

**MINUTES OF THE  
SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE**

Room 30 House Building, State Capitol Complex  
Thursday, February 2, 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. David Litvack  
Rep. Daniel McCay  
Rep. Ronda Rudd Menlove  
Rep. Kraig Powell  
Rep. Evan Vickers  
Rep. Larry B. Wiley

MEMBERS EXCUSED: Sen. Margaret Dayton  
Sen. Peter C. Knudson  
Sen. Wayne L. Niederhauser  
Rep. John Dougall

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](http://www.le.utah.gov)  
A list of visitors and a copy of handouts are filed with the committee minutes.

Co-Chair Christensen called the meeting to order at 8:21 am.

**1. Public Testimony on Medicaid Issues**

Ms. Joyce Dolcourt, Legislative Coalition for People with Disabilities, spoke about supplemental funding for the Medicaid home and community based waivers administered by DSPD. The Subcommittee is aware that through intent language the Legislature authorized the division to use non-lapsing funds to provide for individuals needing emergency services, individuals needing additional services, children turning 18 and leaving state custody from DCFS and Juvenile Justice Services (JJS), and individuals court-ordered to receive services. DSPD has little control over these situations, and these individuals put tremendous pressure on the budget. Without supplemental funding, the only short term solution to the budget shortfall is to reduce provider rates. This would do substantial harm to the fragile system that exists. Ms. Dolcourt asked the Subcommittee please fund the supplemental request.

Ms. Brooke Wilson spoke about her son, Clayton, who has Autism. She addressed mental illness. The mental health funding request for early intervention will help keep families together, kids in their homes and in school and will allow them to manage their lives in a productive manner. Nearly one in five children have a mental, emotional or behavioral disorder that cause some level of impairment. Ms Wilson also addressed DSPD. She noted that 4,694 individuals were receiving services but 1,953 eligible individuals remain on a waiting list. The services provided really improve the quality of life. When someone is diagnosed with a disability it affects the whole family.

Ms. Judi Hilman, Executive Director, Utah Health Policy Project, talked about the changes made in the way Utah pays for Medicaid through ACO's. The Subcommittee has the opportunity to move the system further down that path. She asked the Subcommittee to approve the Governor's budget and to consider audiology and dental services in Medicaid.

Mr. Dan Hull, Executive Director, Home Care and Hospice Industry, and Mr. Brent Jones, CEO, Community Nursing Services, support the Medicaid block of funding, encourage home healthcare and basically support all of the programs in the state. But they are concerned about ACO's becoming a cheaper version of the current HMO system without proper policy as well as funding. There has not been a rate increase for providers in ten years and they suggested that it is time for a rate increase. Mr. Jones spoke about the tele-health system that they use because of their rural locations. They receive no reimbursement. It can greatly reduce the cost of Medicaid services. They see it as a great way to work with patients in the home.

Ms. Sheila Walsh-McDonald, Healthcare Advocate, Salt Lake Community Action Program, asked for dental resources and Medicaid base budget improvements. Utah has been too dependent on supplementals and needs to provide ongoing funds as outlined in the Governor's budget. It is critical that this Subcommittee understand what is in the Governor's budget. There are three major issues; Medicaid has been operating at a structural deficit, there has been an increase in growth with 22,700 new recipients in FY 2012, and there needs to be proper support for Accountable Care Organizations. Ms. Walsh-McDonald asked the Subcommittee to fully fund CHIP.

Ms. Michelle McOmer, Utah Medical Association, spoke on behalf of the physicians in Utah. Medicaid reimbursement rates are very low at about 55 percent of Medicare rates. There was a promise made to physicians when they agreed to the preferred drug list (PDL) that they would recognize some of the savings after the first year. Because of the economic downturn, the physicians received no increase. They are asking the State to honor that agreement. Ms. McOmer recommend a six percent increase in pay for doctors. The physicians are also in agreement with adding mental health drugs to the PDL, but again would like to see some of the savings for their work.

Ms. Vicki Goodman, President, Youth Providers Association, and Ms. Julie Dunn, Medicaid billing specialist, have been asked to represent private providers currently under contract with DCFS and JJS, to provide the Subcommittee with information with how billing Medicaid directly has impacted private providers that work with the youth in State care. In 2010 the providers were told they would be responsible to bill Medicaid directly for mental health services as mandated by CMS. The training they were promised was little more than an introduction to

the Clearinghouse company, UHIN, that would be used to process all the claims. The providers had to pay a fee to get their claims processed in a timely manner. The fee varied from provider to provider. On top of the fees, new contracts were being written with reduced rates on mental health services. Providers were not given a choice in the matter. The DOH can't register mental health providers fast enough so their billing is three months out. Ms. Goodman asked the Subcommittee to re-evaluate mental health service rates and restore them to previous levels, closer to the federal government rates, to compensate providers for the additional costs.

Ms. Jodi Hansen and Mr. Jacob Hansen appeared before the Subcommittee with their son, who has cerebral palsy and cystic fibrosis. They have DSPD services to help with the high cost of his care, \$7,601 every month. They have private insurance but their 20 percent would still be \$1,500 per month. Ms. Hansen indicated that some individuals who have children with disabilities and don't have services, have poor health themselves because they don't have any help. Ms. Hansen asked the Subcommittee to find resources to help those not receiving services.

Mr. Tom Bradley, advocate for people with disabilities, wanted to advocate for more funding for dental and vision care in Medicaid. He can't get his teeth done because there is no dental for him. Mr. Bradley asked the Subcommittee for funds for dental and vision.

Mr. Jerry Costley, Executive Director, Disabled Rights Action Committee, was advocating for dental services for Medicaid patients. He indicated that Medicaid patients end up having their dental work done in the emergency room because they can't get services any other way and that's not a good use of taxpayer dollars. A better use of tax dollars is to give the individual a filling up front. Mr. Costley indicated that in a year of surplus the amount being asked for is not much but critical.

Co-Chair Christensen wanted to correct one thing. Utah is not in a surplus year, it's still in a deficit. Utah has money they didn't think they were going to have but the federal mandates have created a deficit. Utah is still trying to find money.

Mr. Costley said he understood and asked the Subcommittee try to find some money for dental services.

## **2. Approval of Minutes**

None.

## **3. Issue Brief: FY 2013 - DOH - Preferred Drug List**

Mr. Frandsen began by thanking the Department of Health (DOH) for the time and efforts they have contributed to putting all of the briefs together. Savings in using the Preferred Drug List (PDL) have been better than expected. There are 38 classes of drugs on the PDL, with approximately one new class added each month. Clients use the medication directed by the PDL unless their physician requests a prior authorization based on information that the preferred drug has not been efficacious for the client. On page two of the brief, there is a table that shows drug categories and what the expenditures are for FY 2011. Mr. Frandsen pointed out that four of the drug classes are currently excluded from the PDL by statute. These four drug types represent 38 percent of all drug expenditures in Medicaid. Seven of the top ten generic drugs all also prohibited from being considered for the PDL based on current statute.

Co-Chair Christensen pointed out that as the DOH looks for money within its own agency, the PDL is one area where cuts could be made with some statute changes. There is a bill being drafted to address psychotropic drugs that will allow some of the savings to be realized by the mental health department. Co-Chair Christensen urged the Subcommittee to watch for the bill and be supportive of it.

Sen. Jones asked if there are some individual that could be added to the PDL without adding the whole class of drugs.

Co-Chair Christensen said he has asked DOH for one class of drugs that could be added to the PDL and they have been resistant. There are several classes of drugs listed in the table to pick from.

Mr. Frandsen indicated that psychotropics, anticonvulsants, ADHD drugs, and antidepressants are currently excluded from the PDL by statute. The Subcommittee has the choice of changing statute to include one or more of these classes or to redefine terms of the statute.

Rep. Vickers said that a couple of big drugs in the psychotropic category would be made in a generic form this year, Xyprexa and Seroquel. There are a number of drugs that have some category crossover. Maybe a baby step would be to carve out a couple of specific drugs to be included on the PDL. The other thing that can be done is to grandfather in drugs that a patient already has history with, allowing them to continue with that drug. He's convinced that several things could be done to increase savings without doing harm to patients.

Mr. Frandsen clarified that the savings Rep. Vickers referred to with the two drugs coming out in generic form, would be from the requirement to use less expensive generic drugs where possible, not because they would be added to the PDL.

Rep. Vickers added that it takes about six months to begin realizing gains from purchasing generic drugs because there is a phase in period.

Co-Chair Christensen noted that Utah was hoping for \$7 to 8 million in savings last year but received more than expected with \$27 million in total savings. With a total expenditure of over \$175 million for Medicaid drugs in this state last year, there is a lot of room for more savings.

Rep. Litvack wanted clarification on mental health drugs that are going generic. He asked if the state would already realize savings from the generic drugs without any statute changes.

Co-Chair Christensen replied there are no exclusions when it comes to generic drugs. There are some mental health drugs on a prior approved status but they would have to be considered preferred in order to get the rebates from the drug companies.

Dr. Patton, Executive Director, DOH, with Mr. Michael Hales, Deputy Director, indicated that they were present to answer any questions.

Mr. Hales explained that the preferred drug list is based on the savings seen in the private sector. One of the key differentials is cost sharing. As was discussed a few days ago, DOH asked for an increase in cost sharing in the waiver that the federal government denied. In the private sector, the patient can choose to pay the higher price for a non-generic drug. In Medicaid DOH can only charge three dollars. They do have exceptions for individuals that fail to improve on a drug so they can get pre-authorization to use a drug not on the list. In the process, DOH takes drugs that have been chosen by their board of physicians and pharmacists (P&T) to a purchasing pool with other states where they negotiate prices with the drug companies. That is where they receive the savings. There is a strong safety net for quality assurance.

Mr. Hales wanted to make the point that there is an override process for obtaining other drugs unlike in Medicare part D where there is a formulary, or fixed list of drugs to choose from and no other drugs are covered.

Rep. Vickers wanted to follow up by saying there are efficiencies seen in the private market in terms of co-pays that are blocked from being used in the Medicaid program by the federal regulations. He thinks there is potential for more savings.

Vice Chair Last asked why the savings were so much better than expected.

Mr. Hales indicated DOH added several new drug classes over the course of the year. In January they renegotiate best price contracts with all the pharmaceutical companies for those medications on the PDL. Compliance rates increased because doctors must use a prior authorization to use certain drugs.

Rep. Litvack asked if the P&T committee includes a psychiatrist.

Mr. Hales said the P&T has several types of doctors including a psychiatrist.

Rep. Litvack asked if DOH is measuring patient outcome.

Mr. Hales indicated that was built into the prior authorization process. If a patient reacts negatively to a preferred drug, another drug may be chosen. If there is an established drug that is successful for a client, and they have failed on the preferred drug in the past, they may stay on that drug but if they are newly diagnosed with a disease the doctor must first try using the preferred drug.

#### **4. Report on Pharmacy Inflation Not Being Funded**

Mr. Hales provided a report on "Pharmacy Inflation Experienced During Fiscal Year 2012". One of DOH's building blocks is Forced Provider Inflation. One component of provider inflation is pharmacy, which is not a rate that can be controlled by DOH. This component was removed from the building block last year with the proviso that DOH come back to the Legislature with this report by December 1, 2011. It is important to note that generic drugs account for only 27 percent of the drug expenditures paid by Utah Medicaid, but account for 75 percent of the drug volume. The net result is a fiscal year-to-date pharmacy program inflation experience of 7.94 percent, with brand name drugs at 10.4 percent inflation and generic drugs at 1.2 percent.

Rep. Vickers added that he can give the Subcommittees information as to why there was inflation when not expected. There is a very complicated formulary but the bottom line is he makes more on selling a banana split than a \$100 prescription.

#### **5. Update on Medicaid Outpatient Fee Schedule Changes**

Mr. Hales discussed how DOH compensates hospitals for procedures performed in an outpatient setting. DOH has been using a percent-of-charge reimbursement methodology, so year after year as the hospitals increased their charge masters there was a corresponding increase of funding needed in the Medicaid program. DOH has been trying to keep pace with the market. DOH had to put several million dollars into the forced provider inflation building block. They tried to reduce the percent-of-charge amount in the past and the federal government said they would not approve. Recently, the federal government has been more willing to allow Utah Medicaid to move towards a system comparable to Medicare's Outpatient Perspective Payment System (OPPS). This has put Utah Medicaid on a very aggressive time table to move away from percent-of-charge reimbursement to a fixed fee system. DOH worked with

MMIS, their claims system, to put an OPPS in place within 14 months. They anticipated three to five million dollars in General Fund request but will not have to ask for funds this year. Through a collaborate effort with the Legislature, the Hospital Association, and DOH they launched in September of 2011.

Co-Chair Christensen clarified that in the past, a hospital might change it's price from \$100 to \$120 and the rate would go up for Medicaid. Now Medicaid is saying we will pay \$67 for that particular service.

Mr. Hales indicated that was correct and DOH has given the Subcommittee a nice acronym, OPPS, to describe it all.

Co-Chair Christensen asked Mr. Hales how to pronounce OPPS. He also said that this system sounds good until the hospital's cost gets so high they will no longer provide service.

Mr. Hales said that was a fair statement. The physicians and hospitals have increased costs and are asking for increased funds. DOH has to work with its partners to understand the underlying market pressures so they don't work their way out of access to key services. This is part of the ACO reform. When DOH bundles all the providers together it is hoped that costs will be contained with a smaller rate of growth.

#### **6. Issue Brief: FY 2013 - DOH - Medicaid Spending Statewide**

Mr. Frandsen presented the issue brief on Medicaid spending. In FY 2011 Utah spent \$381,931,700 in General Fund on Medicaid which represents 18 percent of all General Fund spending statewide. In reference to the table on page one, DOH is the major entity involved in Medicaid but not the only agency. FY 2011 was the last year that the State received stimulus money from the federal government to help reduce the State commitment. In FY 2012 Medicaid spending will account for about 22 percent of spending from the General Fund. Even when receiving a match from the counties, most of the money originated in General Fund.

Mr. Frandsen referred to three general categories of offsets to Medicaid expenditures, which totaled \$321,520,900 in FY 2011. First, Medicaid collected \$231 million from third parties including Medicare, private insurance and parties causing medical injury. In FY 2011 about one-quarter of Medicaid clients had another medical insurance. Second, the State collected \$75 million in rebates from volume discounts in pharmacy. Third, Medicaid clients contributed \$15.5 million to participate in the Medicaid program. On page 3, the table shows that children make up 57.3 percent of the eligible clients and Utah Medicaid spends 23.8 percent of their funds on children, whereas the disabled represent 11.8 percent of clients but cost 38.1 percent of Medicaid funds. The three most expensive groups are the aged, those with breast or cervical cancer and the disabled.

Rep. Litvack asked if the Subcommittee would be able to identify the costs in the crosswalk previously provided by staff, where those one-time reductions in the base budget and loss of ARRA funds were taken from.

Mr. Frandsen said the Analyst could provide a breakdown. In general, in FY 2011 there was \$126 million of ARRA funding for the Medicaid program.

Mr. Hales answered that as the Department of Health, when the ARRA amount was available, money was taken out of their base budget. Most of those funds have been replaced.

Vice Chair Last asked Mr. Frandsen if the chart on page 4 was created using a factor, not an actual dollar amount.

Mr. Frandsen acknowledged that was correct.

## **7. Quarterly Status Reports on Replacement of MMIS**

Mr. Hales referred to the quarterly report from December 2011. To date, DOH has implemented an upgraded data warehouse system that has helped with data analysis on claims payment. As part of fraud, abuse and waste prevention, they put in a pre-payment editing tool. DOH offset \$2 million in claims that would have been paid without that tool. The next major component will be the pharmacy point of sale system. This is how Medicaid will interface with the pharmacies and pay for prescriptions. The system is planned to go online over the weekend of President's Day holiday. With the system in place, DOH will be in compliance with the new requirements for transaction standards in the pharmacy arena. Along with this there will be improvement in getting information from the pharmacies and DOH can better track rebates. The main core of MMIS has been waiting for federal government approval then they will accept bids for the design, development and implementation of the new program. DOH does depend on receiving \$3 million this year and \$3 million next year in nonlapsing funds to make it work.

Sen. Christensen asked if it was realistic to expect that the system will only cost \$6 million more.

Mr. Hales indicated that it is only an estimate but it's based on bids from other state's systems. The good news is that whatever the variability is, Utah will only absorb 10 percent on the State General Fund side. In looking at recent bids for procurement of these types of system development projects, the estimate should be good. This is DOH's good faith estimate based on the information available at this time.

## **8. Budget Brief: FY 2013 - DOH - MMIS Replacement**

Mr. Frandsen indicated that all of today's budget briefs address the base budget for Medicaid. These are significant amounts of money being spent. He suggested the Subcommittee look at these amounts to determine if things are going in the direction desired. The Executive Appropriations Committee allocated the same base budget as last year but will be entertaining requests for building blocks and supplementals. In the briefs there will be Analyst recommendations to forward to the Executive Appropriations Committee. The budget is based on obtaining a balanced budget by the Analyst. In looking at all the budget briefs presented by staff statewide, the funds add up to a balanced budget. The Analyst also provided intent language, largely to allow for nonlapsing authority to carry forward funds into the next year. There are also some internal re-allocations recommended by staff for the consideration of the Subcommittee.

Mr. Frandsen addressed the MMIS replacement budget brief. Mr. Hales gave the Subcommittee a pretty good analysis of the MMIS. DOH is asking for phase three of four, \$3 million this year. The Analyst has recommended an allocation of \$1.5 million one-time funds for this purpose. DOH has approximately \$4.5 million in one-time funds that the department would like to carry forward to finish implementing the MMIS system. On page four is the Analyst's recommendation to approve a base budget for FY 2013 for the MMIS replacement line item in the amount of \$19,465,800. The Analyst further recommends the Subcommittee adopt the intent language as stated. The Analyst recommends forwarding to the Executive Appropriations Committee Analyst-recommended items for further consideration as discussed in this brief.

## **9. Budget Brief: FY 2013 - DOH - Health Care Financing**

Mr. Frandsen said the Fiscal Analyst is recommending a base budget of \$101,650,100 for FY 2013 as detailed on page four. At the top of page two, there is intent language to retain up to \$50,000 in nonlapsing funds for computer equipment. The Analyst recommends using the three percent maximum

for administration from the Nursing Care Facilities Account as permitted to offset the loss of tobacco settlement funds for CHIP. The Governor's Budget included funding for \$670,000 General Fund to be used for Accountable Care Organization Administration and \$62,000 General Fund in FY 2012 and \$247,000 General Fund in FY 2013 for eleven FTE's to address caseload growth, federal mandates and additional reporting requirements. On page three, Mr. Frandsen noted that one percent of clients accounted for 25 percent of all expenditures. The Legislative Action is listed on page four. The Analyst recommends approving the base budget and adopting the intent language in the brief.

Rep. Litvack asked Mr. Frandsen if the one percent population has been compared to the analysis in the table on page three of Issue Brief: Medicaid Spending Statewide.

Mr. Frandsen said the Analyst had not made such a comparison but it could be done.

Mr. Hales indicated the one percent are often individuals with very serious diseases that don't originally qualify for Medicaid but spend down to receive Medicaid assistance. These individuals are the very sick.

#### **10. Budget Brief: FY 2013 - DOH - Medicaid Sanctions**

Mr. Frandsen explained that Medicaid Sanctions come from fines that are levied on providers, primarily nursing homes and restriction on their uses. The Analyst recommends approving a request to transfer \$100,000 of Beginning Nonlapsing to the Family Health and Preparedness line item from Medicaid Sanctions in FY 2012. This will allow Family Health and Preparedness to use these fund as matching funds for the federal National Background Check Program grant as well as a project to reduce hospital re-admissions within 30 days of leaving a hospital. The Analyst also recommends intent language concerning nonlapsing funds.

#### **11. Budget Brief: FY 2013 - DOH - Children's Health Insurance Program**

Mr. Frandsen referred to the CHIP budget brief. The Analyst's base budget recommendation is \$82,771,700 for Children's Health Insurance Program in FY 2013. CHIP provides health insurance coverage to uninsured children living in families with incomes less than 200 percent of the Federal Poverty Levels (FPL). On page two, the Analyst recommends using savings from Medicaid of \$1,488,800 General Fund in FY 2012 and \$1,557,000 ongoing General Fund in FY 2013 to replace some of the shortfall in Tobacco Settlement funding. There are two building block requests included in the Governor's budget. There is intent language addressing nonlapsing funds on page three.

#### **12. Budget Brief: FY 2013 - DOH - Medicaid Mandatory Services**

The Analyst's base budget recommendation is \$988,745,500 for Medicaid Mandatory Services in FY 2013. Mandatory services in the Medicaid Program are those that the federal government requires to be offered if a state has a Medicaid program. Medicaid has grown 177 percent from FY 1998 to FY 2011, with Inpatient Hospital Care growing the most. In prior years, some provider rates have been reduced to balance the budget. If new regulations proposed by federal rule are approved, this could potentially delay when Utah Medicaid can reduce those rates. The Analyst recommends the ongoing transfer of \$56,100 beginning in FY 2012 from the General Fund Restricted - Nursing Care Facilities Account from this line item to Health Care Financing the facilitate using the maximum three percent of this fund for administration. There are four building block requests included in the Governor's budget. The first one addresses the fund shortfall period as the department changes from pay-per-service to ACO's. Additional General Fund is required to replace a reduction in federal funds. The consensus forecast is a caseload increase of approximately 8.3 percent in FY 2012 and 5.5 percent in FY 2013. There is a need for Forced Provider Inflation for service rates the agency cannot control.

**13. Budget Brief: FY 2013 - DOH - Medicaid Optional Services**

The Analyst's base budget recommendation is \$825,196,600 for Medicaid Optional Services in FY 2013. This is a reduction in base budget because of unanticipated savings in the pharmacy program. The budget also supports three FTE. The Analyst recommends moving funds into CHIP. The Building blocks included in the Governor's budget include: \$486,000 one-time General Fund to pay for service claims if Medicaid transitions to a prospective payment system model and \$5,800,000 one-time General Fund in FY 2012 and \$5,800,000 ongoing General Fund in FY 2012 for a new "clawback" payment to the federal government for the pharmacy program. The Fiscal Analyst recommends that the Subcommittee forward to the Executive Appropriations Committee for further consideration the increase as discussed on page two. Two of the five categories in Medicaid clients, children and family, have grown faster than the overall caseload growth rate.

**14. Other Business**

None.

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

None.

**MOTION:** Sen. Jones moved to adjourn.

Co-Chair Christensen adjourned the meeting at 9:52 am.

Minutes were reported by Mrs. Pope, Senate Secretary

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Sen. Allen M. Christensen Co-Chair

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Rep. Bill Wright, Co-Chair