



State of Utah

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Utah Department of Health

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February 6, 2013

Members of the Executive Appropriations Committee, the Health Reform Task Force, and the Business and Labor Interim Committee
State Capitol
Salt Lake City, Utah 84114

Dear Committee Member:

In accordance with the reporting requirements of Utah Code Title 63M-1-2505.5, the Department of Health (Health) submits this report on items from federal health care reform that are scheduled to be implemented.

Mandatory Changes to Medicaid Eligibility

Health, Workforce Services (DWS), and Technology Services (DTS) are requesting enhanced Federal Financial Participation (FFP) from the Centers for Medicare and Medicaid Services (CMS) to enhance the State's existing eligibility system (eREP). This enhancement will include the development of a Modified Adjusted Gross Income (MAGI) methodology, which will enable the system to make Medicaid and Children's Health Insurance Program (CHIP) eligibility decisions based on the requirements established by federal health care reform. This enhancement encompasses the mandatory changes to Medicaid and CHIP eligibility and does not include changes that would implement an optional Medicaid expansion to new adult groups.

To accomplish this system enhancement, DWS/DTS must move eREP from the proprietary platform that was originally used to create the system to an open source code that will allow greater flexibility in revising and customizing eligibility determination rules. The system will need data interfaces with new sources (including the Federal data hub) and will need to be able to integrate that information into the eligibility determination process. The application and renewal process for Medicaid and CHIP will need to be revised. DWS will need to make changes to its communications and contact center phone systems.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Title II of Public Law 111-148, the Affordable Care Act (ACA), requires numerous changes to the Medicaid and CHIP eligibility determination processes. Title I, Subtitle E has requirements for interaction between the Medicaid and CHIP agency and the health insurance exchange (either the federal exchange or an approved state exchange.)



2) Whether the reform provision has any state waiver or options

In June 2012, the Supreme Court ruled that states have the option to expand Medicaid to cover adults age 19 through 64 up to 133 percent of poverty. However, the Supreme Court's decision did not provide states with the opportunity to opt out of other mandatory changes to Medicaid and CHIP eligibility. Health is not aware of any waivers that are available for the mandatory changes to Medicaid and CHIP eligibility.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

The mandatory changes to eligibility mostly affect parents and caretaker relatives, pregnant women, and children under age 19 for both Medicaid and CHIP, but a few changes affect all eligibility groups. These changes will be implemented in eREP, as well as through policies and procedures, and include:

- Removing the asset test for certain eligibility groups
- Increasing the income limit for children age 6 through 18 to 133 percent of poverty
- Applying MAGI when determining income eligibility for certain eligibility groups by using federal tax rules regarding income and household size
- Increasing the age limit for children aging out of foster care to age 26
- Using a single streamlined application process and transferring information to and from the health insurance exchange
- Using electronic verification, including verification through the federal data hub

These changes need to be in place by October 1, 2013 in order to provide benefits by January 1, 2014.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Individuals impacted include parents and caretaker relatives, pregnant women and children under age 19. Currently these groups constitute about 120,000 cases on Medicaid and CHIP. The number of individuals affected would be higher because there are often multiple individuals on a single case and because additional families will gain eligibility for these programs based on the mandated changes to eligibility. Failure to implement these changes would mean individuals who could be eligible in the future for Medicaid or CHIP based on the new eligibility rules would not be able to receive those services.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

DWS, DTS, and Health estimate the cost to implement these provisions will be approximately \$17.1 million in total funds – \$15.2 million in federal funds and \$1.9 million in state funds. No additional state appropriations are being requested for the changes to eREP – current state match dollars will be extended by moving staff from work where 50 percent of their costs are funded by the federal government to this project where 90 percent of their costs will be funded by the federal government. The departments will then use the match savings to help backfill positions to cover existing workload during the course of this project.

6) Consequences to the state if the state does not comply with the federal reform provision.

The State of Utah could lose significant federal funding for its Medicaid and CHIP programs if CMS decided to disallow federal payments because eligibility determinations in Utah were not conducted according to federal law. If all Medicaid and CHIP payments are disallowed, the State could lose approximately \$1.4 billion in federal funds each year. If CMS chose to disallow payments only for the groups most impacted by the law (parents and caretaker relatives, pregnant women and children under age 19), the State would lose approximately \$0.6 billion in federal funds each year.

Enhanced Payments to Physicians for Medicaid Services

Regulations issued by CMS require state Medicaid programs to pay certain qualified providers at the current Medicare rates for various evaluation and management (E&M) and Vaccines for Children (VFC) codes starting January 1, 2013 through December 31, 2014. These enhanced payments will be funded with a 100 percent federal match for the portion of this reimbursement that exceeds the state Medicaid rates that were in place as of July 1, 2009 for the codes specified.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Please see the following sections in the Code of Federal Regulations (CFR):
42 CFR 438.6, 42 CFR 438.804, 42 CFR 441.600, 42 CFR 441.605, 42 CFR 441.610, 42 CFR 441.615, 42 CFR 447.400, 42 CFR 447.405, 42 CFR 447.410, and 42 CFR 447.415

2) Whether the reform provision has any state waiver or options

There is no state waiver or option for this provision.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

In order to qualify for these enhanced payments, Medicaid providers must self-attest they meet one of the following criteria:

1. They have a specialty designation of family medicine, general internal medicine, or pediatric medicine.
2. They have a subspecialty within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the American Board of Physician Specialties (ABPS).
3. As part of that attestation they must specify that they either are currently Board certified in an eligible specialty or subspecialty and/or that 60 percent of their Medicaid codes for the prior year were for the E&M codes (99201 – 99499) and vaccine administration codes (90460, 90461, 90471, 90472, 90473 or their successor codes) specified in the regulation.

Within the guidelines set forth through this regulation, Utah Medicaid is proposing a State Plan amendment to make quarterly lump sum payments to qualifying fee-for-service providers or current managed care plans for the difference between the current Utah Medicaid and Medicare rates.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Only physicians who qualify and self-attest to a specialty designation of family medicine, general internal medicine, pediatric medicine or who have a subspecialty recognized by the ABMS, AOA, or ABPS will be impacted by the adoption of this federal reform provision. It is unclear at this time if the enhanced payments to the physicians will result in additional physicians providing Medicaid services and thereby increasing client access to physicians.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

These enhanced rates are paid with 100 percent federal funds. There will be no additional General Fund cost to implement these enhanced rates. In fact, it is anticipated that compliance with this provision will result in some General Fund savings for two calendar years (2013 and 2014) since the State has been paying the General Fund match on inflationary increases that have been added to physician rates since July 1, 2009.

6) Consequences to the state if the state does not comply with the federal reform provision.

Unknown. No consequences were stated when the CFRs for these rates were released.

Concurrent Hospice Care for Children

Under a new provision in the ACA, children will be able to elect hospice care without losing access to other Medicaid services.

1) Specific federal statute or regulation that requires the state to implement a federal reform provision

Please see Section 2302 of the ACA.

2) Whether the reform provision has any state waiver or options

There is no state waiver or option for this provision.

3) Exactly what the reform provision requires the state to do, and how it would be implemented

Under the law, the State will assure that voluntary election of hospice care will not constitute a waiver of any of the child's rights to be provided with services or to have payment made for services that are related to the treatment of the child's terminal condition. The law will be implemented by modifying currently existing hospice payment edits within the Medicaid claims payment system, MMIS. These edit modifications will allow payment of all Medicaid services children receive, rather than the previous policy of allowing only coverage of palliative services once a person elected the hospice benefit.

As a result of this provision, skilled nursing facilities that provide complex care to children in hospice will be reimbursed 100 percent of the amount the facility would have been paid had the child not elected to enroll in hospice. To implement the change to the nursing facility payment, Health intends to submit a State Plan Amendment and an administrative rule amendment.

4) Who in the state will be impacted by adopting the federal reform provision, or not adopting the federal reform provision

Children with terminal conditions, their families and service providers will be impacted by this provision. Parents of children with terminal conditions will not have to choose between palliative care for their children and having access to the remaining Medicaid services. Under this provision the child will have access to both types of services. Medicaid providers will be reimbursed for services the child receives whether the services are palliative or treatment based.

5) What is the cost to the state or citizens of the state to implement the federal reform provision

Health estimates the annual General Fund cost to implement nursing facility reimbursement change will be approximately \$4,000 per individual. Health estimates approximately four individuals per year would utilize the services. Because hospice enrollees have not previously been able to receive hospice care and other treatments simultaneously, it is difficult to predict the number of terminally ill children who may elect to receive the hospice benefit and access additional treatment concurrently. It is estimated that Medicaid would have incurred the majority of the treatment costs regardless, because parents would likely not have elected the hospice benefit for their child in the past.

6) Consequences to the state if the state does not comply with the federal reform provision.

In terms of enforcement, the consequences are unknown. No consequences were stated in Section 2032 of the ACA. The consequence for children could be that families may not choose to enroll their child in hospice care if they do not have the option to continue to receive additional treatment services.

Please let me know if you have any questions on the implementation of these items from federal health care reform.

Sincerely,



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