

CORRECTED
**MINUTES OF THE
SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE**
Room 30 House Building, State Capitol Complex
Friday, February 15, 2013

MEMBERS PRESENT: Sen. Allen M. Christensen, Co-Chair
 Rep. Ronda Rudd Menlove, Co-Chair
 Rep. Daniel McCay, House Vice Chair
 Sen. Deidre M. Henderson
 Sen. Luz Robles
 Sen. Brian E. Shiozawa
 Sen. Evan J. Vickers
 Sen. Todd Weiler
 Rep. Rebecca Chavez-Houck
 Rep. Tim Cosgrove
 Rep. Edward H. Redd
 Rep. Marc K. Roberts
 Rep. Earl D. Tanner

MEMBERS ABSENT: Sen. Peter C. Knudson
 Pres. Wayne L. Niederhauser
 Rep. Brad L. Dee
 Rep. Paul Ray

STAFF PRESENT: Mr. Russell Frandsen, Fiscal Analyst
 Mr. Stephen Jardine, Fiscal Analyst
 Ms. Paula Winter, Secretary

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

Co-Chair Menlove called the meeting to order at 8:11 a.m.

Unfinished Items from Previous Agenda

Stephen Jardine, Fiscal Analyst, presented several Briefs:

- a. Division of Child and Family Services (DCFS) Budget Brief which gives a brief description of the division and recommends approval of the Budget with a change in Federal Medical Assistance percentage. There is also a recommendation to approve intent language having to do with non-lapsing carry over as well as change in Federal law indicating the Government regulations have been changed for who qualifies for use of their expenditures. Mr. Jardine pointed out that staffing for this program is one of the largest in state government and most of the funding is from the General Fund along with a significant amount of Federal funding.
- b. The Division of Child and Family Services - Performance Measures Brief illustrates measures reviewing an eight year history and highlights changes from information presented a year ago.

It identifies measures that have improved or declined by more than 5 percent. The Brief was reviewed by Mr. Jardine.

- c. SAFE Modernization in the Division of Child and Family Services -This Brief includes intent language that requires DCFS report back regularly as it makes improvements to its system.
- d. Division of Child and Family Services - Federal Funds addresses Child and Family Services federal funding amounts, the history of these funds, and the choices Legislators have in dealing with that.

Rep. Menlove asked a question regarding the rate of growth in state and federal funding and inquired whether the state's rate of growth is influenced by Federal policies which require us to interact in a certain way. Mr. Jardine referred to the history chart in the Brief and replied that the state growth in this case was not influenced so much by Federal policies as it was instead influenced by the *David C. Lawsuit*.

Rep. Tanner asked for clarification on the Foster Care Grant and queried whether the Federal Funds create perverse incentives to pull children out of homes due to the amount of money and influence it might have. Mr. Jardine stated he addressed this because of the frequency it comes up. He referred to the Brief and a waiver option that would allow the state to serve children in their own homes.

Brent Platt, Director, Division of Child and Family Services (DCFS), introduced Cosette Mills, Federal Revenue Manager. Mr. Platt addressed the issue of incentivizing DCFS to bring children into custody in order to draw down additional Federal Funding. Mr. Platt stated that only about 38 percent of the total number of children involved with DCFS qualify for Federal funds. The others' receive services that are paid for from the General Fund. A caseworker would have no idea if children are drawing down Federal funds. The focus is on whether or not the child is safe. Rep. Tanner asked Mr. Platt to address the waiver and he deferred to Ms. Mills. She explained that the waiver was granted by the Federal Government to test innovative home services to be more effective in keeping children at home. The waiver caps the federal funding amount and gives us more flexibility to keep more children at home by being able to shift the funding to in-home services which we previously could not do. Rep. Tanner asked how much of the \$20 million for foster care can be used for the program. Ms. Mills replied that as much as they could save from foster care can be used for in home care. She said they are estimating it to be about \$1.5 million. The waiver creates an incentive for the Division to serve children in their own homes.

Mr. Jardine continued with the Briefs:

- e. Division of Child and Family Services Front Line Staff Turnover Rates – The rate of turnover is about 19 percent and is critical to management of difficult cases. Intent language was proposed last year by a member of this Subcommittee to review the issue internally and come up with solutions. This Brief reviews this study and their recommendations. No Legislative action is required on this brief.

Rep. Tanner asked a question about the front line turnover rates and the demographics of the people in the turnover. He wondered if the employees were married, fresh out of college etc. and voiced concern about the importance of decisions being made and the experience level of staff.

Brent Platt, of DCFS, addressed the question by referring to the workload study of the frontline staff. He stated that 252 are female and 80 are male. Every social worker who works with families is required to have at least a bachelor's Degree in social work, psychology or behavioral sciences. They are also encouraged to be licensed as a social services worker in the state. There are 235 with Bachelor's degrees and 95 with Master's degrees. He stated that their ages range from 26 years old to retirement age. The division does not ask if they are married or single when they hire someone. These positions are entry level so the employees will probably be looking for other opportunities for advancement. Rep. Tanner asked a

question about whether or not they have children and Mr. Platt stated that is not a selection criteria and also stated he understood why that was being asked but informed the Committee that there is a good practice model in place and the statute and rules are clear about when services are offered. Centralizing intake was instituted to bring consistency to the process. There are clear parameters. Supervisors, attorneys, court orders, and judges are involved in the decision. Decisions are not made by only one person. There are always others involved. Mr. Platt invited anyone from the committee to participate in the qualitative review process.

Palmer DePaulis, Director of Human Services, came forward and stated there were no more summary issues they had. There were no further questions from the Committee.

Nurses in Medicaid for Case Management in Targeted Rural Areas

Michael Hales, deputy director, Utah Department of Health (UDOH), spoke on a motion made in the last Legislative session to transfer money from the program budget to the administrative budget in order to increase capacity in the State to do case management of individuals with chronic conditions. A request was put out to the rural local health departments to see what they would propose for a pilot case management program in their community. The pilot project was selected in the Bear River Health Department which provides services to individuals in Box Elder, Cache, and Rich Counties. Their proposal was to hire case managers to work with local pediatric offices to better coordinate care, identify individuals who have chronic conditions and to make sure those individuals understood how to get referrals to appropriate providers and community services available to get proper treatment. The staff was brought on in October and the UDOH has been working with them to make them aware of resources available along the Wasatch front. Current staff is working with Treehouse Pediatrics in Logan to collaborate with the physician's office and receive access to electronic health records to identify individuals with chronic care needs in order to start working on better coordination of care with the ultimate hope of reducing cost of care for services actually paid for out of the Medicaid program. Mr. Hales proceeded to explain why the rural communities were chosen.

Rep. Menlove asked if this program was far enough along to tell if we might want to expand the program and Mr. Hales replied that we are not yet at the point to have results yet and still need to see how we will measure the effectiveness of the program and getting the appropriate training in place. Evaluation will be ongoing and documenting will be important in measuring the data appropriately.

Medicaid State Plan

Michael Hales, again addressed the committee in regard to statutory language that requires the Department of Health (DOH) to submit to this appropriations subcommittee changes that the Department makes to the Medicaid state plan and to any of the waivers. He proceeded to explain the state plan with the federal government on services and reimbursement methodology. We attempt to submit this information on a quarterly basis. Mr. Hales continued and highlighted some of the items submitted in the state plan amendment. In the March 30, 2012 letter a state plan amendment was submitted to allow presumptive eligibility determinations to be made for certain children and their siblings leaving the foster care system. This step was the final one was in response to receiving a \$10 million one-time bonus for making it easier for children to qualify for the Medicaid program or be retained on the Medicaid program. He explained more about the program. Mr. Hales then explained about moving to a capitated model for substance abuse as well as technical changes to some waivers which would allow individuals who have been in a nursing facility for at least 90 days to dis-enroll from the facility and take the money that has been paid for them to stay in the facility into a community facility and the minimum age for that was 21 years of age but has been reduced to a minimum age of 18. Costs in a nursing home are higher costs than

is they are in a community facility and this program is federally-mandated to be funded. That savings is usually immediate.

Rep. Menlove asked if these placements are more like a normal life where they would have peers and some social interaction or interaction in the community. Mr. Hales responded that there are a lot of options but that probably is the case in most instances.

Sen. Christensen inquired what the effect would be for removing the provision for mandatory 90 day nursing home placement and Mr. Hales responded that this may be a policy decision that may have to be made as it relates to the Medicaid program and how it is structured with relation to what is a mandatory service and what is optional. The nursing home benefit is a mandatory service and the state has an obligation to cover that service. The home and community programs are optional and the state can limit the number of enrollees and increase the waiting list. The 90 day stay is currently in place so that there is a budgetary obligation to pay for these people in a nursing facility and establish that they are accessing a mandatory benefit before resources are committed to them if they go back into the community.

Rep. Tanner asked for a clarification of the amount saved when a person is moved back into the community. Mr. Hales clarified that the cumulative savings for 20 to 30 individuals is about \$30,000. Including state and federal funds the savings is about \$3,500 per person.

Russell Frandsen, fiscal analyst, clarified that in the 2011 General Session HB 357 proposed removing the 90 day provision for the New Choices Waiver and the fiscal note was a \$1.7 million ongoing General Fund impact to serve 237 new individuals.

Sen. Christensen, questioned the necessity of going into the nursing home to qualify for Medicaid payment. Mr. Hales stated that there is still the measure that the client needs a nursing level of care so there is medical criteria necessary to be met. A conversation occurred between Sen. Christensen and Mr. Hales about how family and neighbor support which allows people to be taken care of in their home settings saves the State from having to pay for care through Medicaid.

Rep. Menlove asked about expanding the waiver and Mr. Hales responded that the number of slots has increased from 1,200 to 1,400 people. The New Choices program has expanded from 500 to 600 to 1,200 in the last five years and is growing. The reason this waiver can be expanded is because we have to have the mandatory money for them to be in the nursing facility and by taking them out money is saved which makes it a self-funding type of program.

Mr. Hales spoke about the second State plan and waiver submission which is the new Medicaid pilot program authorized from HB 272 from the last legislative General Session. It was submitted on June 29, 2012. Approval was received in late September. Its purpose was to enroll children in services in the Medicaid Autism Program.

Rep. Menlove clarified that this is the autism pilot in which children between the ages of 2 and 6 are allowed to enroll in behavioral and other services needed. Mr. Hales stated that 176 children are currently enrolled and are waiting for some to respond to the documentation and will continue to enroll up to 250 children. Some will leave and the total number served could be about 300.

Sen. Robles asked about the number of people who have applied for the program.

Mr. Hales stated there were about 370 applicants for services for 250 slots. The effort is being made to ensure that those accepted will have at least 6 months eligibility.

Sen. Shiozawa requested comment on the provider reimbursement through Medicaid and the Autism Treatment Account. Mr. Hales reviewed the varying methodologies, fee schedules, and services paid for

through Medicaid and proceeded to explain the Autism Treatment Account model. Sen. Shiozawa asked for a comparison of the Medicaid rates and the Public Employees Health Plan (PEHP). Mr. Hales did not have the rates and it was decided to address this question later.

Rep. Menlove stated the point is that Medicaid reimbursement is not as high as PEHP. Mr. Hales stated the commercial and PEHP rates are the greatest reimbursement to providers then Medicare and last Medicaid.

Rep. Redd questioned if all 250 children have been enrolled in the autism pilot. Mr. Hales proceeded to illustrate the procedure for selecting those eligible for the program with the requirements necessary and the protections in place to include as many as respond. Some have not done so in the allotted time and will be terminated and others on the wait list will be added.

Michael Hales proceeded to address the next item which was to change the 1115 Waiver that allows for a premium subsidy to be paid to subsidize the health insurance benefit which increases the threshold from 150 percent of the poverty level to 200 percent of the poverty level for adults. This waiver allows the number of individuals to be limited and better aligns the families with children who made the Children's Health Insurance Program. Mr. Hales skipped some areas and mentioned the state plan for the dental services pilot program which had a state plan amendment to cover the targeted or limited emergency benefits was submitted prior to July 1, 2012 implementation. The October 1, 2012 letter talked about continuing quality incentive payments for nursing facilities. Mr. Hales continued with the state plan and gave information about the Accountable Care Organization plan waiver and was resubmitted to the government per their request.

Additional Screening and Verification Tools

Michael Hales informed the committee that the Department of Health was given intent language to explore an asset verification and provider screening tool and the State has hired a company called LexisNexis, a comprehensive data base and search facility. The proposal was that they would provide information that the Department may not have access to on their own and this may prevent certain types of providers being enrolled in the Medicaid program and help to reduce the fraudulent billing. Mr. Hales continued to explain the procedure used to collect information and the result that there was nothing in the 10 percent review of providers but the Department decided to purchase the full survey for \$75,000 and run through the information on the providers. The system has been updated with the provided information but no cases of providers participating in fraudulent billing has been detected. The determination has been made that this program would not be cost effective to continue. He stated the asset verification was something they hoped to pursue but was not approved by the granting agency. However the federal government has mandated an asset verification system be put in place and have submitted the proposal to the government for the asset verification approach to find a tool. A cost effective program is being searched for where assets will be identified for those applying for Medicaid that have not been disclosed in the application in process and might prevent them from enrolling in the program.

Replacement of the Medicaid Management Information System (MMIS)

Chair Rep. Menlove advised that this is something in the budget asking for continued funding and is an important update. Michael Hales reviewed that with the intent language established the Department of Health (DOH) is required to report to the analyst's office quarterly, the status of the funds appropriated to date for implementing the Medicaid Management Information System. DOH has received \$6 million of General Fund appropriations and has spent about \$1 million of that amount. Mr. Hales continued that

there has been procurement of a bidder to rebuild the core of the MMIS. A company called CNSI based in Gaithersburg , Maryland was awarded that contract. They are onsite as of a week ago. The component of the pharmacy point of sale system was put into place about a year ago and we are expecting a certification letter from the Federal Government. He also informed the committee that there is an independent audit function making sure the programming contractor is doing their job. Of 6 bidders a firm called Cognizante has been selected. Mr. Hales also reported that a pre-screening tool to identify claims that shouldn't be paid has been implemented and for the first two years the DOH has saved \$5million in claims that would otherwise have been paid.

Budget and Issue Briefs

Russell Frandsen, fiscal analyst, proceeded to review briefs:

- a. Medicaid Management Information System (MMIS) Replacement-the legislative action is to adopt the intent language statements discussed in the brief. Adoption of the intent language provides a base budget for FY 2014 of \$34,454,500 with \$29 million in federal funds.

Rep. Redd asked for an explanation of the MMIS. Mr. Frandsen explained that the system used to pay claims is based on a 1975 operating system which is being updated to handle the 7 million claims made.

Rep. Tanner asked if we go with the federal exchange will it affect this system and Mr. Frandsen responded that affects us but not in this area at all. Mr. Hales explained that the system is how people are billed and does not involve the federal exchange which is an entirely different program separate from Medicaid. He further explained that there will need to be eligibility information given through the exchange. The exchange coordinates the purchase of health insurance with a subsidy someone may receive. Medicaid covers a different population and pays for the services.

Rep. Redd asked whether this system would be able to communicate directly with the billing systems of providers of the Accountable Care Organizations. Mr. Hales reported that about 93-96 percent of the claims are processed electronically but agreed to talk off line to address specific capacity and stated also that this system allows there to be more nimbleness in applying methodologies in a more timely manner and have better waste, fraud, and abuse controls in the system. Sen. Christensen stated that this sounds like this is catching errors on the front end rather than on the back end and then recover.

Russell Frandsen, fiscal analyst, referred to a table that showed the 999 edits of the system that are used to check to see if there should be a denial for claim. Mr. Frandsen continued with the briefs:

- b. HB 25 Patient Identity Validation – for information only

Rep. Redd stated that he has constituents concerned about the system and requested someone to talk with about the process. Barry Nagle from the Department of Health agreed to talk with him concerning this issue.

Rep. Menlove reiterated the importance of making the system viable so that as we progress the unique identity of individuals will be available between systems. She stated this legislation was brought to us by the health care providers in the state.

Russell Frandsen continued:

- c. HB 46 Electronic Personal Medical Records – This was passed last general session. It has helped to enroll 360,000 individuals in the electronic exchange of clinical health records from Medicaid, the Children's Health Insurance Plan, and the Public Employees Health Insurance Program participants.

Rep. Menlove stated this is a step to increase membership in our clinical health information exchange which anyone can participate in if their provider works with them. We decided this year to not move forward with moving more people in. Next year there will be more discussion and potential legislation.

Sen. Christensen welcomed students in the audience to the process and described the job of the committee

and informed them this is important to people for the coming fiscal year. Rep. Powell stated the students are from Park City High.

Russell Frandsen continued:

- d. HB 98 Continuous Eligibility for Medicaid – For information only. It permits 12 month eligibility for an individual if it would increase quality of care and it is cost effective. It was determined that the program is not cost effective.

Rep. Redd needed clarification on explanation of cost effectiveness.

Michel Hales explained that the Children's Health Insurance Program has a 12 month eligibility and saw that the average stay is 11 months. For Medicaid the average enrollment for children is 9 ½ months. The test was if we change the policy for Medicaid eligibility for children to have them be eligible for 12 months as opposed to month to month eligibility with a 6 month review we would anticipate that the average enrollment increase from 9 ½ to 11 ½ months and for as many children enrolled, 140,000 to 150,000. For two months increase \$540 for that many children would be the cost. The benefit eventually would be that their continuity of care and better managed care would affect the Accountable Care Organizations would receive reduced premiums in order to offset the costs. Rep. Redd inquired about how much it costs to do the reviews month to month. Mr. Hales replied that in general the Medicaid program deals with a 5 percent cost.

Mr. Frandsen asked if the Department looked just at children under a capitated system and Mr. Hales stated that they used their average cost for all children in the system. Mr. Frandsen continued:

- e. HB 272 Pilot Program for Autism Spectrum Disorders Services – there is an action item related to this bill that the analyst recommends which is to provide the Department \$500,000 in spending authority from the Autism Treatment Account in FY 2014 so the Department can spend the donations that the fund has received.

Sen. Christensen inquired whether there could be an unlimited spending authority on money they collect themselves and Mr. Frandsen replied there would be a problem with this fund because it is a General Fund Restricted Account, a restricted account which needs to be annually appropriated but the nature of the fund could be changed to an expendable fund that says once it's in there it can be spent. You could give them more spending authority than they could possibly use or you could change the fund to say whatever you get you can spend. Rep. Menlove asked Mr. Frandsen to come back with intent language for this issue.

Mr. Frandsen proceeded with the last brief:

- f. Hospital Provider Assessment – Action may be needed. In July of 2013 there will no longer be authority to collect \$41.5 million in hospital assessments. SB 166 would prevent the sunset of this provision but if the bill did not pass there would be \$41.5 million less state match being used to pay hospital provider rates.

Mr. Frandsen referred to the updated motion sheet distributed to the committee and explained that underlined items are new, crossed out items are deletions and comparing of the first day motion sheet will show what is new.

Rep. Menlove advised of the new schedule for next week. Tuesday and Wednesday at 8 a.m., Thursday at 3:10-5 p.m., and Friday at 2:10-4 p.m. so that some who could not come in the morning could attend later.

MOTION: Sen. Christensen moved to adjourn
Co-Chair Menlove adjourned the meeting at 9:50 a.m.

Minutes were reported by Ms. Paula Winter, Senate Secretary

Sen. Allen M. Christensen, Co-Chair
Rep. Ronda Rudd Menlove, Co-Chair