

**MINUTES OF THE  
SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE**

Room 30 House Building, State Capitol Complex  
Thursday, January 26, 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. Luz Robles  
Sen. Todd Weiler  
Rep. Jim Bird  
Rep. Rebecca Chavez-Houck  
Rep. Daniel McCay  
Rep. Evan Vickers  
Rep. Larry B. Wiley

MEMBERS EXCUSED: Sen. Margaret Dayton  
Sen. Peter C. Knudson  
Sen. Wayne L. Niederhauser  
Rep. John Dougall  
Rep. David Litvack  
Rep. Ronda Rudd Menlove

MEMBERS ABSENT: Rep. Kraig Powell

STAFF PRESENT: Mr. Russell Frandsen, Fiscal Analyst  
Mr. Stephen Jardine, 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](http://www.le.utah.gov)  
A list of visitors and a copy of handouts are filed with the committee minutes.

**1. Unfinished Items From the Previous Agenda**

None.

**2. Introduction**

Co-Chair Sen. Christensen called the meeting to order at 8:20 am.

**3. Approval of Minutes**

None.

**4. New Mexico's Emergency Room Diversion Efforts for Medicaid**

Mr. Jardine introduced Ms. Cathy Rocke, Contracts Administration Bureau Chief for the Medical Assistance Division in New Mexico. Ms. Rocke explained, via. telephone, that her department

manages the contracts for providers of physical and mental healthcare to Medicaid recipients through a managed care system. They started with managed care in 1997 with physical and behavioral health benefits. In 2009, New Mexico implemented long time service benefits under the CoLTS (Coordination of Long-Term Services) program which now covers about 80 percent of Medicaid recipients. The 20 percent not under managed care are largely the Native American population. New Mexico has about 500,000 individuals in Medicaid which represents approximately 25 percent of the population. They have seven managed care organizations; four deliver physical health, two deliver long term services and one that delivers behavioral health services. In 2009, the physical health managed care organizations were looking to contain costs. The emergency room was a good place to start. They developed a triage letter (handout) that was sent to all emergency care facilities for use with non-emergent care Medicaid patients. The hospital would then advise the patient that they were responsible for emergency care costs or would redirect them to an urgent care facility or their primary care physician's office. During this time, many managed care ER visits were denied coverage and the non-emergency rates were established. This did not apply to fee-for-services individuals. The total estimated savings from this process was approximately \$1,000,000 using a conservative methodology. Almost every county in New Mexico has an urgent care available.

Sen. Christensen asked about the uninsured individuals that Medicaid usually covers.

Ms. Rocke explained they have an insurance pool of funds from which hospitals can apply for reimbursement. Every licensed managed care insurance company contributes to the pool. The new program does not apply to the uninsured. The managed care providers do have to absorb the costs of the uninsured.

Sen. Christensen asked about the triage personnel, and whether they are trained professionals. He also inquired as to whether patients are refusing to sign the letter.

Ms. Rocke said a nurse is usually the person responsible for conducting the triage. They would then redirect the patient to an urgent care for non-emergent services or disclose the fee associated with care. The biggest complaint comes from the managed care facilities not paying the hospitals for care after the fact. The state of New Mexico would be happy to help any other state with developing a similar program.

Rep. Chavez-Houck asked how they are communicating about this program to the recipients. She also wanted to know how they are dealing with the challenge of not having urgent care facilities in every county.

Ms. Rocke indicated that it was the responsibility of the managed care organization to educate patients about what is emergency care. They send out flyers to hospitals and have patient navigators that help the patient schedule appointments. Where they don't have a managed care facility, services won't be denied by the emergency room. In one case, an urgent care facility was built using a grant that the hospital received from the managed care facility.

Mr. Dave Gessel, Vice President, Utah Hospital Association, asked if the New Mexico program was approved of or mandated by their Legislature or was it a voluntary effort within the system.

Ms. Rocke stated that this effort was worked through the managed care organizations. In FY2012, federal approval was received when their rates were affected. The department let the system develop themselves for a year to a year and one half without impacting the rates.

Mr. Michael Hales, Deputy Director, Department of Health, was invited to the speaker podium for answering questions.

Rep. Last asked if this type of program could be done in Utah because it sounds like a great idea.

Mr. Hales pointed out this is not just for Medicaid patients, it's across the board. He feels very uncomfortable with the lack of approval for New Mexico's plan in terms of risk or liability in denying care. He would want to bring CMS (Centers for Medicare and Medicaid Services) into the picture up front. It has some merit to explore within Utah in terms of how fees are paid. The department has specific fees for certain visits. They have approached emergency room diversion through a different avenue. They try to connect an individual with a primary care physician assuming the patient has a lack of access to services. With the new accountable care organization model, they might look at additional client incentives.

Ms. Rocke wanted to compliment the Utah Medicaid program for using an outpatient perspective payment system which could save the state \$100 million. She would chose to follow that system over the emergency room initiative for larger savings.

Sen. Christensen asked if their guidelines apply to fee-for-service patients or those with regular insurance.

Ms. Rocke indicated that it has not been applied consistently, but it has included all patients in some areas.

Rep. Last would like the state to look into this program. This is something Utah needs to look into long term.

Mr. Gessel said the association was supportive in working with institutions to implement a similar program. They would like to have a more measured look at this program and programs in other states. Mr. Gessel cautioned that when a patient signs a triage assessment to stay at the ER, the hospital is asking them to pay thousands of dollars that will never be collected. Studies show 17% of everyone's private health insurance is a cost shift from Medicaid, Medicare and the uninsured. The association would like to work with the Department of Health in developing something over the next couple of years.

Rep. Last said that it was nice to have a third party opinion. It sounds like a good way to save money.

Sen. Christensen stated that the biggest problem seems to be with the uninsured. It's his understanding that a hospital can't turn away a potential patient and the costs are reimbursed at Medicaid rates at least.

Mr. Gessel said that the hospital won't get paid if it is a non-emergency and that Medicaid would only pay for Medicaid patients. Hospitals try to collect fees from the uninsured but that's difficult when they are required by law to treat ALL people, even if they have signed the triage plan. It is hard to make any kind of decision based on a few days of information.

Sen Christensen stated that he doesn't want to see hospitals pass the charges onto the consumer and asked if there were still some individuals that were covered by Medicaid funds even though they aren't on Medicaid, specifically illegal aliens.

Mr. Hales indicated the uninsured must be stabilized in an emergent situation. There are some provisions set up by Medicaid to offset costs for illegal aliens and those whom have been in the country less than 5 years as immigrants. This is actually a cost savings measure. Utah has a disproportionate share hospital program, primarily used for the teaching and rural hospitals because there aren't enough funds to cover private hospitals. There are some offsets from the University Hospital through taxes.

Ms. Michelle McOmber, CEO, Utah Medical Association, would be interested in looking into a similar program. Physicians are contracted by the hospital, they are not employees. So the problem of collecting payment is not just for hospitals but for physicians too. The association would like to be part of the ongoing discussion.

Ms. Judi Hilman, Executive Director, Utah Health Policy Project (UHPP), is concerned the Subcommittee and departments may be putting the cart before the horse. She is anxious to hear about waiver requests in relationship to accountable care. The UHPP would expect that Utah would build-in redirect programs as the departments develop the multi-year transition to an accountable care program. Once the payments are tied to the right incentives to deliver care and manage conditions in the right setting, and there is a teamwork approach to working with patients, the managed care plans will have the right incentives to work with the hospitals. UHPP would like to come back to look at a managed care program similar to New Mexico's after receiving data on waivers and what steps have already been taken towards accountable care.

## **5. Department of Health Update on Medicaid Waiver (SB 180 from 2011 General Session)**

Dr. David Patton, Executive Director, and Mr. Michael Hales, Deputy Director, Department of Health (DOH), gave an update on Medicaid waivers. Dr. Patton indicated that the New Mexico system might work very well with Utah's waiver system. He reviewed what the waiver system entailed. Sen. Liljenquist, DOH, the Governor's office and other community partners started discussion on how cuts could be made to Medicaid expenses. SB 180 came from that discussion and was passed in 2011. The Legislature asked the DOH to prepare and submit a waiver to ask the federal government for a change in how Utah handles Medicaid funds. Utah would pay providers for keeping individuals healthy rather than just pay to care for the ill. In the last couple of weeks, the DOH has received a more definitive response on what the CMS will and will not accept in that waiver. Dr. Patton said Mr. Hales would explain the CMS response.

Mr. Hales reported on the items the CMS would approve or not approve. The key provisions included removing incentives for billable events, to focus more on quality. Rep. Last has

expressed an interest in "telemedicine" where a follow up visit could be conducted over the phone but the federal government hasn't given Utah much leeway for that type of program in the past. Utah would like to take advantage of the technology available and allow doctors to be paid for using technology to interact with patients. The federal government is now willing to work with Utah to approve this piece of the waiver. Utah will be able to bring doctors, pharmacies, hospitals, and covered ancillary services into one payment model where a lump sum will be paid, for each client, to Accountable Care Organizations (ACO) that will be held accountable for meeting quality standards. The DOH is looking at quality standards that are in place as an established benchmark and will make enhancements from there.

There was a provision for a premium subsidy where a Medicaid client could use the commercial insurance package of their employer. Medicaid would pay the cost of the client's insurance premium so they would have all the benefits of a commercial package. The federal government wanted to include a cap on expenses of five percent of an individual's gross income. This would be similar to CHIP and the DOH agreed to add that protection. This provision was then declined because of the co-payment that would be required under a commercial plan. All the Medicaid clients in the DOH target area, Weber, Davis, Salt Lake, and Utah counties, would be included. Essentially the federal government is saying that we can't allow Medicaid patients to make choices on their own.

Another key provision was controlling the rate of growth. If the cost per person were to grow faster than the General Fund rate, then DOH wanted a mechanism for curtailing those costs. Enrollment can't be contained because Medicaid is an entitlement, but if DOH can contain the cost of growth on a per person basis in relationship to the General Fund rate, then the system would be more sustainable. DOH wanted to model a provision from Oregon, a program already approved of by the CMS, where the State would work with clinicians and other stake holders to create a prioritized benefit list that would rank all of the services provided under Medicaid by cost and value of intervention, with the highest value of intervention at the top of the list. DOH would then look at the costs and determine how far down the list the General Fund would go. Anything below that line would not be covered. CMS told DOH that this approach would not be approved.

The cost sharing structure is 30 years old with only one change made in 2005, which now allows for a medical inflation rate to be factored into the co-payment. The DOH wanted to raise the co-payment to \$5 for an office visit and emergency room use for non-emergencies. Currently there is a \$6 co-payment for a non-emergency in the ER with no co-payment for an emergency. The DOH wanted to raise that co-payment to \$25. The CMS said no to all of the DOH cost sharing proposals.

The last provision addressed was to engage clients more in managing their own health. The provision allowed the accountable care organizations to provide some small incentive for the client. Initially, CMS said no. DOH challenged that decision with new data and CMS will now allow Utah to provide client incentives as an option for the Accountable Care Organizations. DOH will move forward with the provisions that have been approved.

Co-Chair Christensen complimented Mr. Hales on his positive attitude and expressed frustration that DOH could only take a few steps in the right direction.

Sen. Robles wanted to know if the State has done any data driven studies on why there is such a heavy use of the emergency room by Medicaid clients. She suggested there might be an access problem that we could correct.

Mr. Hales answered that DOH has not done any statistically significant research. In terms of access, the success of the emergency room diversion program points to an access problem that is being corrected. Another factor includes the hours doctors' offices are open and providing access later in the day, especially pediatricians since 70 percent of Medicaid clients are children.

Rep. Chavez-Houck asked about the non-approval of the provisions, especially in regards to the program in Oregon, and what DOH is going to do.

Dr. Patton responded that DOH was baffled by the refusal of that provision. The Governor's office is getting involved in the process. They will still push ahead to address the provisions the State was denied as well as implement the provisions that passed. Dr. Patton suggested that a resolution from the people might be helpful to show united support to the federal government.

Sen. Christensen asked about the proposed start date for the ACO and whether DOH will be able to meet the July 1, 2012 date.

Mr. Hales said they are targeting an October 1, 2012 date for implementation because of all the contracts that will need to be negotiated and with the addition of the pharmacies in the group.

## **6. Report on Agency Suggestions from Medicaid Survey**

Mr. Hales, Deputy Director, DOH, gave some background on how the Medicaid survey came about. A couple of years ago, a letter was sent to all of the agencies that participate in the Medicaid program as well as to providers, clients and other stake holders, and asked for feedback about what could be done better. The fiscal analysts compiled the ideas and now the departments are reporting on the suggestions made and what legislation might be taken. First on the list is a bill Co-Chair Christensen and Vice Chair Last sponsored in 2008 called the TEFRA lien bill (SB50). In addition to paying for acute care services, and unlike most commercial health insurance programs, Medicaid pays for long term care. About 60 percent of nursing home bed days are covered by Medicaid. Under this bill, individuals that receive long term care, may have their assets liquidated or a lien may be placed on their home, to help recover the cost of their care. This bill didn't pass but could be reintroduced.

Co-Chair Christensen said he'd like to see that bill reintroduced but the Office of Recovery Services (ORS) doesn't have the staff to facilitate collections for the bill.

Mr. Hales said that a fiscal impact note would be attached to the bill for ORS. The cost would be up front with the savings on the back end.

Another change would be to replace the Medicaid Management Information System (MMIS). The system has been in place for over 30 years. The Legislature has made two one-time installments of \$3 million, with two additional installments required to fully fund implementation. The new system would be a more robust waste, fraud and abuse tool, provide

better systems integrations, better reporting and lots of potential for managing the program better. One piece of the system is a new pharmacy point of sale system. This will be implemented in February.

Co-Chair Christensen asked if the \$12 million will be enough to replace the system.

Mr. Hales pointed out that the \$12 million is the state general fund portion; the federal government will pay for 90 percent of the system. It will cost over \$100 million to replace the entire system. This is based on estimates from other States that have bid out similar systems.

Item #15 recommended the establishment of the Office of the Inspector General. This has been done with Mr. Wycoff as the Inspector General. With this office, DOH is looking for better recovery of funds. Item #27 includes the use of the preferred drug list (PDL). By statute, there is a prohibition for mental health and immuno-suppressant type medicines. These drugs account for over 40 percentage of Medicaid pharmacy expenses. Removing that prohibition from Medicaid could be considered for legislation as an area of potential savings. Medicaid saved \$27.6 million in total funds for FY 2011.

Rep. Vickers asked if DOH has seen any changes with a couple of mental health drugs becoming generic recently.

Mr. Hales said that it's too early to see the savings but they were anticipating some savings.

Rep. Vickers asked about the study done on inflation in pharmaceuticals and if the Subcommittee could have a copy of that report.

Mr. Hales indicated the study has been done and the information is available. It was submitted to the Fiscal Analysts' office.

Mr. Jardine said the information was slated to be presented on February 2, 2012.

Mr. Hales continued with Item #29 concerning the development of additional disease management models. For example, DOH has seen substantial savings in the cost for Factor Eight for individuals with Hemophilia. DOH is working with the federal government to get approval for additional disease management systems with Multiple Sclerosis, Cystic Fibrosis, and Rheumatoid Arthritis.

## **7. Report on Suggestions from the Public in Medicaid Survey**

Mr. Hales indicated that there were 145 pages of suggestions from the public. There was a recommendation for quality of care by bundling services. A request was made for client incentives for more active participation in taking responsibility for their own health. The New Choices Waiver allows individuals to leave the nursing home setting and return to a community based setting which saves the system funds. A suggestion was made to have Medicaid patients help to offset some of the costs by doing community service, as sponsored by Rep. Menlove. On page 24 there is a suggestion to have better electronic communications by helping individuals to enroll in the clinical health information exchange to have their information more readily

available to multiple providers. Rep. Menlove is sponsoring HB 46 in response to this suggestion. Another idea is to have a secure patient directory with patient identifiers which is embodied in HB25 by Rep. Barlow. The survey from the public is very consistent with some of the things DOH is doing and it's also generated some of the legislation presented in this session.

Sen. Christensen asked if there was anything that really stands out in the suggestions.

Mr. Hales couldn't identify an item they are not working on. DOH feels very comfortable they are meeting the requests.

## **8. Building Blocks from the Department of Health**

Dr. David Patton, Executive Director, DOH, spoke about the governor's budget and the numbers that DOH presented based on trends in August 2011. There is still some negotiating to do with the Fiscal Analyst to establish consensus numbers on enrollment growth in Medicaid. The first item Dr. Patton discussed was concerning the cigarette tax restricted account. The tax passed two years ago, almost doubling the taxes. DOH's concern is that none of the new money went to prevention of tobacco use. The new tax collected doesn't go to the restricted account. The restricted account doesn't all go to DOH. The supplemental request for FY 2012 is for the decrease DOH realized because tobacco sales dropped. Sen. Hillyard is sponsoring a bill concerning this.

Co-Chair Christensen explained that the tax increase of last year reduced the tobacco sales leaving a deficit. Until Utah is 100 percent tobacco free, Utah needs to find revenue to continue with prevention.

Utah is the only state in the country where the Medical Examiner doesn't have any jurisdiction over highway deaths. Amendments are being brought forth this year to fix the problem so DOH can contract with investigators to determine the cause of death. This is necessary because families have been delayed from obtaining death certificates for funeral services or insurance purposes. DOH is asking for a supplemental of \$120,000, based on an agreement made with the Highway Patrol, for FY 2012. DOH is also requesting \$369,000 in ongoing funding. Funding is needed to pay for investigation, transportation and lab testing. The bill sponsored by Co-Chair Christensen for this supplement has passed in the Senate and has been sent to the House.

Co-Chair Christensen asked if all highway deaths would go through Salt Lake. He also asked if this will expedite getting a death certificate or slow down the process.

Dr. Patton indicated that deaths would normally be determined within the county of the accident but might need special help from Salt Lake. This will greatly expedite the processing of death certificates.

The last item is concerning the Medicaid caseload growth. The FY 2012 budget was not fully funded. DOH will be requesting funds for this deficit as well as for the growth. For FY 2013 DOH will need the same base budget with growth built in.

**9. Other Business**

None.

**10. Items From the Next Day's Agenda**

None.

Sen. Christensen asked the members of the Subcommittee to arrive on time for the meeting, Friday, January 27, 2012 at 8 am.

**MOTION:** Rebecca Chavez-Houck moved to adjourn. The motion passed unanimously.

Co-Chair Christensen adjourned the meeting at 9:57 am.

Minutes were reported by Mrs. Diane Pope, Senate Secretary

---

Sen. Allen M. Christensen, Co-Chair

---

Rep. Bill Wright, Co-Chair