



REQUIRED REPORTS – DEPARTMENT OF HEALTH

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANSEN

ISSUE BRIEF

SUMMARY

This Issue Brief provides information regarding 11 reports currently required to be given to the Social Services Appropriations Subcommittee by the Department of Health. This brief also includes a list of 14 other reports given to the Legislature but not specifically to the Social Services Appropriations Subcommittee, that may be of interest. This brief is for informational purposes only and requires no Legislative action.

DISCUSSION AND ANALYSIS

Department of Health's reports that are required by statute

- 1) **SB 180 "Medicaid Reform" Waiver Report** – "(4) No later than June 1, 2011, the department shall submit a written report on the development of the proposal to the Legislature's Executive Appropriations Committee, Social Services Appropriations Subcommittee, and Health and Human Services Interim Committee. No later than July 1, 2011, the department shall submit to the Centers for Medicare and Medicaid Services within the United States Department of Health and Human Services a request for waivers from federal statutory and regulatory law necessary to implement the proposal. After the request for waivers has been made, and prior to its implementation, the department shall report to the Legislature in accordance with Section 26-18-3 on any modifications to the request proposed by the department or made by the Centers for Medicare and Medicaid Services." The report and original proposed waiver are available at the following links <http://le.utah.gov/interim/2011/pdf/00000860.pdf> and <http://le.utah.gov/interim/2011/pdf/00000861.pdf>. Below are some highlights from these reports:
 - a. "The Utah Medicaid ACO model is distinct from the model adopted by the Medicare program. For the purposes of its Medicaid program, the State is willing to consider as an ACO any organization that can (1) manage risk and accept a capitated premium for its services, (2) distribute payments across the continuum of scope of service providers and (3) meet the quality standards required under contract."
 - b. "While an ACO model may at first seem quite similar to a traditional managed care, the key differences are (1) that the ACO payments eliminate the incentives to provide excess care and (2) the contracts will be maintained only if the ACO meets established quality and access criteria."
 - c. "Another main goal of the reform is to align incentives in such a way that the delivery patterns move away from billable events and to focus more on patient outcomes and the quality of care."
 - d. "What the Utah proposal does is incorporate what is working well in the current system, adds new innovative aspects, and modifies the delivery and reimbursement system to conform to the ACO model."
- 2) **Medicaid Efficiency, Cost Avoidance, and Internal Auditing Report** – UCA 26-18-2.3 - this report was reported on and included starting on pdf page 21 of the Issue Brief entitled "*Medicaid Review; Status of Recommendations*" (<http://le.utah.gov/interim/2011/pdf/00000180.pdf>).
- 3) **Medicaid State Plan Amendments** – UCA 26-18-3 directs the Department to report to the Health and Human Services Appropriations Subcommittee when beginning or changing waivers, Medicaid State

Plan, or rate changes that require public notice. There are two reports included as Appendix A, which represent all the reports submitted since the 2011 General Session through December 2011.

- 4) **Committee to Evaluate Health Policies and to Review Federal Grants** – UCA 26-1-4 requires an annual report by November 30th on the work done by a local health department and Department of Health consultation committee, which coordinate the sharing of federal grants between the Department of Health and local health departments. This report is Appendix B and is available at <http://health.utah.gov/legislative/Governance%20Report.pdf>. The tables showing the shared grant funding between the Department of Health and local health departments are pages 2 and 3 of the Budget Brief entitled “*Local Health Departments.*” Below is a quote from the report:
 - a. “Since January 2011, the Governance Committee has reviewed 49 grants. 28 were approved for submission and 21 were exempted from review.”

- 5) **Tobacco Settlement Restricted Account** – UCA 51-9-201 directs all agencies receiving funds from the Tobacco Settlement Restricted Account to provide a report on program activities by September 1 of each year. The Department of Health receives money from this account and combines this report with Children’s Health Insurance Program report discussed as #6 further below under the other reports section.

- 6) **Tobacco Prevention and Control in Utah** - UCA 51-9-203(3) requires the Department of Health to report on all programs and campaigns that received tobacco money funding. This report is available at <http://www.tobaccofreeutah.org/tpcfy11report.pdf>. The following are some quotes from the report:
 - a. “The Utah Quit Line and Utah QuitNet have served nearly 87,000 registered users since the TPCP began offering the telephone-based quit program in 2001 and the online program in 2003. In FY 2011, the Quit Line and QuitNet served an average of 860 Utahns per month with free counseling and tailored quit information.”
 - b. “Since 1999, smoking among pregnant women has decreased by 21%”
 - c. “In 2010, 1.9% (or 16,600) Utah children age 17 and younger were exposed to secondhand smoke inside the home.”

- 7) **Expansion of 340B drug pricing programs** – UCA 26-18-12 requires quarterly progress reports on expanding the use of 340B drug pricing programs within the Medicaid program. This report is Appendix C. The following are some quotes from the November 21, 2011 report:
 - a. “Program staff submitted a final draft State Plan Amendment (SPA) to the Denver Regional CMS office on May 3, 2010 for review. The SPA includes the following six disease states: hemophilia, multiple sclerosis, cystic fibrosis, rheumatoid arthritis conditions, hepatitis C, and Crohn’s disease...The feasibility of additional disease management programs is likely since approval of this SPA looks promising.”
 - b. “The feasibility of expanding disease management into other disease states is greatly reduced as clients along the Wasatch front will be part of an ACO in the future. This may impact the willingness of 340B providers to bid for other disease management programs (lacking economies of volume).”

- 8) **Assistance to Persons with Bleeding Disorders** – UCA 26-47-103-(5)(b) requires an annual report on the grant program for persons with bleeding disorders. In FY 2011, \$234,500 in grants served 60 individuals. This report is Appendix D. The most recent report is available at <http://health.utah.gov/primarycare/pdfs/BleedingDisordersFactSheet.pdf>.

- 9) **Kurt Oscarson Children’s Organ Transplant Fund** – UCA 26-18a-3(5) states that there shall be an annual report, “Regarding the programs and services funded by contributions to the trust account.” The report indicates that in FY 2011 \$56,518 was collected from tax returns and used to help 20 families with the financial costs of their children’s organ transplants. This report is Appendix E and is also available at <http://health.utah.gov/legislativereports/Kurt%20Oscarson%202011.pdf>.
- 10) **Organ Donation Contribution Fund** -UCA 26-18b-101(2)(c) requires annual report on the activities on the fund. The report indicates that in FY 2011 the fund received \$79,945 from voluntary donations through motor vehicle license registrations that were used to promote organ donation. This report is Appendix F and is also available at <http://health.utah.gov/legislativereports/Organtransplant2011.pdf>.
- 11) **Autism Treatment Account Advisory Committee** – UCA 26-52-202 requires an annual report on the activities of the Autism Treatment Account Advisory Committee. The report is available at <http://www.health.utah.gov/cshcn/AutismTxAcct/PDF/LegRpt112011.pdf> and is Appendix G. The following is a quote from the report:
 - a. “A draft request for proposal (RFP) has been written that will be used to prioritize and allocate funds. The RFP will be reviewed and finalized when funds become available.”

Other Department of Health Reports That May be of Interest

- 1) **Annual Financial Audit (FY 2011)** - of the Department of Health by the Utah State Auditor. This report is available at <http://www.sao.utah.gov/finAudit/rpts/2011/11-11.pdf>. The Budget Brief entitled “Executive Director’s Operations” includes a discussion of each finding from the audit.
- 2) **Drug Utilization Review Board** – UCA 26-18-103 requires an annual report to legislative leadership on the activities and results from work by the board. The federal FY 2010 report is available at <http://health.utah.gov/medicaid/stplan/LegReports/Utah%202010%20DUR%20Report.pdf>. Below is some information from the report:
 - a. \$19,276,323 estimate of net savings from the policies established by the Drug Utilization Review Board.
 - b. “Each year, [Prospective Drug Utilization Review] provides cost savings by identifying potential therapeutic problems (e.g. excessive dose, drug-drug interactions, etc)... For all drugs, savings are estimated at over \$1.27 million. [Prospective Drug Utilization Review] not only enhances client safety, but provides savings to Utah Medicaid.”
 - c. “The [University of Utah Drug Regimen Review Center] assists the prescribers in streamlining drug therapy in order to reduce potential adverse drug reactions, unnecessary, and/or duplicate prescriptions. These efforts have resulted in a savings of over \$1.35 million over the last 12 months for which data is available (July 2009 through June 2010).”
- 3) **Cancellation of Request for Proposals for Medicaid Dental Services** - “If the division cancels the request for proposals [for dental services] under Subsection (6)(a), the 159 division shall report to the Health and Human Services Committee regarding the reasons for 160 the decision” (HB 256 - <http://le.utah.gov/~2011/bills/hbillenr/hb0256.pdf>). The Department is going forward with contracting for services, so there will be no report.
- 4) **Children’s Health Insurance Program (CHIP)** – UCA 26-40-109(2) instructs the Department of Health to report annually on its evaluation of the performance measures for CHIP. CHIP has both performance objectives and core performance measures. This report is available at http://health.utah.gov/medicaid/stplan/LegReports/CHIP_Annual_Report2011.pdf. The following are some quotes from the report regarding meeting those objectives and measures:

- a. “86.10% of parents surveyed said they ‘Always’ or ‘Usually’ got timely care.”
 - b. “89% of all CHIP enrollees had one or more visits with a primary care practitioner in 2010.”
 - c. “86.1% of parents said that getting necessary care for their child was ‘Not a problem’”
 - d. “91.10% rated their personal doctor or nurse as 8, 9, or 10”
- 5) **Process to Promote Health Insurance Coverage for Children** – UCA 26-18-15 required a one-time report from Department of Workforce Services, the State Board of Education, and the Department of Health on developing a system to promote health insurance options during appropriate times of the school enrollment process by November 19, 2008. The report arrived in March 2011. This report is Appendix H. Below is a quote from this report:
- a. “Federal regulations for free and reduced price meal programs administered under U.S. Department of Agriculture allow for information sharing with Medicaid and CHIP whereas the federal regulations for student data (FERPA) do not allow sharing of student data to these programs. The conflict between these regulations has made sharing information challenging since child nutrition program information is collected at the school and becomes part of the student record. The current workaround (school personnel sort the Free and Reduced Price School Lunch application information to comply with FERPA and then provide this to Medicaid and CHIP) is time consuming, ineffective, and not scalable to a statewide operation.”
- 6) **Primary Care Network** – UCA 31A-22-633 requires an annual report from the Department of Health to the Health and Human Services Interim Committee regarding the Primary Care Network. The FY 2011 is available as number 6 at <http://image.le.utah.gov/Imaging/History.asp?MtglD=8910>. Below are some quotations from the FY 2011 report:
- a. “In FY 2011 average monthly enrollment in (Primary Care Network) was 18,126.”
 - b. “In FY 2011 total PCN claims were \$20,219,686.”
 - c. “In FY 2011, the Department received 2,016 referrals for specialty care and arranged 696 specialty care visits.”
- 7) **Cigarette Tax Restricted Account** – UCA 59-14-204 directs all agencies receiving funds from the Cigarette Tax Restricted Account to provide a report on program activities by September 1 of each year. The Department of Health receives money from this account and combines the report with the Tobacco Prevention and Control in Utah discussed above.
- 8) **Primary Care Grant Program** – UCA 26-10b-105 requires an annual report on the implementation of the grant program for primary care services. In FY 2011 \$1,166,100 in grants served 42,700 individuals. The most updated report is available at <http://health.utah.gov/primarycare/pdfs/PrimaryCareGrantsFactSheet.pdf>.
- 9) **Emergency Medical Services Five Year Strategic Plan** – this report goes to the Judiciary, Law Enforcement, and Criminal Justice Interim Committee. This report is available at http://health.utah.gov/ems/about/strategic_plan.pdf. The report includes 15 goals with timelines for improving the Emergency Medical Services System in Utah.
- 10) **Rural Residency Physician Training Program** – UCA 63C-8-106 directs the Medical Education Council to report annually by November 30th to the Health and Human Services Interim Committee on the implementation status of a pilot project to put physicians into rural residency programs. The pilot project is scheduled to sunset July 1, 2015. This report is available at http://www.utahmec.org/uploads/Rural%20Report_2011.pdf. The following is a quote from this report:

- a. “Since 2007, the Utah Medical Education Council (UMEC, www.utahmec.org) has sponsored 222 clinical rotations for 180 health care students in the rural and underserved areas of Utah. This initiative was created to attract and retain health care providers in Utah, specifically to the rural and underserved areas. These rotations provide students with a chance to experience and see firsthand rural life and practice, thereby improving chances of these students returning to rural Utah for practice.”

- 11) **Standards for the Electronic Exchange of Clinical Health Information** – UCA 26-1-37 directs the Department of Health to reports to the Health and Human Services Interim Committee annually by October 15 on the use of standards for the electronic exchange of health information. This report is available at <http://health.utah.gov/phi/getfile.php?id=316>.
- 12) **Testing for Suspected Suicides** – UCA 26-4-28 requires an annual report from the Department of Health to the Health and Human Services Interim Committee by November 30 regarding the types of substances found in people suspected to have died of suicide or suspected suicide. The Department reports that of the 473 suicides investigated by the Medical Examiner in FY 2011, 86 had some substances/drugs in their body at the time of death. This report is Appendix I.
- 13) **Abortion Informed Consent Material Penetration** – UCA 76-7-305.7 directs the Department of Health to report annually to the Health and Human Services Interim Committee after July 31 regarding specific information for abortions. The Department reports that there were 8 abortion patients that were excused by a physician from receiving the required information. This report is Appendix J.
- 14) **HB 174 2011 GS report** – “The department, the Department of Workforce Services, and the Privatization Policy Board shall, prior to October 20, 2011, report to the Legislature's Health and Human Services Interim Committee and to the Social Services Appropriations Subcommittee regarding the findings of the study and any recommendations and options regarding the advantages and disadvantages to the state in privatizing the eligibility determination system.” <http://le.utah.gov/~2011/bills/hbillenr/hb0174.pdf>
The report is available as number 9 at <http://image.le.utah.gov/Imaging/History.asp?MtgID=8900>.

APPENDIX A – MEDICAID STATE PLAN AMENDMENTS



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

David N. Sundwall, M.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

March 31, 2011

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Subcommittee Member:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(a), the following is a summary of recent changes:

State Plan Amendment

The Department of Health has transmitted a State Plan Amendment to add Peer Support Services as a rehabilitative mental health service to the Utah State Plan. The Department has worked collaboratively with the Department of Human Services, Division of Substance Abuse and Mental Health, over the past two years to develop this service.

This service is provided for the primary purpose of assisting in the rehabilitation and recovery of adults with serious and persistent mental illness (SPMI), assisting young adults who are 16 through 18 years of age with Serious Emotional Disorders (SED), and assisting children with SED. SED is the inclusive term for children and adolescents whose emotional and mental disturbance severely limits their development and welfare over a significant period of time and requires a comprehensive coordinated system of care to meet their needs. This service will be provided under the Department's 1915(b) mental health waiver, the Prepaid Mental Health Plan.

The county mental health authorities provide the Medicaid state match for Medicaid mental health services. It is also anticipated that as this service is implemented by mental health providers, utilization of other rehabilitative mental health services may be reduced.

The Department does not anticipate any change in annual expenditures as a result of this SPA and there is no cost shift to more expensive services.

The proposed effective date of this State Plan Amendment is July 1, 2011, and it is pending CMS approval.



Waiver Amendments

The Department has transmitted two waiver amendments and a waiver renewal to CMS. The first amendment is for the Prepaid Mental Health Plan 1915(b) waiver. The purpose of this waiver amendment is to change the Prepaid Mental Health Plan contractor in Salt Lake County from Valley Mental Health to the Salt Lake County Division of Behavioral Health Services, to cover Peer Support Services under the waiver, to revise the definition of Respite Care and to add provisions authorizing the Prepaid Mental Health Plan contractors to use substitute health services in lieu of inpatient hospital services provided in a psychiatric unit of an acute care hospital if such services are, in the judgment of the Prepaid Mental Health Plan contractor, medically appropriate and cost-effective. Substitute health services may be provided by a private facility that is licensed as a psychiatric specialty hospital and is Medicare-certified.

The second waiver amendment is for the Community Supports waiver. The purposes of this amendment are to amend the service limitation description for the Day Supports service and to add the service description and rate for daily, Utah Transit Authority-provided, transportation service.

The proposed effective date of both the Prepaid Mental Health Plan waiver and Community Supports amendments is July 1, 2011. Both are pending CMS approval. There is no anticipated cost increase to the waivers associated with these amendments.

Waiver Renewal

The Department has submitted a waiver renewal for the Utah Home and Community Based Waiver for Individuals with Physical Disabilities, which expires June 30, 2011. The major changes to this waiver are the administrative case managers will now be required to have face-to-face visits at least once every six months and additional contacts will take place by phone on at least a quarterly basis. Additionally, there are modifications to the circumstances under which parents or step-parents may be paid to provide personal assistance services.

The proposed effective date of the waiver for Individuals with Physical Disabilities is July 1, 2011. It is pending CMS approval. There is no anticipated cost increase to the waiver.

Please let me know if you have any questions. You can reach me at 801-538-6689.

Sincerely,



Michael Hales
Deputy Director, Utah Department of Health
Director, Medicaid and Health Financing



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

CRP-441-11

June 29, 2011

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Subcommittee Member:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(a), the following is a summary of recent changes.

Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

The Department has transmitted a State Plan Amendment to implement Section 6505 of the Affordable Care Act. This section of the Act prohibits payments to entities located outside of the United States who provide items or services under the State Plan or a waiver.

The Department does not anticipate any change in total annual expenditures and this amendment does not result in any cost shift to more expensive services.

Disproportionate Share Hospital Payments

The Department has transmitted a State Plan Amendment to allow the State Psychiatric Hospital to receive direct disproportionate share hospital (DSH) payments at different intervals in a fiscal period based on the uncompensated care cost survey data that the hospital submits. Like other disproportionate share hospitals, the hospital may receive payments on either a monthly, quarterly, semi-annual, or annual basis, or any combination of those time periods.

This amendment also clarifies the DSH add-on calculation, notes that DSH is not paid to out-of-state hospitals, clarifies specifics of the redistribution of disallowed DSH payments, adds information relating to the annual DSH audits performed, updates the Low Income Utilization Rate (LIUR) definition, specifies the need for hospitals to submit an annual survey to become qualified for DSH payments, updates the methodology for payments to the state teaching hospital, and simplifies the calculation for claims add-on DSH payments.

The Department does not anticipate that annual provider payments will change as a result of this update and there is no cost shift to more expensive services.



Medical Education and Supplemental State Teaching Hospital Payments

The Department has transmitted a State Plan Amendment to propose the Graduate Medical Education (GME) payment pool for state fiscal year 2012 to be \$6,336,524. This change also amends the calculation for supplemental payments to the state teaching hospital up to the Medicare upper payment limit to include inflation and utilization factors, and removes the 90 percent interim payment approach. These changes are being made to reflect the GME funding levels and are based upon discussions with the state teaching hospital.

The Department anticipates that, subject to the upper payment limit, total annual expenditures will be similar to current levels for the supplemental payments and for graduate medical education payments.

This change does not result in any cost shift to more expensive services.

Resources

The Department has transmitted a State Plan Amendment to implement a provision of the Tax Relief Unemployment Insurance Reauthorization and Job Creation Act of 2010. As part of the eligibility determination process, this provision excludes as a resource for 12 months after receipt a state tax refund that an individual receives between January 1, 2010, and December 31, 2012.

The Department does not anticipate a substantial impact to annual expenditures because the total refund amount for all Medicaid recipients is limited and should only affect a small number of individuals.

There is no cost shift to more expensive services and a few Medicaid recipients will see limited savings.

Waiver Renewal

The Department has submitted a waiver renewal for the 1915(b)(4) Freedom of Choice Transportation Waiver which ends June 30, 2011. The purpose of this waiver is to allow the state to contract with a single provider for statewide non-emergency medical transportation services. The waiver program has operated since 2000. The contract provider is PickMeUp Medical Transport.

On May 11, 2011 CMS approved a two-year renewal of the waiver for the period July 1, 2011 through June 30, 2013.

New 1115 Waiver

In compliance with S.B. 180 the Department has submitted a Section 1115 Research and Demonstration Project Waiver. As delineated in S.B. 180 the purpose of the waiver is to “modify the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models.” The waiver proposes reforming Medicaid to implement payment reforms and more appropriately align financial incentives in the health care system.

As required by S.B. 180 the Department developed the waiver with “input from stakeholder groups representing those who will be affected by the proposal.” A workgroup was formed to provide

input, consultation and feedback for the provisions of the waiver application. Meetings were open to the public and were attended by individuals from provider professional organizations, state legislative representatives, consumer advocates and members of the public. We appreciate the many hours of thought and effort contributed by these individuals.

Please let me know if you have any questions on any of these State Plan and waiver changes. My number is 801- 538-6689.

Sincerely,

A handwritten signature in black ink, appearing to read "Michael Hales". The signature is fluid and cursive, with the first name "Michael" and last name "Hales" clearly distinguishable.

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

APPENDIX B – COMMITTEE TO EVALUATE HEALTH POLICIES AND TO REVIEW FEDERAL GRANTS



26-1-4 Report: Utah Department of Health and the Local Health Departments - Allocation of public health resources and federal grant funding



1. Governance Structure

The Utah Department of Health (UDOH) and the state's 12 local health departments manage as required by UAC 26-1-4, a committee consisting of three local health officers and three department representatives including the Executive Director of UDOH “to evaluate health policies and to review federal grants.” The Committee referred to as the Governance Committee or Governance reviews all UDOH proposed and current grant funding and activities.

2. Governance Meetings

The Governance Committee conducts bi-monthly meetings held on the first Monday of each month and additional meetings as needed, at 11:30 a.m. in the Cannon Health Building. All meetings are posted in compliance with Utah’s Open and Public meetings laws and posted on the state’s Open and Public Meetings Website.

3. Governance Grant Proposal and Funding Review Process

UDOH (www.health.utah.gov/governance) has a website created to provide all pertinent proposed grant information to the Governance Committee, all 12 local health departments and the public. This information provides transparency for the UDOH grant writing and application process. All 12 local health departments have designated staff that receive this information and in turn can make a determination as to how they will participate in the grant writing process. The Governance Committee has undertaken a review of all federal grant funding and a report will be given to the Health and Human Services Appropriations Committee in October. Documents provided to the Committee are included with this report.

4. Governance Staff Training

Governance Committee staff met with UDOH grant writing and management staff to discuss the Governance process and the steps that are required to gain Governance approval for a grant to be submitted to the granting agency. UDOH procedures have been written to help guide staff in submitting grant information. Future trainings are planned for local health department staff.

5. Number of Grants Reviewed

Since January 2011, the Governance Committee has reviewed 49 grants. 28 were approved for submission and 21 were exempted from review.

6. Policy and Issue Resolution

The Governance Committee is a mechanism through which local and state public health leadership can work for consensus on statewide policy development and resolution to programmatic issues. In the past year, three programs have received extensive

review through the Governance process, the Tobacco Prevention and Control Program, the Immunization Program and the Maternal and Child Health Block Grant.

Final Approved 10-17-11

APPENDIX C – EXPANSION OF 340B DRUG PRICING PROGRAMS

Report to the Health and Human Services Interim Committee and Social Services Appropriations Subcommittee

Expansion of 340B Drug Pricing Programs

Volume 15

Prepared by the Division of Medicaid and Health Financing

November 21, 2011



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H.B. 74 –Expansion of State Medicaid 340B Drug pricing program

The 2008 Legislature directed the State Medicaid agency to expand program use of savings under the 340B drug pricing program. Specifically, the Department of Health shall determine:

- The feasibility of developing and implementing one or more 340B pricing programs for a specific disease, similar to the hemophilia disease management program;
- Whether the 340B program results in greater savings for the department than other drug management programs for the particular disease. The Department shall report regarding:
 - Potential cost savings to the Medicaid program from the expansion of use of the 340B program;
 - Amendments and waivers necessary to implement increased use of 340B pricing;
 - Projected implementation of 340B pricing programs;
- The Department shall work with the Association for Utah Community Health to identify and assist community clinics that do not have 340B drug pricing programs to determine whether:
 - Patients of the Community Health Center would benefit from establishing a 340B drug pricing program on site or through a contract pharmacy;
 - The Community Health Center can provide 340B drug price savings to the Health Center’s Medicaid patients

Previous versions of this report have provided explanations and descriptions of program requirements, limitations, expectations, and obstacles. Attention should be directed to these earlier versions for information concerning those details. This version will focus on progress since the August 2011 report.

Feasibility of Additional Disease Management Programs

Designing a disease management program and securing approval from the Centers for Medicare and Medicaid Services (CMS) presents challenges. Program staff submitted a final draft State Plan Amendment (SPA) to the Denver Regional CMS office on May 3, 2010 for review. The SPA includes the following six disease states: hemophilia, multiple sclerosis, cystic fibrosis, rheumatoid arthritis conditions, hepatitis C, and Crohn’s disease. That draft has been reviewed by CMS in both the Regional and the Central CMS offices and has received a tentative approval. Follow-up with CMS occurred in June, August and October 2010, January and May of 2011.

With the passage of Health Care Reform, CMS expressed some uncertainty surrounding the best method for implementing an expanded disease management program. At various points in the past, CMS separately asked that the State consider:

- Medical Homes provisions contained in the legislation as a vehicle for implementing the proposed disease management program,

- implementing solely through a State Plan amendment,
- dropping the need for a 1915(B)(4) Waiver,
- giving enhanced attention to the cost effectiveness requirements of a waiver,
- altering the need for a request for proposal, and
- consulting with the Indian tribes prior to approval being granted.

Following additional discussions between the state and CMS, CMS determined that many of its recent suggestions were not feasible. CMS provided the state with a request for additional information and ultimately decided that three processes now need to be done along with tribal consultation:

1. A request for proposal (RFP),
2. A 1915(B)(4) Waiver, and
3. The cost effectiveness portion of the waiver.

CMS does not have a template for this waiver type as they have never approved one like this before. The template provided needs to be extensively adapted to this situation and CMS has to collaborate on that requirement.

Since the February report, additional consultations with CMS have taken place to discuss details involving the necessary requirements. The feasibility of additional disease management programs is likely since approval of this SPA looks promising. After additional reviews with the CMS central office of our existing Disease Management Contract, other conference calls will be scheduled by CMS to discuss the next steps.

Senate Bill 180 in the 2011 Utah Legislative General Session

With the passage of Senate Bill 180 in the 2011 Utah Legislative General Session, Medicaid prepared and submitted an 1115 Waiver application to CMS which, if approved, will convert the existing managed care model to one of Accountable Care Organizations (ACOs). The ACOs are anticipated to include most pharmacy services. ACOs will only be operating in the four Wasatch Front counties. Individuals who are in rural areas will continue to be served under the fee-for-service model. Mental health therapeutic classes of drugs (e.g., atypical anti-psychotics, psychotropic drugs) have been excluded from the waiver request and subsequent ACO management.

The Deficit Reduction Act of 2005 requires Medicaid to collect rebates on physician administered drugs even when provided under Managed Care Organizations. The Affordable Care Act of 2010 requires Medicaid to collect rebates on all pharmaceuticals provided under Managed Care Organizations.

In the future, providing Medicaid pharmaceutical care through an ACO model along the Wasatch Front would greatly reduce the population base for expansion of 340B drug pricing programs under fee-for-service. In all cases, Medicaid is still required to track and report utilization to ensure required rebates are collected.

The feasibility of expanding disease management into other disease states is greatly reduced as clients along the Wasatch front will be part of an ACO in the future. This may impact the willingness of 340B providers to bid for other disease management programs (lacking economies of volume).

The state has been working with CMS to obtain approval of the 1115 Waiver request titled *Utah Medicaid Payment and Service Delivery Reform*. A decision from CMS is anticipated in January 2012.

Potential Cost Savings

The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of covered outpatient drugs to certain federal grantees, federally-qualified health center look-alikes and qualified disproportionate share hospitals. Significant savings on pharmaceuticals may be seen by those provider entities that participate in this program. The 340B program is operated under the jurisdiction of the Office of Pharmacy Affairs (OPA). A component of the Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services (HHS), the Office of Pharmacy Affairs has three primary functions:

1. Administration of the 340B Drug Pricing Program, through which certain federally funded grantees and other safety net health care providers may purchase prescription medication at significantly reduced prices.
2. Development of innovative pharmacy services models and technical assistance, and
3. Service as a federal resource about pharmacy.

In all of its activities, OPA emphasizes the importance of comprehensive pharmacy services being an integral part of primary health care. Comprehensive pharmacy services include:

- patient access to affordable pharmaceuticals,
- application of "best practices"
- efficient pharmacy management, and
- the application of systems that improve patient outcomes through safe and effective medication use.

The interest that HRSA (a sister agency to CMS under HHS) maintains in Medicaid 340B programs stems from the fact that all parties involved must take strict measures to ensure that drug manufacturers are not exposed to a "double" rebate. Medicaid drug expenditures are entitled to a manufacturers rebate back to Medicaid. Drugs reimbursed to a 340B covered provider entity under the OPA program are prohibited from being subject to any rebate.

All savings to Medicaid from implementing a 340B based program come entirely from the providers. Additional revenues from the 340B program were intended to help 340B providers offset losses resulting from the high volumes of discounted and free medical services provided to the uninsured and underinsured, which volumes qualify them for participation in the program. A change requiring 340B providers to fill prescriptions and bill Medicaid at 340B cost pricing requires providers to share all of their savings with Medicaid and would essentially eliminate that revenue, thus discouraging provider participation. Therefore, it becomes important to find a means to maintain provider interest.

340B pricing information is not accessible directly to Medicaid, as this information is considered proprietary. Cost savings were originally calculated based on estimated 340B prices. Bill Von Oehson, president and general counsel of "The 340B Coalition," a national organization of safety net Disproportionate Share Hospitals (DSH) based in Washington D.C. maintains that 340B prices are on

average AWP minus 49 percent. The actual price varies by drug product. There is little question that potential cost savings exist. Those savings are not always easily calculated given the constraints of the system, such as 340B requirements, CMS approvals, and availability of willing contractors. Medicaid has delayed revising savings calculations pending the outcome, extent, and scope of CMS approvals.

Necessary Amendments and Waivers

There are several distinct components for the 340B program. The medical component deals with pharmaceutical services provided in a physician's office setting (e.g., hospital clinics, or community clinics). The point-of-sale (POS) component, deals with prescriptions obtained through a pharmacy. A third component, referred to as disease management, is administered through a POS setting with some medical services also provided.

In previous reports, the Division has addressed the third component, expansion of the current 340B Disease Management program, which includes the management of additional disease states. As reported under the section addressing feasibility, the Division, has, in the past, involved itself in negotiations with CMS to finalize a SPA, waiver, and RFP for disease management. The Division has included the disease management expansion program as part of the 1115 Waiver request titled *Utah Medicaid Payment and Service Delivery Reform*.

Projected implementation of 340B programs

Fill-and-Bill and Buy-and-Bill at 340B Pricing

Previous reports have detailed the opportunities and obstacles for implementing "fill-and-bill" and "buy-and-bill" arrangements with providers. (Please refer to previous reports for more detail.)

Approval of the 1115 Waiver will have an impact on 340B programs administered by the state. Mapping specific areas of impact is difficult until final approval of the 1115 Waiver is obtained. Nevertheless, further negotiations with hospital providers are being scheduled in hopes of obtaining additional savings. Even though the net gain is less than a full 340B discount, the net result will be additional savings to the Medicaid program and preserving interest in the program by the participating 340B providers.

To aid in this process, Utah Medicaid staff is acquiring a dispensing fee survey. The survey will provide Medicaid with the information necessary to establish a specific 340B dispensing fee. If dispensing fee differentials are identified, the state would need to submit a State Plan amendment to CMS for approval of the new dispensing fees. Since the August 2011 report, the State has secured a vendor for this survey and the survey is anticipated to be completed in the near future.

With information from the dispensing fee survey, staff will begin negotiations with 340B entities in order to have the providers fill-and-bill at 340B pricing. Medicaid would put an edit in the claims payment system to ensure those providers are billing at 340B costs and that those claims are not included in the rebate invoicing program.

Disease Management

Freedom of Choice Waivers have proven to take a long time to work through the approval process with CMS. Such was the case with the original hemophilia program. Given the pace of the process with CMS in working to expand the disease management program and the fact that it is part of the recent 1115 Waiver application, it is difficult to estimate the completion date at this time.

Association for Utah Community Health

The Association for Utah Community Health (AUCH) is an organization of 340B qualifying community health centers, federally qualified health centers, and family planning clinics. There are 29 covered entities in the AUCH organization. AUCH pharmacies charge 340B clients the cost of the 340B drugs plus a five dollar co-pay, providing a great benefit to their patients. Medicaid patients of the 340B AUCH providers do not use the 340B program and, in fact, are sensitive as to whether 340B purchased drugs are used since using 340B drugs would change their co-pay (Medicaid clients cannot pay more than three dollars for a co-pay).

Past negotiations with the AUCH organization focused on methods to make it attractive for the Medicaid client while maintaining the revenue for the covered entity. Similar to other 340B providers, as stated previously, the contracted pharmacy retailers providing services to 340B AUCH clients have also voiced discontent with participation unless reimbursement issues (e.g., higher dispensing fees or co-pays) are addressed. Results from the dispensing fee survey should help resolve those concerns. A cost settlement approach has not been discussed with the AUCH organization at this time.

A 340B covered entity by definition buys 340B drugs for use in the facility. All covered entities provide 340B purchased medications, at least in the physicians' offices, whether or not pharmacy services are available onsite or through a contracted pharmacy. Most AUCH members have onsite pharmacies or have a contracted pharmacy. Presently, covered entities can elect whether or not they will choose to fill-and-bill with 340B purchased drugs for their Medicaid patients; none have elected to do so. AUCH has indicated to Medicaid that its organization of covered entities will, however, work towards participation pending satisfactory resolution of reimbursement issues such as an increase in the current dispensing fee.

APPENDIX D – ASSISTANCE TO PERSONS WITH BLEEDING DISORDERS

**Office of Primary Care and Rural Health
Assistance for People with Bleeding Disorders
Updated October 25, 2011**

Function

The Office of Primary Care and Rural Health continues to be a resource for Utah's rural, multi-cultural, and underserved communities. The Office works with communities that need assistance in conducting needs assessments, recruiting health care professionals, identifying sources of funding, and implementing other projects related to decreasing disparity and increasing access to primary health care.

Program Description

The Assistance for People with Bleeding Disorders Program is set up to assist persons with bleeding disorders with the cost of obtaining hemophilia services or the cost of insurance premiums for coverage of hemophilia services. Utah Code Annotated, 26-47, authorizes the Assistance for People with Bleeding Disorders Program.

Key Facts

- Eligible individuals are persons with a bleeding disorder:
- a. Whose health insurance coverage either:
 - 1) Excludes coverage for hemophilia services;
 - 2) Exceeded their health insurance plan's annual maximum benefits;
 - 3) Exceeded their annual or lifetime maximum benefits payable under Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act; or
 - 4) Has health insurance coverage available under either private health insurance, Title 31A, Chapter 29, Comprehensive Health Insurance Pool Act, Utah mini COBRA coverage under Section 31A, 22-722, or federal COBRA coverage, but the premiums for that coverage are at or greater than 7.5 percent of the person's annual adjusted gross income.
 - b. Who is low income;
 - 1) Is without health insurance, including CHIP and Medicaid, or
 - 2) Is without health insurance that covers hemophilia services, or

- 3) Is without health insurance that covers a particular hemophilia service.
- c. *Who Resides in the State of Utah.*
- d. Are low income defined as including individuals at or below the 200 percent of poverty level as established annually by the Department of Health and Human Services and published annually.
- e. Eligibility means an application received from an individual, or their family member, who meets the criteria established in Utah Code Annotated, Section 26-47-103 (1)(b), and that individual's health insurance is at or greater than 7.5 percent of the individual's adjusted gross income.
- f. Target population is any individual residing in the State of Utah who has been diagnosed by a health care professional with a bleeding disorder.
- g. Underinsured are individuals with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay; and/or individuals which:
 - 1) are unable to afford health insurance;
 - 2) are denied paid health care from work;
 - 3) are denied full coverage plans from work;
 - 4) have health insurance plans which only cover the worker and not the family or extended family; and/or
 - 5) have insurance plans with unreasonably high deductibles or co-insurance.
- h. Uninsured are individuals who lack public or private insurance.

Appropriation

The Utah Legislature has annually appropriated \$250,000 for the Assistance for People with Bleeding Disorders Program since State Fiscal Year 2005.

Intent Language

The Utah Legislature has annually included intent language for the Assistance for People with Bleeding Disorders Program allowing up to \$50,000 be considered non-lapsing.

ASSISTANCE FOR PEOPLE WITH BLEEDING DISORDERS HISTORY

	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012 estimated	Cumulative
Rural Served	7	15	18	24	15	11	6	14	110
Urban Served	7	21	29	31	38	32	54	36	248
Total Served	14	36	47	55	53	43	60	50	358
GOAL	50	50	50	50	50	50	50	50	400
Expenditures	\$225,000	\$167,540	\$170,500	\$386,960	\$213,669	\$228,200	\$234,500	\$175,000	\$1,801,369

Contact Information:

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APPENDIX E – KURT OSCARSON CHILDREN’S ORGAN TRANSPLANT FUND

THE KURT OSCARSON CHILDREN'S ORGAN TRANSPLANT FUND

November 2011

The Kurt Oscarson Children's Organ Transplant Fund was established in 1992 (UCA 26-18a) to provide financial support for children who require organ transplants and to promote organ donor awareness. A five-member committee oversees this restricted fund, which is funded through "check-off donations" on the Utah State Income Tax Form. Authority to make expenditures from the fund is granted by an appropriation from the Legislature. The committee may award financial assistance to eligible families through interest-free loans. The committee establishes the terms of repayment, which may include a waiver of the loan repayment. The committee works actively with families to help them secure other financial assistance as well as referring families to other agencies for support services. The committee has also approved expenditures to encourage organ donation. (Lack of donors is a greater problem than actually paying for the transplants.) Utah code requires the committee to make an annual report to the Appropriations Subcommittee.

During the 2011 Fiscal year, \$56,518 was collected through the tax check-off on the Utah State Tax Form. The fund assisted 20 transplant recipients (children under the age of 18 years) with transplant related expenses totaling \$39,415. In addition, the committee worked toward promoting organ donation awareness through Intermountain Donor Services. A total of \$45,100 was expended for promotion and awareness purposes in FY11 leaving a year-end balance of \$123,174.

Below is a summary of current and historical data:

Fiscal Period	Revenue Collected From Tax Returns	Donor Promotion Expenses	Medical Assistance Expenses	Fund Balance Year End	Number Families Assisted
Fiscal Year 2011	\$56,518	\$45,100	\$39,415	\$123,174	20
Prior 3 yr Average	\$60,783	\$46,643	\$31,335	\$144,565	18
Fund 19 year History	\$1,330,538	\$658,141	\$549,223	\$123,174	98

Contact: Lori Utley, Fund Support Services Coordinator

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APPENDIX F – ORGAN DONATION CONTRIBUTION FUND

THE ORGAN DONATION CONTRIBUTION FUND

November 2011

The Organ Donation Contribution Fund was established in 2002 (UCA 26-18b) to promote and support organ donation, assist in maintaining an organ donation registry, and provide donor awareness education. The fund receives revenue from voluntary donations collected with motor vehicle registrations and driver licenses. A committee of five members administers and approves expenditures from the fund. This committee also administers the Oscarson Children's Transplant Fund. Authority to make expenditures from the fund is granted by an appropriation from the Legislature.

During the 2011 Fiscal year, \$79,945 in donations was collected through the Motor Vehicle and Driver License registrations, from which \$15,989 was reimbursed to the Divisions of Motor Vehicles (DMV) and Driver's License (DDL) for collection expenses. Expenditures of \$85,272 were made to Intermountain Donor Services for donor promotion services leaving a year-end balance of \$52,388 as of June 30, 2011.

Below is a summary of current and historical data:

Fiscal Period	Revenue Collected from Motor Vehicle License Registration	Less: Collection Expenses	Donor Promotion Expenses	Fund Balance Year End
Fiscal Year 2011	\$79,945	\$15,989	\$85,272	\$52,388
Prior 3 yr Average	\$89,859	\$17,972	\$86,424	\$70,703
Fund 9 yr History	\$829,682	\$159,293	\$618,001	\$52,388

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APPENDIX G – AUTISM TREATMENT ACCOUNT ADVISORY COMMITTEE

FY 2011 Report to Legislature Autism Treatment Account

Overview

The Autism Treatment Account was established in March 2010 by the Utah Legislature with the passing of House Bill 311. This account is a restricted special revenue account for the receipt and expenditure of funds to be used for assistance in funding service and treatment to eligible Utah children less than 8 years of age with Autism Spectrum Disorders (ASD). In addition to legislative appropriations, the account may accept “gifts, grants, donations, and bequests of real property, personal property, or services, from any source, or any other conveyance that may be made to the account from private sources, interest and other earnings derived from the account money.”

The Executive Director of the Utah Department of Health is responsible for administering the Account, with staff support from the Bureau of Children with Special Health Care Needs Bureau (CSHCN), in the Division of Family Health and Preparedness. Once funds become available and policies and procedures are established, they may be expended to:

- a. assist eligible families of young children with ASD with the cost of evaluating and treating children with an autism spectrum disorder;
- b. provide young children with treatments for ASD that utilize early intensive behavior therapy; and
- c. provide grants to persons or organizations to provide the services described in a or b.

Autism Treatment Fund Advisory Committee

The legislation required establishment of an Autism Treatment Account Advisory Committee for the purpose of recommending how funds should be managed and expended. The five members serving on the committee include Harper Randall, MD (representing Utah Department of Health), Peter Nicholas, PhD (providing expertise in treatment of ASD), Paul Carbone, MD (pediatrician), Leeann Whiffen (parent advocate/family member), and Cheryl Smith (president of the Autism Council of Utah). Leeann Whiffen was selected by the committee to serve as chair.

The committee has held three meetings to date: February, July and September 2011, with an additional meeting scheduled for December 2011. The committee has drafted a rule governing; 1) criteria and methods for selecting service and treatment providers, and 2) conflict of interest within the Advisory Committee. They have also approved a policy dealing with committee membership. A draft request for proposal (RFP) has been written that will be used to prioritize and allocate funds. The RFP will be reviewed and finalized when funds become available.

Contact:
Holly Williams, Bureau Director
Children with Special Health Care Needs
801-584-8239, hollywilliams@utah.gov

Submitted: November 16, 2011

APPENDIX H – PROCESS TO PROMOTE HEALTH INSURANCE COVERAGE FOR CHILDREN

March 9, 2011

Members of the Social Services Appropriations Subcommittee
350 North State Street, Suite #320
P.O. Box 145115
Salt Lake City, UT 84114

Dear Members:

Utah Code Section 26-18-15 directs the Utah Department of Health (UDOH), the Department of Workforce Services (DWS), and the Utah State Office of Education (USOE) to collaborate to develop a process to promote the health insurance coverage for children in schools, especially in regards to Free and Reduced Price School Lunch applications. This report describes the activities carried out in response to this direction. Some information on these efforts was provided previously in a handout to the Health Reform Task Force in June 2008.

Collaboration Activities:

- **March 2008** – UDOH collaborated with USOE to add information about the Children’s Health Insurance Program (CHIP) to the 2008 Free and Reduced Price School Lunch application.
- **May 2008 – December 2008** – UDOH met with the Covering Kids & Families Coalition on a regular basis (usually monthly) to discuss progress on HB 364 (2008). Members of the Coalition (including representatives from school districts, advocacy agencies, local health departments, UDOH, DWS and legislators) provided feedback and recommendations to help move forward on developing a school lunch process.
- **July 2008** – USOE provided the Coalition with a survey of six districts. In their survey responses, the districts reported what information they collected electronically from the Free and Reduced Price School Lunch application. Three of the six survey participants captured the “opt-out response” in their electronic systems. This response indicates to the district if they can share a student’s information with the Medicaid and CHIP programs.
- **October 2008** – UDOH collaborated with DWS to create a combined application for all medical programs including CHIP, Utah’s Premium Partnership for Health Insurance (UPP), the Primary Care Network (PCN) and Medicaid. The new application has a single page tear off sheet that applicants can use to start their eligibility process. This single page sheet can be used at the schools and/or with the Free and Reduced Price School Lunch application.
- **October 2008** – UDOH met with DWS to discuss a potential pilot program with one school district to test the process of capturing student information and interfacing with DWS’ eREP system to compare data with existing clients. Once the information had been collected and compared, DWS and UDOH would then develop the best outreach tactics to work with those families. It was also determined that an additional question

would need to be added to the Free and Reduced Price School Lunch application, one asking parents if their children had health insurance.

- **November 2008** – UDOH presented several options at the Coalition meeting regarding the information provided about CHIP on the Free and Reduced Price School Lunch application, as well as placement of the additional insurance question. The Coalition decided that the best placement for both would be at the top of the page, above the “Sharing Information with Medicaid/SCHIP” section.
- **December 2008** – UDOH spoke with USOE and was informed that additional information could only be added at the bottom of the page, below the “Sharing Information with Medicaid/SCHIP” section. Although the placement was not ideal, UDOH made the edit and sent the information to USOE to be included on 2009 Free and Reduced Price School Lunch application. This application was not available for the 2009-2010 school year, but was used during the 2010-2011 school year.
- **January 2009** – UDOH worked with USOE to distribute an electronic survey to every school district in the state to obtain a better understanding of what information, if any, is collected electronically from the Free and Reduced Price School Lunch application. The survey also asked if the school district would be willing to participate in a pilot program to help families receiving Free or Reduced Price School Lunch obtain health care. Thirty six school districts participated in the survey. It was found that the majority of the districts keep Free and Reduced Price School Lunch information in the Student Information System (SIS) provided by USOE. However, only 10 of the school districts electronically record the opt-out response to share school lunch information with Medicaid and CHIP.
- **August 2009** – UDOH and the Emery School District began a pilot project. Emery School District sent UDOH copies of the school lunch applications where parents had not opted out of having their information shared with Medicaid and CHIP. The following is a synopsis of this activity:
 - 188 school lunch applications were received by UDOH and manually compared to Medicaid and CHIP enrollment.
 - 69 (37%) of the families were already enrolled in Medicaid or CHIP.
 - 118 families were sent medical applications and information explaining how to apply for medical assistance. 9 of the 118 families submitted a medical application, 5 families were enrolled, and 4 were denied because they did not return requested information.
 - 25 of the 109 families who did not submit a medical application were surveyed to find out why they didn’t complete an application. 22 of the 25 families called said they were enrolled in employer-sponsored or private health insurance.
- **December 2009** – In conjunction with community advocates, UDOH and the Salt Lake School District began discussions concerning development of an electronic data match between the children enrolled in Free and Reduced Price School Lunch in the district and Medicaid and CHIP enrollment.
- **May 2010** – UDOH and Salt Lake School District entered into a contract that will allow DOH to receive an electronic file of children who are enrolled in the Salt Lake School District’s Free and Reduced Price School Lunch program. The first file was received in

August 2010. Current data will be analyzed in 2011 to test the effectiveness of the match.

- **August 2010** – UDOH worked with USOE to add a field to SIS, which some schools use to keep Free and Reduced Price School Lunch information. This field will be used to record when a family opts out of sharing information with the Medicaid and CHIP program. This will allow these school districts to provide UDOH a list of parents who did not opt-out of receiving Medicaid and CHIP information.
- **August 2010** – UDOH, DWS, and the Salt Lake School District participated with community advocates in several enrollment events where Medicaid and CHIP eligibility staff were onsite to take Medicaid and CHIP applications during several of Salt Lake School District's 2010-2011 school registration events.

Outstanding Issues:

- Federal regulations for free and reduced price meal programs administered under U.S. Department of Agriculture allow for information sharing with Medicaid and CHIP whereas the federal regulations for student data (FERPA) do not allow sharing of student data to these programs. The conflict between these regulations has made sharing information challenging since child nutrition program information is collected at the school and becomes part of the student record. The current workaround (school personnel sort the Free and Reduced Price School Lunch application information to comply with FERPA and then provide this to Medicaid and CHIP) is time consuming, ineffective, and not scalable to a statewide operation.
- USOE was working with a company, Digital Bridge, to develop a statewide student information system that UDOH thought could be used to assist in electronic transfer of Free and Reduced Price School Lunch information to Medicaid and CHIP and to collect online medical assistance applications from families during the school enrollment process that would be electronically submitted to DWS. UDOH and DWS met with Digital Bridge many times to develop a potential system. Digital Bridge has defaulted putting USOE far behind on being able to develop a statewide database with a student information system and costing the State a significant amount of money. The company's failure has removed, for the time being, an option to build on a statewide education network to improve collection of school lunch information.

If you have any questions or would like additional information about these efforts, please contact Laura Belgique, Utah Department of Health, at 801-538-9928 or lbelgique@utah.gov.

Sincerely,

Michael T. Hales
Deputy Director
Utah Department of Health

APPENDIX I – TESTING FOR SUSPECTED SUICIDES



Utah Suicide Toxicology Report Fiscal Year 2011

UAC 26-4-28 Report to the Legislature

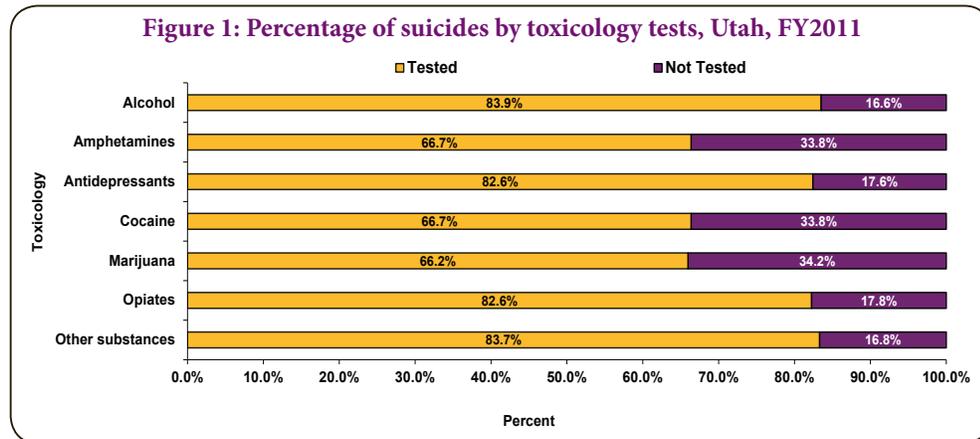
Introduction

As a requirement of UAC 26-4-8, the Utah Department of Health is required to report “the types of substances found present in the samples taken from the body of a person who is suspected to have died as a result of suicide or assisted suicide.”

Toxicology Results

In fiscal year 2011 (June 2010 through July 2011) there were 471 suicides.¹ Toxicology tests were conducted in 84.1% of suicides. Toxicology tests are not conducted for all suicides. For example, based on investigation and medical history, tests for illicit drugs may not be conducted.

Tests for alcohol and other substances were conducted for approximately 83.0%, tests for antidepressants and opiates were done for approximately 82.0%, and tests for amphetamines, cocaine, and marijuana were conducted for approximately 66.0% of suicides (Figure 1).



The most common drug found in victims who died from suicide was other substances (43.7%). This category includes over-the-counter medications and benzodiazepines, such as anti-anxiety medications and muscle relaxants. The least common was cocaine (2.2%) (Table 1).

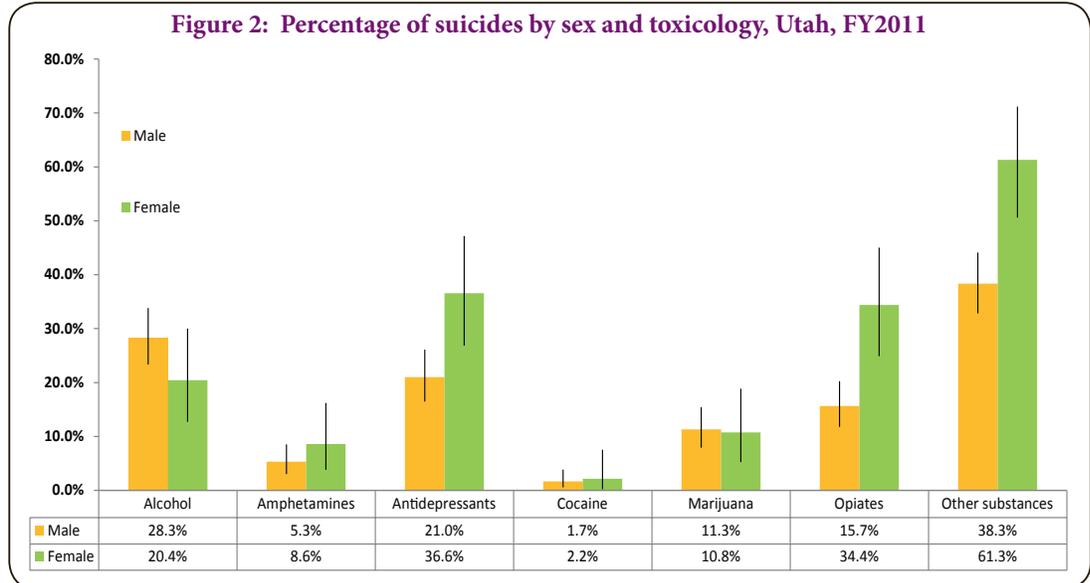
Table 1: Summary of suicide toxicology test results, Utah, FY2011

Toxicology	Screened	Present	Percent
Other substances	394	172	43.7%
Alcohol	395	104	26.3%
Antidepressants	389	97	24.9%
Opiates	389	79	20.3%
Marijuana	312	44	14.1%
Amphetamines	314	24	7.6%
Cocaine	314	7	2.2%

Of those who tested positive for alcohol, the average Blood Alcohol Concentration percent (BAC) was almost two times (0.15%) the legal limit. The legal BAC for Utah is 0.08%.

Females were significantly more likely to test positively for antidepressants, opiates, and other substances compared to males (Figure 2). There were no significant differences seen between age groups.

Figure 2: Percentage of suicides by sex and toxicology, Utah, FY2011



Last updated: January 25, 2012

References

¹Data is from the Utah Violent Death Reporting System (UTVDRS). UTVDRS is an initiative of the U.S. Centers for Disease Control and Prevention (CDC) to systematically collect violent death data from death certificates, medical examiner records, police reports, crime lab records, and supplemental homicide reports on suicides, homicides, deaths of undetermined intent, unintentional firearm-related deaths, and deaths due to legal intervention.

Our Mission...

Is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

APPENDIX J – ABORTION INFORMED CONSENT MATERIAL PENETRATION

Utah Bureau of Vital Records and Statistics

Abortion Informed Consent Material Penetration

	Number of Patients who Received Materials	Number of Patients who Did Not Receive Materials	Number of Patients Excused by Physician	Number of Abortions YTD
2011				
YTD Total	2,326	0	8	2,384

YTD--January through October 2011.