

Dr. Robert Rolfs, Deputy Director, DOH, said the department receives 107 individual grants or contracts for 70 percent of their funding. A cut of 25 percent would have a large impact on their department. Changes in CHIP or Medicaid would require statutory changes. The infrastructure of DOH would be vastly altered leaving the citizens vulnerable in the epidemiology area. There are some very important services that would be lost.

Co-Chair Christensen asked what the plan would be, what is the bottom line.

Dr. Rolfs replied they would cut services. People would be harmed but DOH would be forced to cut services. If the federal government changes the funding as expected they will also change the requirements.

9. Other Business

None.

10. Items from the Next Meeting's Agenda

None.

MOTION: Rep. McCay moved to adjourn. All were in favor.

Co-Chair Christensen adjourned the meeting at 9:53 am.

Minutes were reported by Mrs. Pope, Senate Secretary

Minutes of the Joint Social Services Appropriations Subcommittee

Monday, January 30, 2012

Page 9

Sen. Allen M. Christensen, Co-Chair

Rep. Bill Wright, Co-Chair