UTAH DEPARTMENT OF HEALTH

Utah Health Status Update:

Transforming Medicaid

September 2011

When it comes to public health in Utah, Medicaid is the 800 pound gorilla. Total Medicaid expenditures for fiscal year (FY) 2010 ($1.9 billion) dwarf all other Utah Department of Health (UDOH) expenditures ($0.2 billion). These Medicaid expenditures represent a significant portion of the State's overall budget (see Figure 1). In addition, nationwide, medical costs keep rising – a 48 percent rise over the last 10 years. The size of the Medicaid program and the rate of increase in medical costs raise concerns about the long-term sustainability of Medicaid.

On June 30, 2011, the UDOH submitted an 1115 Waiver Request to the federal government to transform the way Utah operates its Medicaid program in order to attempt to slow the growth of it's costs. Three of the major goals for the proposal are to:

- Restructure the program's provider payments to reward health care providers for delivering the most appropriate services at the lowest cost and in ways that maintain or improve recipient health status.
- Pay providers for episodes of care rather than for each service.
- Restructure the program's cost sharing provisions and other incentives to reward recipients for personal efforts to maintain or improve their health and use providers who deliver appropriate services at the lowest cost.

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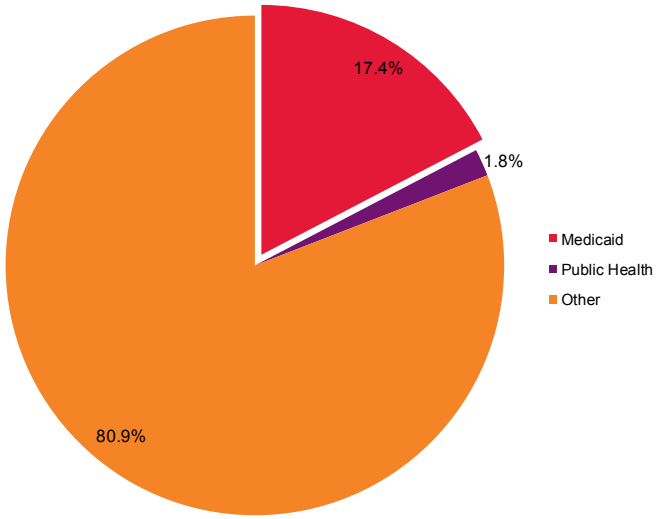
Health Costs in State Budget

Figure 1. Percentage of Total Expenditures, Utah, Fiscal Year 2010



Source: Governor's Office of Planning and Budget FY 2012 Budget Summary

In order to accomplish these goals, the proposal requested the following key modifications to the Medicaid program:

Accountable Care Organizations (ACOs)

The proposal would replace the current Utah Medicaid fee-for-service/ managed care model with the Utah Medicaid Accountable Care Organization (ACO) model. The ACO contracts would essentially provide the ACOs with monthly risk-adjusted, capitated payments based on enrollment. The ACOs would then create an environment in which they deliver necessary and appropriate care, while demonstrating that quality of care and access to care are maintained or improved.

The ACOs would also have more flexibility to distribute payments to their network of providers. Rather than reimbursing providers based on the units of service delivered, the ACO could make payments for delivering the necessary care to a group of Medicaid enrollees for a specified period of time. The ACO could also choose to distribute incentive payments through its network of providers when various cost-containment, quality or other goals are met.

A centerpiece of the ACO care delivery model is a "Medical Home." Each Medicaid client would have access to a primary care provider or a group of primary care providers who would deliver care, as well as coordinate the client's use of medical services throughout the ACO network of providers.

Scope of Benefits
Utah's current Medicaid managed care contracts generally include only inpatient hospital, outpatient hospital, physician services and other ancillary services. Along with these services, the reform proposal looks to include non-behavioral health pharmacy benefits in the ACO benefit package. The UDOH believes that including these pharmacy benefits in the ACO scope of services will better align the incentives of prescribers with the goal of providing the most appropriate service at the lowest cost.

Quality of Care Standards
Utah Medicaid also intends to monitor the ACOs' quality of care by using HEDIS data. The agency will utilize existing processes and procedures which have been established and guided by federal regulation for managed care organizations. In addition, in order to renew a contract authorized under this 1115 Waiver, the ACOs will be required to participate in quality improvement activities. They will also be required to adhere to metrics specific to an ACO that the UDOH will develop with input from providers and client advocates.

Individual Accountability and Responsibility
This proposal seeks to engender an enhanced sense of responsibility and accountability on the part of Medicaid clients. Medicaid clients would participate more in the cost of their health care. Through this proposal, the UDOH seeks to update archaic limits on Medicaid co-payment amounts.

An important aspect for enhancing physical well-being and reducing service utilization is patient compliance with recommended treatment. Increasing patient compliance results in better outcomes, lower costs and long term stabilization of chronic conditions. This proposal would allow an ACO to offer incentives that will help increase patient compliance for victims of chronic disease states. Two of these proposed incentives would be (1) limiting or waiving co-payments and (2) granting limited cash awards for compliant behavior, which reduces the need for additional service.

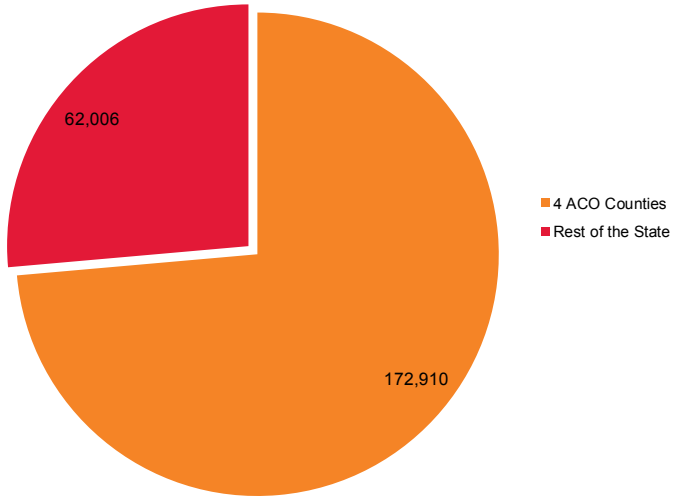
Premium Subsidy Option
Under a federal waiver, Utah currently offers a health insurance premium subsidy to low-income individuals who are not eligible for Medicaid coverage. This reform proposal seeks to also allow a Medicaid client the option to receive a premium subsidy and purchase a health insurance product through the Utah Health Exchange as an alternative to enrolling in the Medicaid ACO product.

Geographic Implementation
Medicaid currently has three managed care organizations providing services to clients in the state's four most populous counties: Salt Lake, Davis, Utah and Weber. The reform proposal looks to implement the ACO contracting model in these same four counties (see Figure 2).

Implementation Time Frames
The State needs federal approval before it can implement these modifications. The UDOH is currently in discussions with the federal government to see which portions of the proposal will be approved. Depending on the timeliness of approval, implementation may begin as soon as July 1, 2012.

Medicaid Clients Potentially Covered Under Proposed 1115 Waiver

Figure 2. Number of Clients on Medicaid, Utah, Fiscal Year 2011



Source: UDOH Medicaid and Health Financing Data

September 2011 Utah Health Status Update

For additional information about this topic, contact Michael Hales, Deputy Director, Division of Medicaid and Health Financing, Utah Department of Health, Salt Lake City, UT, (801) 538-6043, email: mthales@utah.gov, or visit http://health.utah.gov/medicaid/index.html; or the Office of Public Health Assessment, Utah Department of Health, Box 142101, Salt Lake City, UT 84114-2101, (801) 538-9191, email: chdata@utah.gov

Breaking News, September 2011

Hookah Use Presents Emerging Public Health Concern

Hookah is a waterpipe used to smoke tobacco. Hookah-focused businesses are gaining popularity throughout the U.S., particularly among college age individuals. Hookah bars targeting the college age population expose people to smoking who may not otherwise be inclined to use tobacco products. This is especially disturbing since data show increases in smoking in the 18–24 age range among people who had never tried smoking before.[1]

In addition to the health risks associated with secondhand smoke exposure, hookah smoking increases other health hazards by putting users at risk for infectious diseases such as tuberculosis, hepatitis, and herpes.[2] Because hookah sessions deliver nicotine via tobacco, they can encourage use of other tobacco products, increase tobacco addiction, and lead to relapse among ex-smokers, especially as many people mistakenly think smoking hookah is safe, even though it is not.[3]

To increase quit success, the Utah Department of Health provides evidence-based quit services, including the Utah Tobacco Quit Line at 1.800.QUIT.NOW (784-8669) and an online service to quit tobacco at www.UtahQuitNet.com.

1. Jamil H, Elsouhag D, Hiller S, Arnetz J E, Arnetz B B. "Sociodemographic risk indicators of hookah smoking among white Americans: a pilot study," Nicotine and Tobacco Research [Epub ahead of print], March 22, 2010.

2. World Health Organization. "Waterpipe Tobacco Smoking: Health Effects, Research Needs and Recommended Actions by Regulators." 2005. Retrieved on August 29, 2011 from http://www.who.int/tobacco/global_interaction/tobreg/waterpipe/en/index.html.

3. Aljarrah K, Ababneh Z Q, Al-Delaimy W K. "Perceptions of hookah smoking harmfulness: predictors and characteristics among current hookah users." Tobacco Induced Diseases. 2009, 5:16. Retrieved on August 29, 2011 from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2806861/pdf/1617-9625-5-16.pdf.

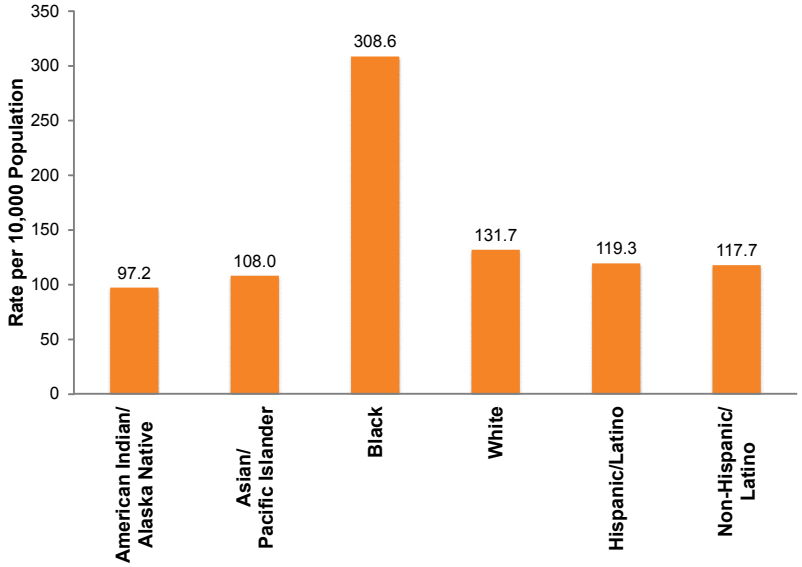
Community Health Indicators Spotlight, September 2011

Utah Heart Failure Hospitalizations by Race and Ethnicity

Heart failure is a form of cardiovascular disease. With this chronic condition, the heart cannot pump enough blood to other vital organs. In the U.S., in 2008, heart failure was the third most common principle diagnosis for inpatient hospital stays, following pregnancy/childbirth/infants and pneumonia.[1] In Utah, Black persons have higher heart failure hospitalization and mortality rates compared to White persons. Between 2007 and 2009, the rates for heart failure hospitalization per 10,000 were 308.6 (254.8–370.4) for Black persons and 131.7 (128.8–134.7) for White persons.[2] Differences for other racial and ethnic groups were not statistically different from the state rate.

The Agency for Healthcare Research and Quality (AHRQ) considers heart failure to be an ambulatory care-sensitive condition, meaning that it could potentially have been prevented with high quality primary care and preventive care. Race-related disparities in heart failure hospitalizations may relate to differences in access to care and quality of care.

Utah Heart Failure Hospitalizations by Race and Ethnicity, 2007–2009



1. Facts and Figures 2008 - Table of Contents. Healthcare Cost and Utilization Project (HCUP). October 2010. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/factsandfigures/2008/exhibit2_1.jsp.

2. Utah Inpatient Hospital Discharge Database, ICD 9 Code 428.

Monthly Health Indicators Report

(Data Through July 2011)

Monthly Report of Notifiable Diseases, July 2011	Current Month # Cases	Current Month # Expected Cases (5-yr average)	# Cases YTD	# Expected YTD (5-yr average)	YTD Standard Morbidity Ratio (obs/exp)
Campylobacteriosis (Campylobacter)	54	49	261	214	1.2
Shiga toxin-producing Escherichia coli (E. coli)	13	25	45	58	0.8
Hepatitis A (infectious hepatitis)	0	1	3	6	0.5
Hepatitis B, acute infections (serum hepatitis)	0	1	2	8	0.2
Meningococcal Disease	0	1	7	4	1.7
Pertussis (Whooping Cough)	3	27	253	229	1.1
Salmonellosis (Salmonella)	30	41	181	193	0.9
Shigellosis (Shigella)	1	5	29	21	1.4
Varicella (Chickenpox)	1	9	207	431	0.5
West Nile (Human cases)	0	8	0	9	0.0
Quarterly Report of Notifiable Diseases, 2nd Qtr 2011	**Current Quarter # Cases**	**Current Quarter # Expected Cases (5-yr average)**	**# Cases YTD**	**# Expected YTD (5-yr average)**	**YTD Standard Morbidity Ratio (obs/exp)**
HIV/AIDS†	21	30	43	60	0.7
Chlamydia	1,687	1,443	3,405	2,946	1.2
Gonorrhea	66	146	119	297	0.4
Tuberculosis	11	9	23	17	1.4
Medicaid Expenditures (in Millions) for the Month of July 2011	**Current Month**	**Expected/ Budgeted‡ for Month**	**Fiscal YTD**	**Budgeted‡ Fiscal YTD**	**Variance - over (under) budget**
Capitated Mental Health	$ 7.2	$ 7.6	$ 7.2	$ 7.6	$ (0.4)
Inpatient Hospital	$ 8.2	$ 9.3	$ 8.2	$ 9.3	$ (1.1)
Outpatient Hospital	$ 3.1	$ 4.1	$ 3.1	$ 4.1	$ (1.0)
Long Term Care	$ 7.2	$ 7.5	$ 7.2	$ 7.5	$ (0.4)
Pharmacy§	$ 13.2	$ 17.0	$ 13.2	$ 17.0	$ (3.8)
Physician/Osteo Services	$ 3.0	$ 3.3	$ 3.0	$ 3.3	$ (0.4)
TOTAL HCF MEDICAID	$ 70.6	$ 79.7	$ 70.6	$ 79.7	$ (9.0)

Program Enrollment for the Month of July 2011	Current Month	Previous Month	% Change¶ From Previous Month	1 Year Ago	% Change¶ From 1 Year Ago
Medicaid	243,762	244,470	-0.3%	222,380	+9.6%
PCN (Primary Care Network)	16,347	16,780	-2.6%	15,293	+6.9%
CHIP (Children's Health Ins. Plan)	37,994	37,700	+0.8%	40,867	-7.0%
	Annual Visits			Annual Charges	
Health Care System Measures	**Number of Events**	**Rate per 100 Population**	**% Change¶ From Previous Year**	**Total Charges in Millions**	**% Change¶ From Previous Year**
Overall Hospitalizations (2009)	276,924	9.3%	-2.6%	$ 5,116.1	+8.8%
Non-maternity Hospitalizations (2009)	166,045	5.4%	-0.7%	$ 4,298.2	+9.5%
Emergency Department Encounters (2009)	684,176	23.3%	-1.1%	$ 1,081.4	+22.9%
Outpatient Surgery (2009)	311,442	10.6%	+1.9%	$ 1,465.7	+14.7%
Annual Community Health Measures	**Current Data Year**	**Number Affected**	**Percent/ Rate**	**% Change¶ From Previous Year**	**State Rank# (1 is best)**
Obesity (Adults 18+)	2010	454,700	23.1%	-4.0%	11 (2010)
Cigarette Smoking (Adults 18+)	2010	180,100	9.1%	-6.9%	1 (2010)
Influenza Immunization (Adults 65+)	2010	175,900	68.2%	-0.8%	23 (2010)
Health Insurance Coverage (Uninsured)	2010	301,900	10.6%	-5.6%	n/a
Motor Vehicle Traffic Crash Injury Deaths	2009	227	8.1 / 100,000	-16.6%	15 (2007)
Poisoning Deaths	2009	543	19.4 / 100,000	+7.0%	49 (2007)
Suicide Deaths	2009	445	15.9 / 100,000	+15.3%	n/a
Diabetes Prevalence (Adults 18+)	2010	128,000	6.5%	+0.2%	15 (2010)
Poor Mental Health (Adults 18+)	2010	296,100	15.0%	+6.8%	17 (2010)
Coronary Heart Disease Deaths	2009	1,469	52.5 / 100,000	-4.4%	1 (2007)
All Cancer Deaths	2009	2,543	90.8 / 100,000	+1.1%	1 (2007)
Stroke Deaths	2009	734	26.2 / 100,000	-2.2%	14 (2007)
Births to Adolescents (Ages 15-17)	2009	992	16.5 / 1,000	-10.6%	19 (2008)
Early Prenatal Care	2009	38,562	71.6%	-9.6%	n/a
Infant Mortality	2009	285	5.3 / 1,000	+11.4%	4 (2007)
Childhood Immunization (4:3:1:3:3:1)	2009	41,500	76.6%	+4.1%	16 (2009)

† Diagnosed HIV infections, regardless of AIDS diagnosis.
‡ Budget has been revised to include supplemental funding from 2011 General Session.
§ Only includes the gross pharmacy costs. Pharmacy Rebate and Pharmacy Part-D amounts are excluded from this line item.
¶ % Change could be due to random variation.
# State rank based on age-adjusted rates.
Notes: Data for notifiable diseases are preliminary and subject to change upon the completion of ongoing disease investigations. Active surveillance for influenza virus has ended until the 2011-2012 season.