UTAH HEALTH POLICY PROJECT

HEALTH MATTERS

Health Matters E-Newsletter

April 20, 2011

In this issue…

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1. *Let's Get Busy*: A To-Do List For Medicaid Reform

2011 will be a busy year for Medicaid in Utah! SB180 (Medicaid Reform sponsored by Sen. Liljenquist) passed out of the Legislature and is now in the hands of the Department of Health (DOH), which is charged with the task of changing the way Medicaid is delivered and paid for in Utah. This bill requires the DOH to work with key stakeholder groups to develop a proposal to move Medicaid into "risk-based delivery models." The rationale for reform is sound: Medicaid costs *are* on an unsustainable trajectory, and the current "fee-for-service" model provides no incentives for reining in costs. The basic idea underpinning Medicaid reform is to move away from paying more for more services—whether the patient needs them or not—towards paying providers more for healthy outcomes.

The first step to implementing SB180 is an 1115 Medicaid waiver that DOH will draft and submit first to the Legislature by June 1, 2011, and then to the Centers for Medicaid and Medicare Services (CMS) by July 1, 2011. Under the *1115 Waiver* process states can request to be exempted from certain Medicaid regulations in order to demonstrate and evaluate a new approach to delivering and paying for Medicaid. What is curious about SB180's to-do list is that most of the key goals set forth in SB 180 actually do *not* require a waiver. These include:

- Creating a restricted account ("Growth Reduction Budget Stabilization Account");
- Moving to full risk-based contracting: right now the 3 managed care organizations vary significantly in their handling of risk;
- Rewarding providers for providing care according to evidence-based standards using bundled payment methodologies.

Depending on the details, these are the provisions that will probably require a waiver:

- Restructure cost sharing provisions to reward healthy behavior;
- Motivate beneficiaries to seek care in the most appropriate settings (not the E.R.);
- The global cap on payment and the cap on cost growth per beneficiary.

The second and more protracted step or process initiated by SB180 will be creating Medicaid Accountable Care Organizations (ACOs). Right now there are three Medicaid managed care organizations in Utah: Molina, Healthy U, and Select Health. These will be moved to an Accountable Care Organization ACO model. This model pays providers a monthly fee for each beneficiary served and provides incentives for providers to improve health outcomes and thus save money over the long term. The plans will have fresh incentives to figure out how to deliver quality care more efficiently and create incentives for clients to improve their health.

Overall, SB180 is positive, but the critical details of what a cost-efficient Medicaid program that delivers high quality care looks like haven't been worked out yet.

Moving forward:

- CMS may have some concerns with the content of Utah's waiver, but there's probably a good chance it will be approved. **CMS will likely get pressure from the White House to give states like Utah broad flexibility in waiver design: thus it will be important for advocates to push for the strongest possible waiver standards that protect beneficiaries' access to quality, affordable care**. Now is the time to orchestrate the campaign. If Utah's waiver is approved it will be implemented July 2012.
- The State is anticipating that additional health plans will be able to meet the requirements of the ACO standards.
- The State will be encouraging innovation in these plans.
- Quality measures will be put into place during the process which may reflect the federal standards.

Over the next four weeks the Department of Health will be holding public meetings which will allow input into the waiver process. Each of these meetings will focus on a different topic.

Medicaid Reform Public Meetings MEETING SCHEDULE
Location: Utah Department of Health, Cannon Health Building, Conference Room 125 for all meetings:

Wednesday, April 20th 3:30 PM -- 5:00 PM (Provider focus): Capitated rate setting process and data requirements

Wednesday, April 27th 8:30 AM -- 10:00 AM (Client focus): Healthy Behavior Incentives (UHPP has been invited to present)

Wednesday, May 4th 3:30 PM -- 5:00 PM (Provider focus): Provider assessment and UPL (Upper Payment Limit) preservation

Wednesday, May 11th 3:30 PM -- 5:00 PM (Client focus): Quality Assurance

Please join us for the UMP Annual Post-Session Retreat May 3, 9am-12pm. RSVP with Shanie for the location & agenda. We will be discussing lessons learned from the 2011 legislative session as well as the current state of Utah Medicaid Reform and what our next steps will be moving forward.

The State of Medicaid after the 2011 Legislative Session
Utah Medicaid survived largely unscathed this session. With higher than projected revenues this year, the budget was brought into balance without any cuts in eligibility or services. For most of the Session we stood to lose low-income women's access to cost-effective breast and cervical cancer treatment, interpreter services, hospice care, and dental and vision care for low income pregnant women. In the end, ongoing funding was found in the last days to continue these services. However, despite these remarkable victories, Utah Medicaid is left with serious challenges going forward.

Medicaid Reform-SB180
SB180 (Sen. Liljenquist) seeks to move Utah Medicaid from the current fee-for-service and managed care payment models toward more of an ACO (Accountable Care Organization) model. The goal of ACOs is "to reduce, or at least control the growth of, healthcare costs while maintaining or improving the quality of care patients receive." Some of the ideas set forth in SB180

will require a federal waiver, but many will not. Given the tight timeframes on the proposed waiver, (July 1, 2011!), we will be develop strategies to ensure Medicaid consumers will have access to much needed services as the reforms are implemented. Within the SB180 reform process, there is ample opportunity to improve quality of care for Medicaid consumers and to tackle longstanding challenges. It will be up to us to fully develop these opportunities—starting with this retreat!

2. Making The Most Of The Interim Session

Executive Appropriations and Health and Human Services Interim Committee's will be meeting throughout the Interim session beginning Tuesday, May 17, 2011 (Exec Approps) and Wednesday, May 18 for HHS Interim and most other committees. The Interim Session gives policymakers an opportunity to study issues in depth and prepare any needed legislation.

See full Interim schedule here.

Check links below to follow committee schedules:
Executive Appropriations Committee
Health and Human Services Interim Committee

3. On The Federal Front: *Rep. Paul Ryan's Budget Will Gut Medicaid And Privatize Medicare*

The proposed House majority budget, introduced by Budget Committee Chairman Paul Ryan (and titled *The Road to Prosperity)*, slashes $1.43 trillion over the next 10 years from Medicare and Medicaid by cutting critical health care for seniors and people with disabilities, as well as children and their families. Ryan's radical proposal will also wipe out Medicare's guarantee of benefits and move Medicare into a voucher system for private insurance by 2022. But a recent survey finds that **"Americans prefer to keep Medicare just the way it is. Most also oppose cuts in Medicaid…"** (See the report in the *Washington Post*.)

The dramatic cuts contained in the proposed budget will have a major, adverse impact on seniors and their families—especially because it reduces help for seniors who need long-term care, whether in nursing homes or at home. Medicare is primarily intended for people over 65 years of age, and the Medicaid program is the largest source of financing for long-term care, including half of all nursing home costs. In addition to the effect on seniors, the proposed Medicaid cuts will cause major harm to children. Approximately 25 million children depend on Medicaid for health care coverage, including more than 180,000 children in Utah.

Ryan's budget aims to shift Medicaid into a block grant. This means that the federal government would provide a lump sum to the states on a yearly basis and states would not see any additional money when enrollment or the cost of care rises. Once the lump sum runs out (and it will) the state becomes compelled to contribute more dollars or cut programs. This would have serious consequences for Medicaid in Utah. For example, during the recession (between 2008 and 2010) Utah's Medicaid caseload grew from 295,000 people to 360,000. The majority of these beneficiaries are children (57%) and people with disabilities (12%). If block granted, Utah would not see any additional federal money with the rise of enrollment.

Utah spends on average $610 per Medicaid beneficiary per month. According to the Congressional Budget Office (CBO), if Ryan's plan had been in place beginning 2000, Utah would have seen a 34% reduction in federal dollars by 2009 (see the CBO report here). Using Utah's 2010 numbers, this would equal a total (state and federal) loss of $554,177,352 from Utah's Medicaid Budget ($415,083,117 of the loss is federal money). At that rate we would lose funding to cover 75,707 lives, most likely leaving that many more uninsured people in Utah. Right now Utah has an uninsured rate of over 14%, approximately 389,840 people. If the number of uninsured increased by an additional 75,707-- our uninsured rate would rise to almost 17% of the state's population.

The loss of $554,177,352 would have additional consequence for Utah's economy. If Utah decreases Medicaid state spending by $554,177,352 Utah would lose:

- $3,158,810,906 in business activity as measured by economic output (the value of goods and services produced in the state)

- 30,369 jobs
- $1,136,063,572 in employee earnings (the wage and salary income associated with the affected jobs).

This is not just a "what if" scenario. The Congressional Budget Office (CBO) estimates that under these proposed cuts Medicaid federal spending would be 35% lower in 2022 and 49% lower in 2030— cutting the program in half! They also note serious implications of the cuts, including even lower provider rates which will make physicians unwilling to treat Medicaid enrollees, cutting off access to care for some beneficiaries as less providers serve Medicaid clients, and saddling providers with more uncompensated care costs as people lose benefits and coverage.

Along with gutting Medicaid, Ryan's budget proposal would fundamentally change Medicare as well. Medicare provides reliable health care coverage for 47million seniors and people with disabilities, including 233,800 people in Utah. The proposed budget would cut $30 billion from Medicare over the next decade, re-open the Medicare prescription donut hole (gap in coverage), and start us down the path where millions of seniors lose guaranteed benefits.

The plan proposes to convert Medicare into a "premium support" program. In this arrangement, the government would give seniors a flat payment to use to purchase private insurance. According to the CBO, this would result in skyrocketing out-of-pocket costs for seniors and people with disabilities. Under the current Medicare system beneficiaries pay 25% of their health care costs. Under the new plan they would pay on average about 68% of their costs through premiums and copayments! Medicare beneficiaries would lose access to care, as nearly half of all people on Medicare have incomes below 200% of the federal poverty level ($21,780/year for an individual) and live on fixed incomes. Seniors simply do not have the resources to handle higher cost sharing obligations.

This policy is bad for Utah, bad for Utah families, bad for Utah children, and bad for Utah seniors—these three groups make up 73% of Medicaid recipients in Utah.

Also significant is the economic impact of the proposed cuts to Medicaid and Medicare and repeal of tax credits for health insurance. All told, Utah would lose $14,016,700,000 over the next 10 years and add an additional 275,100 people to the ranks of the uninsured here. Utah started down the path of state health reform in 2008 with the goal of expanding coverage for all Utahns, and this policy would set our state's progress back.

4. ON THE STATE FRONT: *WHAT'S BEST FOR UTAH?*

Utah's health system reform is based on the principle that the market is the best mechanism for improved access to quality, cost effective health care.

That's why the Utah Health Exchange (Utah's key tool in state reform) is based on an "operational model," which welcomes all insurers who meet minimum standards into the Exchange, relying on market forces to generate product offerings. The result? Currently four insurers (SelectHealth, Altius, UnitedHealthcare, and Regence BlueCross BlueShield of Utah) offer a total of over 120 plans on Utah's Exchange. The Exchange is growing at a slow but steady pace. As of April 1, over 80 small businesses are enrolled (2,472 lives) with an additional 86 businesses at various stages in the enrollment process for the next couple of months.

Despite the upswing in interest, Utah's Exchange is still a mixed bag for those who buy health insurance there.

The big benefit for employers who use the Exchange is that they can make a "*defined contribution*" towards employees' premiums. This is a pre-determined amount of money each employee receives towards his or her insurance premium. This is different from the standard way employers contribute to their employees' premiums: paying for a specified percent of each employee's premium. While this makes costs easier for the employer to predict, the employees stand to lose if their premiums increase and their employer chooses not to increase the defined contribution towards the premium.

Participating employees will appreciate having more of a choice of plans when they are insured through the Exchange. No longer do they have to take the plan their employer has chosen for them, but can hand-pick a plan that best meets their

needs—whether a lower cost high deductible plan with a health savings account, or a more traditional insurance plan with higher premiums and a low deductible. However, if the employee chooses a product that costs more than the defined contribution made by the employer, the employee pays the difference.

So far the Exchange has made a very small dent in Utah's uninsured population. Just 17 of the small businesses that are buying health insurance through the Utah Health Exchange did not previously offer health insurance to their employees. This means that in terms of key reform goals like covering the uninsured, the Exchange so far falls short. And a big part of the problem is cost—Utah's small businesses want affordable, accessible health care coverage, but the price is too high for many of them. As reported by Small Business Majority (see the full report here) in 2009:

- Just 40% of Utah small business owners surveyed by the Small Business Majority reported paying for health insurance for their employees—of those, 78% say they're **really struggling** to do so.
- Of the 60% who don't provide insurance, 88% say they **can't afford** it.
- The number one concern for Utah's small business owners regarding healthcare reform is **controlling costs**, followed by having coverage that is guaranteed and covers everybody.

It's time for Utah's leaders and the Health System Reform Task force to get serious about addressing cost—for employers, taxpayers, *and* consumers. Utah's Exchange needs affordability standards, real risk pooling, and seamless integration of eligibility screening of premium subsidies and public programs.

Reporting on Utah's Health Care Quality, Safety, and Cost

Among the many positive provisions of the recently passed HB128 (Health Reform Amendments, sponsored by Rep. Dunnigan) is a requirement that the Health Data Authority compile and make public a yearly report about physician and clinic quality, safety, and cost in Utah. This is great news for Utah consumers. According to a recent report published by the Robert Wood Johnson Foundation:

> *It's a coin toss whether U.S. patients will receive all the health care recommended for them, with research showing people get the care they need from their doctor only about half the time. Experts agree that a good first step toward fixing this problem is to* ***measure the quality of care that physicians and hospitals provide and sharing that information publicly.*** *The government already reports on care provided in hospitals and the health reform law calls for increased reporting on the performance of local doctors.*

To this end, the state of Utah has for nearly 2 years been collecting the information needed for the new reporting required by state health reform in the All Payers Database (APD)—a system for collecting and analyzing data about health care (read more about Utah's APD here). Starting in October, that information will be made available to assist you in making informed health care decisions.

HealthInsight is currently seeking health care consumers/patients to serve on an advisory workgroup that will give input on the development of consumer tools for healthcare decision making and self management. Among other tasks, this workgroup will advise on the development of a new consumer-oriented website which displays comparative health care information that can be used to make more informed health care decisions. This group will meet once a month for a 1.5 hour meeting. Please contact UHPP (kim@healthpolicyproject.org) if you are interested in serving on this workgroup.

The Governor's Recent Vetoes

The Governor vetoed four bills on March 30th:

- HB0328, State Government Work Week (Rep. Michael Noel)
- SB0229, Transportation Funding Revisions (Sen. J. Stuart Adams)
- SB0294S2, Patient Access Reform (Sen. J. Stuart Adams)
- SB0305S2, Economic Development Through Education/Career Alignment (Sen. Howard Stephenson)

The Governor issued the following statements about his reason for vetoing SB 229 and SB 294, two bills that have

implications for health care in Utah:

> "**S.B. 229** would earmark a growing percentage of certain sales tax proceeds for transportation projects. Although I agree that a modern and effective transportation system is vital to Utah's economic success, I am concerned that S.B. 229's automatic earmark will translate into decreased ability to fund other budget priorities, such as higher education, human services, and economic development, in future years. The recent past has taught us that economic tides can turn quickly. To maintain our position as the best-managed state in the nation, Utah must be able to react quickly to changed financial circumstances."

SB229 would earmark, in perpetuity, over $59 million from the General Fund for transportation only. This means that money would not be available for any other needs, like public health. For example, if Utah found itself in the grips of a measles epidemic, the money quickly and vitally needed for the public health system to treat and contain the epidemic would be legally tied up and difficult to divert to the front lines of Utah's health.

Gov. Herbert explained his veto of SB294 as follows:

> "The Utah Health Exchange is a nationally recognized effort to expand access to, and reduce the cost of, health care. **S.B. 294**, which was publicly released in the waning hours of the 44th day of the session, would hurt the Exchange's ability to operate effectively. It would likely lead to a redistribution of premiums in a fashion that would negatively impact older Utahns. S.B. 294 also carried a fiscal note the Utah Legislature did not fund. At a time when we are challenging the federal government's unconstitutional attempt to regulate health care, and asking that this be left to the states, it is imperative Utah have the tools it needs to provide an example to the nation of how reform should occur."

It is true that SB294, because it was unfunded, would require the Exchange to re-tool without financial support, setting progress back a few months. The redistribution of premiums would have had a mixed effect: lowering premiums for some (notably for single parent-one child families) and raising them for others.

If a veto override session is called by the Legislature, it must be called by May 10th.

5. The HEALTH SYSTEM REFORM TASK FORCE and U-SHARE (Health Reform Coalition)

The Health System Reform Task Force will meet on Wednesday afternoons during the interim (location TBA).

- May 18th 2-5 PM
- June 15th 2-5 PM
- July 20th 2-5 PM
- September 21st 2-5 PM
- October 19th 2-5 PM
- November 16th 2-5 PM

You can find the interim schedule on the Utah legislature's website: www.le.utah.gov. Please make a point of attending these sessions, as they are the main theater of activity for addressing the delicate interface between state and federal health reform.

This year we plan to work with U-SHARE and other partners to generate stronger reform and Exchange measures out of the task force process. If Utah wants to run the ACA exchanges and not have the feds do it for us, the state's Exchange must be ready to demonstrate the ability to do so by January 1, 2013. **Now is the time** to set up governance structures and to define affordability standards, for example, and the list goes on.

Roll up your sleeves at **U-SHARE's Post-Session Lunch Retreat!**

Where: **Olmstead Room, East/Senate Bldg, State Capitol**
When**: May 18th 12:00-2:00 pm (grab your lunch in cafeteria)—in between HHS Interim & the Task Force!**

6. **Looking Forward: Long Awaited Draft Plan For Improving Health Equity Released By HHS**

Last Friday, April 8, the US Department of Health and Human Services presented a draft 2-part plan to move the nation toward improved health equity. This is big news for Utah, where health disparities can be very significant. For details on disparities in Utah, see these links at the Utah Department of Health's Center for Multicultural Health:

- **Moving Forward in 2010**
  This report describes trends in Utah minority health since CMH was established in 2005.
  www.health.utah.gov/cmh/data/movingforward.pdf
- **Utah Health Status by Race and Ethnicity: 2010 Report**
  A new and comprehensive reference of public health data about the state's diverse racial and ethnic groups.
  www.health.utah.gov/cmh/data/healthstatus.pdf
- **Utah Health Indicators by Race and Ethnicity**
  See current graphs by race and ethnicity for a wide range of health issues.
  www.health.utah.gov/cmh/data/indicators.htm

The causes of these problems run deep, far beyond access to insurance coverage or health care. They include the "social determinants of health," including the jobs we get, the places we live, the foods we eat, and the quality of schools for our children. The strategies outlined in the new plan are aimed broadly at these social determinants. The full impact of the plan will depend on how well the strategies are implemented at the local level. Note that the new plan seeks to coordinate health equity measures in the Affordable Care Act, Healthy People 2020, and other existing federal initiatives.

National Plan Links

- National Partnership for Action
- HHS Action Plan to Reduce Racial and Ethnic Health Disparities
- National Stakeholder Strategy for Achieving Health Equity

Part one (HHS Action Plan to Reduce Racial and Ethnic Health Disparities) sets forth 5 broad goals, ranging from expanding access to health care to diversifying the health workforce. Specific steps include implementing the long-awaited Community Transformation Grants, creating an online registry of medical interpreters for patients who don't speak English, expanding the use of community health workers in the Medicaid program, and expanding preventive dental care for children. All of these are critical priorities for Utah, and the UHPP looks forward to maximizing these and related opportunities with our partners.

Part 2 is the National Stakeholder Strategy for Achieving Health Equity (see especially section 4 about operationalizing the plan), which provides a second set of goals and strategies for initiatives and partnerships designed to foster community-level engagement. This strategy was developed over several years through local, regional and national meetings called the National Partnership for Action (UHPP was there in Kansas City with 20 other Utah partners). The document describes 20 strategies ranging from training youth to be health leaders to ensuring the availability of health data on underserved populations—Utah's Medicaid reform process presents a wonderful opportunity to collect better data on the underserved. It calls for the formation of 10 regional health equity councils (more on this later) to coordinate and galvanize the work, and promises to provide local communities with technical assistance and tool kits to move forward.

We share our national partners' concern that *no new money is attached to the plans*. The federal work will draw on existing funding, including money from the Affordable Care Act currently under siege – another reason to defend that funding. For the most part, the local initiatives will need to find their own resources. Fortunately, the stakeholder strategy lays out hundreds of objectives which could be the basis for local organizing and could be attractive to local funders.

Next Steps for Utah

- We strongly recommend that all partners interested in improving health equity sit down with these documents and

digest them thoroughly.

- We want to suggest that the new Utah Health Disparities Council (now in the formation stage) work to re-convene stakeholders around these new plans. This group will be heavily focused on such efforts and proven strategies for addressing the social determinants of health.
- To maximize impact, we will look for opportunity to align the new health equity goals with local interventions that are *already* focused on social determinants. For example, the United Way of Salt Lake has introduced a new model of collaboration called "community impact," which will be situated in 8 low-income and diverse neighborhoods and communities. The agency will facilitate partnerships around specific community goals in the areas of education, income and health. The National Plan will create opportunity to augment these efforts and vice versa.
- Stay tuned: we will bring Lorenzo Olivas (our regional minority health consultant) out to strategize around these new plans.

Source: Adapted from Community Catalyst: www.communitycatalyst.org and localized for Utah.

7. **ANNOUNCEMENTS**

- **Monthly Meeting** is May 4th at Department of Health, Cannon Health Building, 288 N. 1460 W in SLC.
  The Health Portion is first, at 1:30 pm.

  Be sure to end any ideas for topics to shanie@healthpolicyproject.org . You might review the minutes from the April 6th meeting to see where we left off on key issues.

- **2011 Utah Global Health Conference**

  Friday, April 22, 2011, 9am to 4pm
  Health Sciences Education Building (HSEB) on the University of Utah campus.
  Free and open to the public (register here)

  The theme for the 2011 conference is "Bridging the Gaps in Global Health: At Home and Abroad" with a focus on proven and effective global health approaches at an international and local level.

  The Utah Health Policy Project's own Shelly Braun, PhD, will be presenting *"Running on Empty: the Shaman's understanding of what makes us sick –implications for health care."* Cultural competency for health care providers is essential to the task of providing health care to Utah's increasingly diverse population. Over 8000 refugees from 42 countries have been welcomed into the state since 2000. All of them bring with them their health concerns, practices, and healing systems from their native lands. It is imperative that everyone involved in delivering health care understand how these may either help or hinder medical care. As UHPP moves forward to address health equity issues in Utah (see above: **LOOKING FORWARD: *LONG AWAITED DRAFT PLAN FOR IMPROVING HEALTH EQUITY RELEASED BY HHS***) we are excited to draw on Shelly's expertise in medical anthropology (the health systems and practices of diverse cultures).

  The conference will also feature speakers from the Himalayan Cataract Project, Doctors Without Borders, Partners in Health, Utah Refugee Services, and more. The target audience is health professionals and students with an interest or experience in providing care internationally, or with underserved populations locally. The goal is to provide participants with tangible and applicable tools and concepts to improve their current practice, or to implement in future endeavors. The conference is free for the public. Continuing medical educations credits will be available for a fee. The conference is proudly presented by the University of Utah Student Global Health Alliance.

  For more information visit the conference website at www.globalhealth.utah.edu/when/conference.html.

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