**MISSION:** To promote, support and advance the work of Community Health Workers (CHWs) in Utah.

**CHW DEFINITION:** The jobs and roles of CHWs are as varied as their titles (promotora, patient advocate, peer support specialist, etc.). All CHWs, however, share trust and a connection with their communities. Community Health Workers are trained lay people who provide education and social support to their neighbors, while serving as a liaison with health care providers. CHWs offer interpretation, provide culturally appropriate health information, assist people in receiving the care they need, help overcome barriers, give informal counseling and guidance on health behaviors, and advocate for individual and community health needs.

**COALITION STRUCTURE:** Led by an Advisory Board, the CHW Coalition consists of three workgroups served voluntarily by members of local government, non-profit organizations, health systems and Utah businesses. The workgroups are: Workforce Development, Advocacy and Sustainable Finance. Workgroup members meet regularly on these focus areas:

- Standardize training of CHW core competencies for CHWs, accessible statewide
- Certification for CHW training upon completion
- Defined Scope of Practice for CHWs
- Development and growth of the CHW Section, under the Utah Public Health Association (UPHA)
- Public and professional recognition for the work of CHWs
- Return-on-investment business case for CHW work, with sustainable finance mechanisms

**Want to help?** We need more people supporting Community Health Workers. Join the Utah CHW Coalition—each workgroup welcomes your passion and skills! To learn more about the Coalition, please contact: McKell Drury at the Utah Department of Health, (801)538-6896 mdrury@utah.gov.
COMMUNITY HEALTH WORKER CORE SKILLS & ROLES

Communication – use language confidently in ways that engage and motivate; communicate with empathy; actively listen; use written and electronic communication methods

Interpersonal and Relationship-building – provide informal counseling, social support, and coaching; use motivational interviewing techniques; manage conflict

Coordination and Navigation – identify and access resources; overcome barriers; develop goals and action plan; coordinate with clinical and community services; follow-up and track outcomes

Capacity-building – help others identify their potential; work to increase individual empowerment; network and build community connections

Advocacy – speak up for individuals and communities; advocate for policy changes

Education and Facilitation – use teaching strategies to facilitate group discussions; plan and conduct classes and presentations; find and share information; collaborate with other educators

Individual and Community Assessment – observe and actively inquire about individuals and the community to develop assessments

Outreach – conduct case-finding, recruitment and follow-up; prepare and distribute material

Professional Conduct – develop and follow a work plan; balance priorities and manage time; use pertinent technology; pursue continuing education; work safely, and observe ethical and legal standards; participate in professional development and networking opportunities

Knowledge – seek and maintain knowledge about physical health issues, healthy living and self-care, mental health, behavior theories, public health principles, background about the community served, social determinants of health, and problem solving techniques
Request: The Utah Asthma Program requests Medicaid allocate $43,250 to cover costs for an additional 150 individuals with persistent, uncontrolled asthma to receive targeted case management through the Utah Asthma Home Visiting Program.

What is asthma?
- Asthma is the most common chronic condition among children and makes it difficult to breathe.¹
- There is no cure for asthma; however, those with asthma can learn to control their asthma and live normal, healthy lives.¹,²,³
- Key factors that lead to uncontrolled asthma include a lack of access to adequate clinical care and medications, not taking prescribed medications correctly, a lack of self-management education, and being exposed to asthma triggers.
- Uncontrolled asthma leads to urgent care visits, ED visits, hospital stays, missed school and work days, and a poorer quality of life.¹,³

The Asthma Burden is Higher among Medicaid Members and is Costly to Medicaid
- The asthma burden is higher among Medicaid members when compared to the overall Utah population.⁵
- Asthma-related ED visits are costly for Medicaid. The 2017 average cost per Medicaid member for an asthma-related ED visits was $1,186.83, costing Medicaid an estimated $2.6 million.⁶
- Currently, Medicaid plans vary in their coverage of asthma self-management education and home visit interventions.⁹

The Utah Asthma Home Visiting Program Addresses Utah’s Asthma Burden
- Our program is evidence-based and provides three visits in the home that targets Utahns with persistent, uncontrolled asthma. Specially trained non-licensed providers in Utah and Salt Lake Counties teach key asthma self-management concepts, link individuals to clinical care, and help to identify and reduce triggers in the home.²,³
- Since January 2016, over 230 patients have enrolled in the program.¹⁰ Patients that complete the program show improved quality of life and increased asthma control.¹⁰
  - A patient from Utah County shared the following: “This program completely turned things around for us. When my son first got diagnosed, I was totally lost, overwhelmed, and nervous about how we would deal with his condition. But this program gave me the tools and confidence to handle his condition.”

Utah Asthma Home Visiting Program Saves Money
- The total program costs on average $288.30 per patient. The cost includes staff, travel, and material costs.¹⁰ 88.5% of Medicaid patients complete the program.
- Program data show a 56% reduction in total ED visits for Medicaid patients.
- For every $1 invested, Medicaid is expected to save $1.31 within 12 months of completing the program, which is consistent with other literature findings.¹⁰,¹¹
Medicaid Budget Ask and Projected Savings

- To provide the program services to all Medicaid members across Utah with uncontrolled asthma, the expected cost would be about $1.4 million annually, which would result in an estimated ED cost savings to Medicaid of $1.8 million.\textsuperscript{10}
- In 2017, 112 patients went through the program.
- The Utah Asthma Program requests Medicaid allocate $\mathbf{43,250}$ to cover costs for an additional \textbf{150} individuals with persistent, uncontrolled asthma to receive targeted case management through the Utah Asthma Home Visiting Program. The program will improve health outcomes and save Medicaid about $\mathbf{56,650}$ in reduced asthma-related ED visits.\textsuperscript{9} The Utah Asthma Program suggests opening the CPT codes 98960, 98961, 98962, 99401, 99402, and/or 94664 to cover the cost of the program.\textsuperscript{12}
- Our program has the potential to save Medicaid money and help people improve control of their asthma. We ask to partner with Medicaid to expand our impact on the asthma burden in Utah.
Suggested CPT Code Definitions:

- CPT Code 98960: Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family); individual patient
- CPT Code 98961: Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum face-to-face with the patient (could include caregiver/family); 2-4 patients, initial or follow-up visit.
- CPT Code 98962: Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum face-to-face with the patient (could include caregiver/family); 5-8 patients, initial or follow-up visit.
- CPT Code 99401: Patient counseling and/or risk factor reduction intervention services; individual patient follow-up visit
- CPT Code 99402: Patient counseling and/or risk factor reduction intervention services; individual patient initial visit
- CPT Code: 94664: Inhalation instructions: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler, or intermittent positive pressure breathing (IPPB) device.

Contact Information
Brittany Guerra, MPH
Utah Asthma Program
Utah Department of Health
801-538-6894
bguerra@utah.gov
References:

6. Count of ED visits came from 2014 IBIS data. Average cost per member for each ED visit comes from 2017 Medicaid claims data.
Increase Home Health Funding

I am Luann Clausen. I am here representing my sister, Samantha, to tell you a few challenges I have had getting her on and keeping her on Medicaid personal care services.

Due to a TBI, Sam's physical balance is unstable, so she needs standby help with showers. She needs help with meals, laundry, and cleaning because her inability to sense time and her short term memory loss. Her TBI makes it difficult to initiate and carry through with daily tasks that have multiple steps, such as making meals or doing laundry. She doesn't drive, nor can she negotiate public transportation on her own so she needs others to shop with or for her. Samantha needs home personal care and homemaking assistance, and transportation services through Medicaid. She also has ongoing medical and mental health needs for which Medicaid is the secondary insurance.

Access Issues:

1. Over last three years since I got her on Medicaid we have had to change home health providers at least 4 times.

   a. Holidays - I was told by one home health agency that we must self pay or forgo care on holidays because Medicaid did not pay enough to cover overtime pay for employees. This happened following a hospitalization when Sam was receiving daily care.

   b. Some agencies have frequent turnover due to low wages. One agency even assigned multiple caregivers, as many as 8 different CNAs in a month. Their service was scheduled at different times every day, and those changed every week. For a person like Sam with TBI it was confusing and created extreme anxiety to have no routine. It's traumatic to get naked in front of new strangers several times a week. However, some elderly friends of mine had same agency at that time paid by Medicare. They had consistency in times and caregivers. We moved to another agency.

   c. We found an agency we liked with consistent caregivers that Sam had adjusted to and was comfortable with over time. Then she was ousted from that agency when they elected to eliminate Medicaid clients. They were unable to receive enough from Medicaid to pay their workers. We had to find another agency again. New strangers to get naked in front of. New strangers to teach how and what homemaking care needed to help when it is difficult even herself to remember the tasks needed.

   d. Providers end up taking the risk when a spend down is not paid at the beginning of the month, even though Medicaid allows medical deductions to be submitted up to 10 days after the end of the month. This is because the medical service may not even take place until later in the month.

However, we were told by more than one agency that no services would be provided until she showed up as eligible. Sam's monthly spend down of $391 must be paid before she shows up as eligible. Sounds easy. However, there are problems with this.
1. spend down is due by 1st of the month or Sam would not receive services. Sam's social security check does not even arrive until the 3rd of the month.

2. Sometimes I submitted medical or dental expenses that are not covered by Medicaid to be used as a deduction to her spend down. She cannot afford to pay both medical expenses plus $391 spend down each month. After the spend down she has $993 for food, housing, and all other expenses. She makes so much money ($1384) she only can receive $15 in food stamps.

Sam had lost all the molars on her lower right quadrant due to not being able to afford dental care or many years. She was experiencing jaw pain and jaw joint pain. Her dentist recommended implants. We submitted the expense and it was used as a deduction of her spend down for 9 months as we paid over time.

For about a year her home care agency worked with me and continued care, knowing how the spend down worked, that a deduction is sometimes not applied until after the month of service ends. I never missed a payment that entire year, although sometimes it was toward the end of the month that she showed as eligible or even during the next month as we awaited Medicaid's decision to use the submitted deduction.

Then the agency changed management. They no longer would provide care if Sam did not show eligible, meaning the spend down paid.

We changed agencies again to one who told me they understood how spend downs work, how the eligibility is not shown until the next month at times. We had to scrape up money from family to pay the first month upfront, assured that that was not necessary going forward. Then they changed their tune. If we did not pay the spend down at the beginning of the month there would be no care.

It came time to complete the dental care; crowns and a bridge to be placed upon the steel implants where there were no molars. I called Medicaid to ask if this was covered by the new Medicaid dental insurance for blind and disabled that began in July 2017. It was not covered, so one would assume that the expense could be used as a deduction of the spend down.

We were able to find a dentist who would allow us to pay over time. If the debt is paid by CareCredit, a medical/dental credit company, it cannot be used as a deduction by Medicaid. But it took many phone calls to find one who would let us pay over time.

The crowns were placed in February. I submitted the $2400 expense, expecting it to be used as the steel implants had before. I looked on MyCase and it showed that the expenses were applied. So Sam was eligible. In March it did not show up as applied. I waited, then finally called. They had used it as an incurred expense, not a deduction, which means it was only used for February and could not be ongoing. I thought that was an error, as it was a non-covered expense. The worker said she would check with a supervisor and get back to me. I ended up calling 3 times in March, always being told I would receive a call back. I never did. Each call included waiting in cue for 30-45 minutes, then a lengthy conversation. Each eligibility agent told me something different and none of them understood exactly why the expenses were not used. I had to take ½
day off work twice to try to work this out.

In the meantime, for the 5 weeks I was waiting and trying to resolve this expense, Sam did not receive shower help, so she did not shower because she was afraid of falling. She did not receive help with her dishes, meals, medication reminders, mail retrieval, nor homemaking from this care agency because she did not show up as eligible. And now we have a debt of several thousand dollars that we thought would count as a deduction of her spend down. Now she has to pay the spend down and the ongoing bill. Not sure how this will happen. Should she not eat? It was finally explained to me by a Medicaid consumer advocate in April that now that there was dental insurance, even though the procedure was not covered, she should have used a Medicaid provider. That is the way to preauthorize a treatment. That is the only way that an expense might be considered to be a medically necessary non-covered expense. I also learned from a Health Plan Representative that there is a page where providers can look up a code to see if it is covered. I found out these two pieces of information after about 10 hours of work, including having to take time off work. However, even after many hours of searching, I had found a Medicaid provider who would let her pay over time, so I could not use a Medicaid provider.

2. How it affected her.
   
   a. meals and clean up dishes after.
   b. laundry / sheets
   c. showers, clean up bathroom, towels.
   d. mail retrieval
Medicaid Care Advisory Committee

June 21, 2018

RE: Medicaid Reimbursement for Private Duty Nursing

Horizon Home Health has been providing in-home Pediatric Nursing care since 2009. Reimbursement rates for these patients have not increased for many years although documentation requirements and open market nursing wages have. Additionally, a nursing shortage exists. Margins on these visits have historically been thin and with these added pressures margins have become so thin as to eliminate the possibility of raising nursing wages for nurses serving pediatric patients. This has led to difficulty in staffing the nursing needs for these patients. Horizon has a waiting list of children needing care that it is unable to staff at current possible wage levels. Additionally, we receive multiple calls per week from parents searching for Private Duty care. A consideration for increased reimbursement is requested.

Additional documentation required beyond Medicaid:

Patients >18yrs of age require an OASIS

-All patients must meet Medicare guidelines including all Conditions of Participation.

-State Surveyors require the same documentation and accountability for all patients regardless of paying body.

Wage growth:

Private Duty reimbursement rate: $11.06 per 15min ($44.24 per hour)

Nursing wages 2013: $28.38/hour Nursing hourly wages 2018: $35.65/hour
June 18, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard:

The Salt Lake County Health Department is pleased to collaborate on the delivery of the Utah Asthma Home Visiting Program and support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the program services.

The mission of the Salt Lake County Health Department is simple, “to promote and protect community and environmental health.” We work to protect and improve the well-being of all county residents by preventing disease, illness, and injury and by impacting social, economic, and environmental factors fundamental to excellent health. The management of asthma through implementing the Utah Asthma Home Visiting Program in Salt Lake County compliments this vision. We can improve the health of those living with asthma in Salt Lake County by empowering those individuals to control their condition through proper medication delivery, trigger reduction strategies, and goal setting.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

While funding exists, we will continue to provide the Utah Asthma Home Visiting Program, a three-visit, evidence-based and multicomponent asthma intervention, to those with persistent and uncontrolled asthma in our region. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. The health care cost savings this program produces are only limited by the number of trained Asthma Home Visiting health educators. Sustainable financing will allow for these cost savings and improved asthma outcomes.

We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma. Salt Lake County Health Department appreciates the collaboration and partnership with the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Gary Edwards M.S.
Executive Director
June 12, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Executive Director of Utah County Health Department, I offer our support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

The Asthma Home Visit Program at Utah County Health Department is run by a passionate Certified Asthma Educator (AE-C) with 18 years of experience. Since January 2016, we have had 184 referrals from hospitals and doctor’s offices. Of the 91 participants currently enrolled, our dropout rate is only 9%.

Asthma is the most common chronic disease among children and the leading cause for missed school days. While there is no cure for asthma, those with asthma can live a full and active life with proper care. This includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three-visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma. The three visits provide self-management education, environmental trigger identification, and home remediation. The program coordinates with physicians to ensure team-based care for the participant. Remediation is possible through a partnership with Habitat for Humanity of Utah County. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The Utah County Health Department values the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Ralph Clegg
Executive Director
Utah County Health Department

151 South University Avenue, Provo, Utah 84601-4427 • www.UtahCountyHealth.org • Phone: 801.851.7000 • Fax: 801.851.7009

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Superintendent Rick Nielsen
Dianne C. Carr, RD
Daniel Magleby
Gaye L. Ray, RN
Teresa Tavares
June 13, 2018

Nichole Shepard, Program Manager  
Utah Department of Health, Asthma and Arthritis Program  
PO Box 142107  
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

The Association for Utah Community Health (AUCH) is pleased to continue to collaborate with the UDOH Asthma Home Visiting Program. Our Community Health Workers (CHWs) have been trained through the program and it has allowed them to provide support and education for the families they assist.

As the Primary Care Association for the state of Utah since 1985, AUCH is committed to offering staff trainings and technical assistance regarding health center policy and program requirements, health center operations, enrolling individuals into coverage, transforming patient care, and expanding access to high quality, affordable primary and preventive health care services. Our 18 member organizations have over 60 clinics across the state.

Wherever possible, and to the extent funding exists, we will continue to provide the Utah Asthma Home Visiting Program through our CHWs to Health Center patients and other people in the surrounding communities as needed. We appreciate that the program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs.

AUCH appreciates the collaboration and partnership with the Utah Asthma Program and we look forward to supporting their efforts to reach more of the population in Utah who suffer from persistent and uncontrolled asthma.

Sincerely,

[Signature]

Alan Pruhs  
Executive Director
June 11, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As the Executive Director of Utah Partners for Health, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Utah Partners for Health is a Federally Qualified Health Center which provides full primary healthcare services to individuals regardless of their ability to pay. Our mission is to provide compassionate, comprehensive, quality care to empower underserved individuals, families, and communities in a patient centered medical home.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

Utah Partners for Health appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Kurt Micka
Executive Director
Dear Ms. Shepard,

As owner of Jolley’s Pharmacy, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

Jolley’s appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Tad Jolley RPh
Jolley's Pharmacy Redwood
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Follow us on Instagram: http://instagram.com/jolleyspharmacyredwood
Follow us on Twitter: https://twitter.com/JolleysPharmacy
June 13, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Salt Lake County, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Salt Lake County Green & Healthy Homes Initiative works closely with Salt Lake County Health Department and the State of Utah Asthma Home visiting program. It has been tremendously helpful to combine the Utah Asthma Home visiting program with the assessment and mitigation of asthma triggers which Salt Lake County provides. It is estimated over the last three years our efforts have resulted in dramatic improvement of health and control of asthma for at least 40 homes and household, and have saved up to $500,000 in Medicaid medical costs and treatment.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

Salt Lake County appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Randy Jepperson
Housing Manager
Salt Lake County
June 11, 2018

Nichole Shepard, Program Manager  
Utah Department of Health, Asthma and Arthritis Program  
PO Box 142107  
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Director of the Utah Pediatric Partnership to Improve Healthcare Quality, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

UPIQ provides education, guidance, tools, measurement, and ongoing support to help bridge the gap between knowing best practices and consistently implementing them in practice. Having worked with over 50% of the Pediatricians in the state of Utah, and a growing number of Family Medicine physicians, Physician Assistants, and Nurse Practitioners, we foster innovation with the use of evidence in clinical practice and delivery systems to provide accessible, coordinated and family-centered healthcare for Utah’s children. UPIQ has supported many healthcare organizations and clinics to improve care delivery, especially practices for the underserved populations.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three-visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The Utah Pediatric Partnership to Improve Healthcare Quality recognizes and appreciates the public health work of the Utah Asthma Program. We look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Diane Liu, MD FAAP  
Assistant Professor, Department of Pediatrics  
Director, Utah Pediatric Partnership to Improve Healthcare Quality
June 11, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Pediatric Population Health Management Initiatives Lead for University of Utah Health, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions. From 2010 to 2015, I served as the Centers for Disease Control Region 8 Pediatric Asthma Faculty Champion, supporting the education of hundreds of health professionals in the environmental management of pediatric asthma. During this role, I learned that asthma control requires a multi-faceted approach, and understanding the home environment is essential. Care in the home goes straight to the source of asthma triggers and is the best place to examine and optimize asthma control. As a physician leader on Intermountain Healthcare’s Pediatric Asthma Work Group, I share responsibility for improving the quality of care for children hospitalized with asthma throughout Utah. Shifting care from the hospital into the community, including home, is a crucial part of our strategy for improving the value of pediatric asthma care.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. I strongly support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The University of Utah Health Population Health Team appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Michelle Hofmann, MD, MPH
Associate Professor of Pediatrics, University of Utah
June 11, 2018

Nichole Shepard, Program Manager  
Utah Department of Health, Asthma and Arthritis Program  
PO Box 142107  
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Director of the Division of Aging and Adult Services, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Utah State Division of Aging and Adult Services works with Area Agencies on Aging to offer services to support quality of life and independent living for seniors. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions. Helping seniors manage asthma heightens the quality of life and serves to delay or prevent the need for institutional care.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The Division of Aging and Adult Services appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Nels R. Holmgren,
Director

NH/tr
June 12, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

On behalf of the Environmental Epidemiology Program (EEP), I am pleased to offer our support for the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Air pollution reduction and the prevention of resulting respiratory and cardiovascular health concerns are a significant part of EEP’s responsibilities. We appreciate partnering with and supporting the Utah Asthma Program in our joint responsibilities over these significant public health concerns.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three-visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utah residents with persistent and uncontrolled asthma.

The EEP appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Sam LeFevre, Manager
Environmental Epidemiology Program
Utah Department of Health
June 11, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As Executive Director of the National Tongan American Society (NTAS), I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

The NTAS is one of very few Pacific Islander nonprofit organizations serving health needs of Pacific Islanders in Utah. We have implemented various health programs, including Chronic Disease Self-Management Program (CDSMP) for over five years.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The NTAS appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of persistent and uncontrolled asthma population in Utah.

Sincerely,

Fahina Tavake-Pasi
Executive Director
June 18, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As a Registered Respiratory Therapist and Clinical Health Educator at Weber-Morgan Health Department, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The Weber-Morgan Health Department appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Yvonne Campbell, MBA, RRT
Registered Respiratory Therapist & Clinical Health Educator
Weber-Morgan Health Department
June 18, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

Action Utah is pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

Action Utah is a community engagement network committed to building bridges and advocating on issues that most Utahns agree on. Utahns overwhelmingly care about family, children, and public health issues. Asthma is the most common chronic disease among children and the leading reason for missed school days.

Asthma cannot be healed, however, those with asthma can live a full, prosperous, and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs.

We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

Action Utah appreciates the public health work of the Utah Asthma Program and their efforts to reach more of the persistent and uncontrolled asthma population in Utah. With the Utah Asthma Program we can create a healthier Utah.

Sincerely,

Andrea Himoff
Executive Director
Action Utah
June 19, 2018

Nichole Shepard, Program Manager
Utah Department of Health, Asthma and Arthritis Program
PO Box 142107
Salt Lake City, Utah 84114-2107

Dear Ms. Shepard,

As an allergist with the University of Utah’s department of Dermatology, I am pleased to support the Utah Asthma Program’s efforts to seek reimbursement and sustainable finances for the Utah Asthma Home Visiting Program services.

As a subspecialty group within the Department of Dermatology, we care for asthmatics, striving to keep children with asthma controlled and out of the ER as well as, participate in research to better serve children with asthma, including those on the Navajo Nation.

Asthma is the most common chronic disease among children and the leading reason for missed school days. While asthma cannot be healed, those with asthma can live a full and active life with proper care, which includes national guidelines-based clinical care, patient education for self-management, and control of environmental factors and comorbid conditions.

The Utah Asthma Home Visiting Program is a three visit evidence-based multicomponent asthma intervention for those with persistent and uncontrolled asthma in Utah. The three visits provide self-management education and environmental trigger identification and remediation. The program coordinates with the primary care doctor to ensure team-based and coordinated care around the participant. The program has shown to be an effective intervention for improving asthma control and reducing asthma-related preventable healthcare costs. We support the Utah Asthma Program’s efforts to establish sustainable financing sources for the Utah Asthma Home Visiting Program and increase capacity and reach of the program to all Utahns with persistent and uncontrolled asthma.

The University of Utah’s department of Dermatology appreciates the public health work of the Utah Asthma Program and we look forward to supporting their efforts to reach more of the persistent and uncontrolled asthma population in Utah.

Sincerely,

Aaron K. Kobernick, M.D., M.P.H.
Assistant Professor, Dermatology
University of Utah Department of Dermatology
Voices for Utah Children

Building Block Requests for Consideration and Prioritization

June 21, 2018

Voices for Utah Children respectfully requests the Medical Care Advisory Committee to consider and prioritize the following requests to assure more children and families receive health coverage and access quality care.

1. Keeping Kids Covered: 12-Month Continuous Eligibility for Children on Medicaid

In April of last year, the Medical Care Advisory Committee recommended that the Department of Health move forward with implementing 12-month continuous eligibility as soon as possible. The MCAC then also prioritized 12-month continuous eligibility last year, ranking it a top funding priority for the Department.

Unfortunately, the Department has not yet adopted a policy of 12-month continuous eligibility. As a result, children continue to unnecessarily lose their health insurance coverage, getting lost in red-tape and administrative hurdles.

While children in CHIP, and the TAM population, are guaranteed 12 continuous months of eligibility, children in Medicaid are not. This is contributing to Utah’s high rate of uninsured children. It also puts children, including children with special health care needs, at risk for worse health outcomes as they experience disruptions in their coverage and care. According to the Department’s analysis, children in the blind/disabled category have one of lower average lengths of eligibility compared to other eligibility groups. This has caused problems for many families with children with special health care needs; parents have experienced a temporary, unexpected bump in income and then subsequently lost Medicaid and the services or care their child needs to thrive.

In addition, continuous eligibility would allow health plans, Medicaid, and this committee, to more accurately monitor and improve care through HEDIS measures. Because HEDIS measures require a one-year standard of continuous enrollment data, children experiencing churn are not captured and HEDIS does not reflect the full make-up of children receiving care. Continuous eligibility can lead to more comprehensive program improvement targets and better health care value for Medicaid enrollees.

We thank the committee for championing this policy in the past, and we respectfully ask that you continue to prioritize 12-month continuous eligibility for children in Medicaid. This is a policy we should already have in place to assure that Medicaid can work as effectively as possible, reduce unnecessary red-tape, and lower Utah’s too-high child uninsured rate. Providers, plans and agencies are already spending the time and money enrolling children in Medicaid; we should make sure kids don’t then unnecessarily lose their coverage and care. We urge the Department to move forward with implementing 12-month continuous eligibility for children in Medicaid.

2. Medicaid Outreach & Enrollment Funding

It is critical that the Department invest in outreach and enrollment funding to children, especially for Latina/o or Hispanic children. The Department once had dedicated funding for outreach, but these funds were cut during the recession - and we are seeing the effect today. Utah continues to have one of the highest rates of uninsured children in the nation, highest rate of uninsured Latina/o children, and highest rate of children eligible, but unenrolled, in CHIP or Medicaid. All of this speaks to a clear need for dedicated outreach funding.

More recently, the delays in CHIP renewal last year created confusion among many families; anecdotally we heard that it may have caused some families to avoid enrolling their children in programs altogether. Moreover, the loss of the CHIPRA grant, as well as significant cuts to the state’s navigator and assistor grant have severely diminished available funding to help families learn about affordable health care options for their kids. The Legislature’s one-time allocation for outreach funding in 2016 was a promising start, but now it is time to continue the work started. We ask that the committee prioritize outreach funding, so the Department can renew its commitment to helping Utah kids and families in need get connected with affordable care.

3. Oral Health Coverage and Care

Preventive Dental Assessments in a Public Health Setting

Every year, tens of thousands of Utah children will experience cavities and dental decay. Tooth decay is one of the top reasons kids miss school, but it is also one of the most preventable chronic diseases among children. Preventive oral health care helps kids avoid tooth decay. But unfortunately, we see serious health disparities among Utah children. Low-income children, children of color and children in rural areas are more likely to report unmet dental health care needs.

To address these needs, we are asking the Department to open and reimburse for dental codes that support greater access to preventive care in public health settings, like schools and early childcare centers. Places where we know it’s easy for kids and families to get their initial care. Specifically, the code D0191 is a preventive assessment that can increase access to care for low-income or vulnerable populations. These codes have the potential to allow more health care providers to offer preventive services, such as school-bases sealant programs. The intent is not to replace a child’s comprehensive exam, but instead to ensure a child can be assessed and then connected with a dental home for a full exam.²

We can make it easier for kids to get connected with preventive dental care. Reimbursing for a preventive assessment in a public health setting will help increase access to care in schools or childcare, and reduce poor health outcomes.

health outcomes for children, ultimately saving Medicaid money that will be spent on costly restorative oral health care like fillings or extractions.

**Adult Dental Health Benefits**

More broadly, adult Medicaid beneficiaries should also be able to access dental care. Children enrolled in Medicaid have a dental benefit; but their parents or caregivers may not have this benefit. Oral health affects all aspects of a person’s life. When people do not have access to dental insurance, their whole family is at greater financial risk. Adult Medicaid beneficiaries should have access to a dental benefit.

Thank you, Committee, for your consideration of these recommendations.
Utah Community Health Worker Coalition

MCAC June 2018

Medicaid Reimbursement for Community Health Workers (CHWs) in Utah

We respectfully request that the Medical Care Advisory Committee support the efforts of the Community Health Workers in Utah and the Community Health Worker Coalition by:

- Supporting formal recognition of Community Health Workers by the Utah State Legislature as vital members of the workforce in the State of Utah.
- Supporting Medicaid reimbursement for services provided by CHWs through a State Plan Amendment, 1115 Waiver Amendment, ACO contract modifications, administrative agreement with community health organizations, targeted programmatic application, and/or another mechanism deemed most appropriate by Medicaid.

According to the 2018 US Department of Labor’s Bureau of Labor Statistics a Community Health Worker is defined as persons who:

“Assist individuals and communities to adopt healthy behaviors. Conducts outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. May provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. May collect data to help identify community health needs.” 1

CHWs are trusted members of the community they serve, and act as liaisons between their community and health and social services. They understand the culture and language of the community where they live and work.

In the past, much of the reimbursement for the CHW services was tied to grant funding. In 2013, the Centers for Medicare and Medicaid Services (CMS) created a new rule which allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. The new rule for the first time offers state Medicaid agencies the option to reimburse for more community-based preventive services, including those of CHWs. The rule went into effect on January 1, 2014. 2,3

Utah currently does not have a standardized financial structure for CHWs. Although there are many community-based organizations that employ CHWs, the wage structure and sustainability of these positions depend heavily on grant funding. 1 One such organization is Holy Cross Ministries. In calendar year 2017 Holy Cross Ministries served 1,388 clients through their community health workers program. Holy Cross Ministries focuses on helping people from socioeconomic disadvantaged background access critical services such as health care services and health insurance. In 2017 Holy Cross Ministries promoters connected 326 clients to basic needs services and 83% successfully acquired them.
They also supported 553 clients to obtain health care access services and/or health care coverage. 89% of these clients successfully obtained health care services and or health insurance coverage. Holy Cross Ministries also conducted 121 prenatal education classes to improve health outcomes of mother and baby. Post-partum data shows that 96% of women who attended classes report no post-partum depression symptoms. 99% of all newborns have up-to-date immunizations and 88% of mother’s report that their babies have “excellent” health. This is just one example that shows the impact one agency that employs CHWs has in a community. As cited in the Leavitt Partners White paper, it is estimated that Utah had 550 CHWs in Salt Lake and Ogden in May 2016. Imagine the impact they have!

Nationwide, there is considerable information on the return on investment for the work that is done by CHWs. As cited in Leavitt Partners Utah Department of Health White paper “Many studies have been performed in the United States to inform the value that CHWs bring to the health care system and patient experience. CHW interventions have been shown to improve outcomes for patients with chronic conditions, enhance disease prevention, reduce 30-day hospital readmissions, improve mental health, promote positive lifestyle behavior change, increase linkages to primary care, decrease hospital costs, and increase patient and provider satisfaction. Estimated savings from CHW interventions range from $1.81 to $5.58 for every $1.00 spent.” The following are just a few of the many examples demonstrating the positive impact CHWs have on decreasing health care costs and improving health outcomes:

**Social Return on Investment: CHWs in Cancer Research:** Wilder Research Center’s 2012 cost-benefit analysis of CHW services in cancer outreach found that for every dollar invested in CHWs, society receives $2.30 in return in benefits, a return of more than 200%.

**The Effectiveness of a Community Health Worker Outreach Program on Healthcare Utilization of West Baltimore City Medicaid Patients with Diabetes, with or without Hypertension:** shows that a CHW intervention program resulted in average savings of $2,245 per patient, and a total savings of $262,080 for 117 patients, along with improved quality of life.

**Measuring Return on Investment of Outreach by Community Health Workers:** a Denver Health study of 590 men in a CHW case management intervention shows increased use of primary and specialty care, and reduced use of urgent care, inpatient and outpatient behavioral health care use. The return on investment (program costs vs. overall reduced costs of care) was 2.28:1.

**A Community-Based Asthma Management Program: Effects on Resource Utilization and Quality of Life:** a CHW asthma intervention in Hawaii shows a decline in emergency room visits and increased quality of life. In one phase of the study, asthma-related per capita charges decreased from $735 to $181.

In addition to the return on investment data, work is being done in Legislation nationwide to help fund the incredible work that is being done by CHWs. The list below shows what some states are doing:

**New Mexico:** Through a Medicaid 1115 Waiver, Centennial Care has leveraged contracts with Medicaid managed care organizations (MCOs) to support the use of CHWs in serving Medicaid enrollees. CHW salaries, training, and service costs are MCO administrative costs and embedded in capitated rates paid to Medicaid managed care organizations.
Utah Community Health Worker Coalition

Washington: Washington’s **1115 demonstration** allows CHWs to be paid as a part of Medicaid value-based payment. CHWs can be part of Washington’s Health Homes, which allows them to receive Medicaid funding for each patient served. According to the National Center for Healthy Housing’s case study on **Medicaid Reimbursement for Home-Based Asthma Services**, CHWs provide environmental home assessments through a program supported by the Environmental Protection Agency.

Oregon: The **State Plan Amendment (SPA)** that created Patient-Centered Primary Care Homes (PCPCHs) explicitly includes CHWs in its description of providers for four of the six core Health Home services. CCOs currently provide care within Medicaid but are being expanded to other groups. CCOs are required to include “non-traditional healthcare workers” like CHWs on their care teams. CHWs must be certified to qualify for Medicaid reimbursement. A health professional must supervise a CHW in order for Medicaid to reimburse for services provided.

Texas: The **Health and Human Services Commission** (Medicaid agency) contracts with MCOs and allows CHW costs to be included in administrative costs in order to receive reimbursement. A 2016 HHSC survey of Texas Medicaid found 18 of 19 MCOs employing CHWs or contracting for CHW services. CHWs are incorporated in a number of quality improvement projects under the state’s **1115 waiver**. Clinics and hospitals use waiver funds to hire CHWs. The **Title V Maternal and Child Health block grant** supports the Promotor(a) or Community Health Worker Training and Certification Program, and also supported Zika education for CHWs in 2017.

Minnesota: Health plans that contract with Minnesota’s Medicaid agency to provide services to Minnesota Health Care Programs enrollees are required to cover diagnosis-related patient education on self-management services provided by certified CHWs working under clinical supervision. The state Medicaid program also reimburses CHWs on a fee-for-service basis as well as via managed care plan payments. CHWs also provide mental health patient education and care coordination pursuant to a Medicaid state plan amendment.

Nevada: Nevada’s CHW Program is funded through the **Preventive Health and Health Services Block Grant** through the Center for Disease Control and Prevention. **SB 498** passed in 2015 mandates the licensure of CHW Pools, which are organizations or agencies that hire CHWs. The law does not provide for individual CHW certification or licensing.

Thank you for your time and consideration of this request.

References


4. Leavitt Partners and Utah Department of Health White paper: “Driving Improvements in Utah’s Health Outcomes: the community health worker solution”


<table>
<thead>
<tr>
<th>Role</th>
<th>Sub-Roles</th>
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<tbody>
<tr>
<td>1</td>
<td>Cultural Mediation among individuals, Communities, and Health and Social Service Systems</td>
</tr>
<tr>
<td></td>
<td>a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate)</td>
</tr>
<tr>
<td></td>
<td>b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Service [CLAS] standards)</td>
</tr>
<tr>
<td></td>
<td>c. Building health literacy and cross-cultural communication</td>
</tr>
<tr>
<td>2</td>
<td>Providing Culturally Appropriate Health Education and Information</td>
</tr>
<tr>
<td></td>
<td>a. Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community</td>
</tr>
<tr>
<td></td>
<td>b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)</td>
</tr>
<tr>
<td>3</td>
<td>Care Coordination, Case Management, and System Navigation</td>
</tr>
<tr>
<td></td>
<td>a. Participating in care coordination and/or case management</td>
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<td></td>
<td>b. Making referrals and providing follow-up</td>
</tr>
<tr>
<td></td>
<td>c. Facilitating transportation to services and helping to address other barriers to services</td>
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<tr>
<td></td>
<td>d. Documenting and tracking individual and population level data</td>
</tr>
<tr>
<td></td>
<td>e. Informing people and systems about community assets and challenges</td>
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<tr>
<td>4</td>
<td>Providing Coaching and Social Support</td>
</tr>
<tr>
<td></td>
<td>a. Providing support and coaching</td>
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<tr>
<td></td>
<td>b. Motivating and encouraging people to obtain care and other services</td>
</tr>
<tr>
<td></td>
<td>c. Supporting management self-management of disease prevention and management of health conditions (including chronic disease)</td>
</tr>
<tr>
<td></td>
<td>d. Planning and/or leading support groups</td>
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<td>Advocating for Individuals and Communities</td>
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<tr>
<td></td>
<td>a. Advocating for the needs and perspectives of communities</td>
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<tr>
<td></td>
<td>b. Connecting to resources and advocating for basic needs (e.g. food and housing)</td>
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<tr>
<td></td>
<td>c. Conducting policy advocacy</td>
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|   | Building individual and Community Capacity | a. Building individual capacity  
b. Building community capacity  
c. Training and building individual capacity with CHW peers and among groups of CHWs |
|---|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
|   | Providing Direct Service                  | a. Providing basic screening test (e.g. heights and weights, blood pressure)  
b. Providing basic services (e.g. first aid, diabetic foot check)  
c. Meeting basic needs (e.g. direct provision of food and other resources) |
|   | Implementing Individual and Community Assessments | a. Participating in design, implementation and interpretation of community-level assessments (e.g. home environmental assessment)  
b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping) |
|   | Conducting Outreach                        | a. Case-finding/recruitment of individuals, families, and community groups to services and systems  
b. Follow-up on health and social service encounters with individuals, families, and community groups  
c. Home visiting to provide education, assessment, and social support  
d. Presenting at local agencies and community events |
|   | Participating in Evaluation and Research   | a. Engaging in evaluating CHW services and programs  
b. Identifying and engaging community members as research partners, including community consent process  
c. Participating in evaluating CHW services and programs  
1) Identification of priority issues and evaluation/research questions  
2) Development of evaluation/research design and methods  
3) Data collection and interpretation  
4) Sharing results and findings  
5) Engaging stakeholders to take action on findings |
May 17, 2018

RE: Medicaid Reimbursement for Community Health Workers (CHWs) in Utah

To Whom It May Concern,

The Division of Substance Abuse and Mental Health would like to express our support for the Utah Community Health Worker Coalition proposal. This includes a request for formal recognition of Community Health Workers by the Utah State Legislature, and consideration of Medicaid reimbursement for services provided by CHWs through the mechanism deemed most appropriate by Medicaid.

CHWs work hand-in-hand with Certified Peer Support Specialists, Family Resource Facilitators, and other paraprofessionals to address barriers to healthcare for individuals and families. CHWs also address health issues on a community-wide basis. Formal recognition and development of the Community Health Worker program supports the “Utah Life Elevated 2020” objective of training a qualified workforce to meet the healthcare demand. In addition, CHW programs have been shown to improve the quality, efficiency and effectiveness of services in culturally diverse settings, and with vulnerable and underserved populations. This includes individuals with mental health and substance use disorders.

Therefore, we encourage the Medical Care Advisory Committee to support this proposal.

Sincerely,

Doug Thomas, Director
Division of Substance Abuse and Mental Health
12 June 18

The Medical Care Advisory Committee

TO WHOM IT MAY CONCERN:

Please accept this letter of support for sustainable financing to support Community Health Workers in Utah.

Perhaps one of the best things we can do to effectively deal with many of the health disparities in our community is to enlist Community Health Workers. For several years we made a difference in our community with Community Health Workers who contacted and helped those in our community to receive better health care. Medicaid funding from the State Legislature needs to be broader and more inclusive.

Among other things, Community Health Workers make individual and personal contact with the least, the last and the lost. They developed meaningful relationships with individuals who need the support. The listened to their concerns and help them make good decisions about their diet, mobility, treatment, and other health considerations.

Let’s work together to make the needed changes. Our state is in the position to be helpful and we urge you as our representatives to do all you can for all of the people. Thank you in advance for what you are going to do.

Sincerely,

France A. Davis, Pastor
## FMS Rate Increases for Non-DSPD Programs

### Proposed Rate: $95.24

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**DOH Funds Total: $38,558.91**

**DHS Funds Total: $17,658.31**

**Total Funds Required: $56,217.22**
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ACO Rates - S9122

ACO Rates - T1000
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### FFS Rates - T1001

- **UB**
- **UA**
- **(San Juan)**
- **(Grand)**
- **TN**
- **(No Modifier)**

### FFS Rates - T1019

- **UB**
- **UA**
- **(San Juan)**
- **(Grand)**
- **TN**
- **(No Modifier)**

### FFS Rates - T1021

- **UB**
ASTHMA HOME VISITING PROGRAM
A free program to help you learn about asthma and make your home asthma-friendly.

VISIT 1
Learn about asthma symptoms, triggers, medications, and inhaler technique.

VISIT 2
Walk through your home to identify asthma triggers, then set goals to reduce these triggers.

VISIT 3
Discuss progress on controlling your asthma and reducing triggers.

CALL 1
You will get a phone call 6 months after completing visit 3 to talk about your questions or concerns.

CALL 2
You will get a phone call 12 months after completing visit 3 to talk about your questions or concerns.

Offered only in Salt Lake and Utah Counties.
For more information, contact
Salt Lake County Health Department (385) 468-5285
Utah County Health Department (385) 309-3350
IN THEIR WORDS
Testimonials from Participants

“It feels like I can do this now. I wouldn’t have made it through the last few months if it wasn’t for you. You are amazing!”

“I love seeing the transformation in families over the course of our visits. They earn their lives back! Seeing our families start out lost, confused, and scared and then seeing them confident and relieved is one of the most rewarding parts of my job.”

“We learned quite a few things we can change, even though we’re pretty knowledgeable on the subject.”

“We are happier! Plans happen, dates occur, friends play. Life is different.”

“It used to be a way of life for [our daughter] to get sick... But after getting educated on her inhalers, and having our home inspected, things changed. In 7 months of school, she’d missed a whopping 27 days of 1st grade. After the asthma visits and implementing what we learned, she missed only two more days of school related to completely unrelated health issues. We are happier! Plans happen, dates occur, friends play. Life is different.”

MEET OUR HOME VISITORS

Andrea Jensen, AE-C, CHES
Utah County Health Department

“Having managed my children’s asthma for the last 17 years, I know how hard it can be without having someone to guide you. I enjoy helping families get the tools and information needed to feel comfortable managing asthma.”

Tiffany Brinton, CHES
Salt Lake County Health Department

“I love seeing the transformation in families over the course of our visits. They earn their lives back! Seeing our families start out lost, confused, and scared and then seeing them confident and relieved is one of the most rewarding parts of my job.”
Homecare Medicaid Rate Increase
(Request Justification)
Matt Hansen, President & Board Chair
Beth Noyce, Executive Director
Ed Dieringer, Government Outreach Chair
Clay Watson, Vice President

- Homecare remains the lowest cost healthcare alternative: The average cost of in-home care is about 50% of nursing home cost.\(^1\) A full year of in-home services often costs less than one hospitalization.

- In the past 12 years, there has been one Medicaid increase for homecare services, and that was 6 years ago. According to the Bureau of Labor Statistics, the Consumer Price Index for Medical services has increased 18% since the last Utah Medicaid rate increase for Homecare in 2012, and 48% since the last rate increase for Homecare in 2006.\(^2\) Services are more costly and access more limited in rural settings.

- Homecare has significant shortages of quality employees due to low wages. Agencies have been unable to increase caregiver wages to meet market demands because Medicaid reimbursement rates have not been adjusted.

- 3 years ago, the average Home Health Aide hourly pay rate in Utah was $10/hour. Today, the hourly rate for a Home Health Aide is $12 - $14/hour, with many agencies having to pay higher rates and greater benefits to remain competitive. These payroll rates do not include increased workers’ compensation insurance, taxes, new labor laws related to overtime, travel/mileage or new technology requirements (e.g. Electronic Visit Verification)\(^3\) which would add an additional 30-35% to the base rate.

- Caregiver turnover has risen from 39% in 2009 to 66% in 2017.\(^4\) The average Home Health Aide works for less than one year\(^5\), increasing costs in training and recruitment, along with greater coverage gaps for patients.

- The Department of Health shows Utah’s Medicaid programs have grown by 100,000 enrollees in the past 10 years, culminating in about 280,000 eligible individuals per year;\(^6\) the Medicaid expansion bill could extend coverage to 90,000 more low-income adults.\(^7\)

- Lack of staffing for support services can lead to institutionalization of more beneficiaries in order to receive necessary care.

- Cost of admission to a skilled nursing facility, per admission is 2.5 times higher than home care for the same time frame.\(^8\)

- By 2020, 56 million Americans will be 65 and older; by 2050, that number will reach 84 million.\(^9\)

- Nine out of ten Americans 65 and older want to stay at home for as long as possible, and 80% think their current home is where they will always live.\(^10\)

- Nearly 70% of Americans who reach 65 will be unable to care for themselves at some point without assistance.\(^11\)

- AARP estimates that the ratio of potential family caregivers to those over 80 will decrease from 7:1 today to 4:1 by 2030, and to less than 3:1 by 2050.\(^12\)

- More family members are living farther away from each other. On average, adults aged 60+ with one or more adult children live more than 280 miles from their nearest child.\(^13\)

We Need Your Support.
References:


4 Researched online at www.homecarepulse.com on June 12, 2018.

5 Home Health Aide Salaries in Utah. Found online at www.indeed.com June 12, 2018.


8 Ibid, Comparison of Long-term Care in Nursing Homes versus Home Health.


13 “Aging, Migration, and Local Communities: The Views of 60+ Residents and Community Leaders.” AARP. Page 130 (September 2006).

Vison Statement: Support Home Health Agencies in their efforts to provide for the well-being of Home Care patients.

Mission Statement: Promote Quality and Excellence through regulatory and legislative action, as well as the education of clinical and management principles.
Asthma is a chronic lung disease and is the most prevalent chronic disease for children. You cannot cure asthma, but you can learn to control it.¹

"It used to be a way of life for [our daughter] to get sick...But after getting educated on her inhalers, and having our home inspected, things changed. In seven months of school, she’d missed a whopping 27 days of first grade. After the [Asthma Home Visiting Program] asthma visits and implementing what we learned, she missed only two more days of school related to completely unrelated health issues.
We are happier! Plans happen, dates occur, friends play. Life is different."
- Participant’s Mother in Utah County

How Do You Control Asthma?

• Asthma guidelines-based clinical care and medication management²,³
• Self-management education²,³
• Home-based trigger assessment and remediation services²,³

Why do Utahns with Asthma End Up in the Emergency Department (ED)?

• Lack of access to asthma guidelines-based clinical care³
• Lack of access to asthma medications³
• Incorrect use of prescribed medications, including inhalers³
• Poor management of asthma symptoms³

How Much Does Asthma Cost Medicaid?

• In 2017, the average Medicaid cost for asthma-related ED visits was $1,186.83 per member.⁵
• Each year, Medicaid enrollees have around 2,011 asthma-related ED visits.⁶
• In 2014, asthma-related ED visits cost Medicaid an estimated $2.6 million.⁵

What is the Solution?

The Utah Asthma Home Visiting Program is an evidence-based program that provides targeted high-risk care management for individuals with persistent, uncontrolled asthma. The program aims to reduce preventable asthma ED visits and hospitalizations and improve asthma control and quality of life.²,³ To date, over 230 adult and children patients have entered the program.⁷ The program is offered by specially trained non-physician healthcare professionals using a standard curriculum and includes three home visit sessions that:
• Assess patients’ asthma knowledge and exposure to triggers in the home
• Provide asthma self-management education
• Assist patients to set goals to improve asthma management and reduce triggers in the home
The Utah Asthma Home Visiting Program requests Medicaid allocate $43,250 to cover costs for an additional 150 individuals with persistent, uncontrolled asthma to receive self-management education through the Utah Asthma Home Visiting Program. Program results include improved health outcomes and a possible cost savings of about $56,650 for Medicaid within 12 months after patients complete the program.

The Utah Asthma Program suggests opening the CPT codes 98960, 98961, 98962, 99401, 99402, and/or 94664 to cover the costs of the home-based program.

The Asthma Prevalence is Higher Among Medicaid Members

- 8.5% of children on Medicaid have asthma compared to 5.8% of all Utah children.8
- 15.5% of adults on Medicaid have asthma compared to 8.3% of all Utah adults.8
- 22% of program participants have Medicaid insurance.7

The Utah Asthma Home Visiting Program is Effective

The Program Decreases ED Visits and Is Cost Effective

- 56% decrease in asthma-related ED visits from one year before the program to one year after completing the program.7
- For every $1 invested in the program, Medicaid is expected to save $1.31.7
- Average yearly program cost (visits 1, 2, and 3) per participant is $288.30.7,9

Patients Have Improved Asthma Control and Quality of Life

- 80% of patients showed improvement in their asthma control test from visit 1 to visit 3.7
- 52% of patients who achieved control in the program reported having controlled asthma 12 months after completing the program.7
- 47% of patients started using their controller medication more by visit 3, and 76% of patients reported increased confidence managing their asthma after the program.7,10

The Request for Medicaid Reimbursement Coverage

The Utah Asthma Program requests Medicaid allocate $43,250 to cover costs for an additional 150 individuals with persistent, uncontrolled asthma to receive self-management education through the Utah Asthma Home Visiting Program. Program results include improved health outcomes and a possible cost savings of about $56,650 for Medicaid within 12 months after patients complete the program.7

The Utah Asthma Program suggests opening the CPT codes 98960, 98961, 98962, 99401, 99402, and/or 94664 to cover the costs of the home-based program.11

References

5. Count of ED visits came from 2014 IBIS data. Average cost per member for each ED visit comes from 2017 Medicaid claims data.
6. 2012-2014 IBIS Data
8. 2016 BRFSS Data
9. Program costs include administrative and staff time, program materials, and supplies per patient.
10. Confidence is measured at intake and six months after completing the program.

Images courtesy of the Noun Project: Inhaler Icon by lastspark
Medical Care Advisory Committee
Expansion of ACO Counties – Mandatory Enrollment
June 21, 2018

The waiver providing authority for the Medicaid ACO program allows UDOH to expand mandatory enrollment to additional counties as long as multiple ACO options with adequate provider networks exist

- Two ACOs, Healthy U, and Molina Healthcare of Utah, are available today in all counties as a voluntary option
- The other two ACOs have started contracting with the hospitals and major medical groups in additional counties in order to expand as a voluntary plan option with hopes UDOH will expand mandatory enrollment counties
- The work to partner and align with important rural hospital and physician partners is underway by all ACOs

Utah ACOs save money and maintain quality – Increase state value by expanding ACO enrollment

- The Utah Coalition of Medicaid Plans unanimously agrees that the logical next step for ACO enrollment exists in the following counties with targeted Medicaid enrollment as follows. Enrollment could be effective as early as July 1, 2019.

<table>
<thead>
<tr>
<th>County</th>
<th>Medicaid Enrollees as of June 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbon</td>
<td>3,095</td>
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<tr>
<td>Duschesne</td>
<td>2,728</td>
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<td>San Juan</td>
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<td>Sanpete</td>
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<td>Sevier</td>
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<td>Uintah</td>
<td>4,116</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>19,199</strong></td>
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Experience from ACO enrollment expansion in new counties effective July 1, 2015

- ACOs effectively partnered with UDOH to ensure network adequacy for hospital, physician, and ancillary providers including home health and skilled nursing facility
- ACOs effectively managed care transitions in cooperation with UDOH to ensure continuity of care for each enrollee
- Overall provider response has been favorable
- The ACO model works – the value of reduced overall cost, improved quality, and improved satisfaction has been achieved

Request from Medicaid ACOs

- We request that UDOH conduct an evaluation to assess the impact of expanding enrollment in these counties
- We request that this evaluation include UDOH’s calculation of the one-time expense associated with medical and pharmacy expenses incurred but not paid prior to an anticipated move to the ACO model
- UDOH submit this expense as part of the consensus budgeting process later this fall
Medical Care Advisory Committee
Annual ACO Rate Increase
June 21, 2018

Utah is a leader in Medicaid accountable care and relying on Medicaid Accountable Care Organizations (ACOs) to achieve Medicaid cost savings and improved patient quality

- Under prior legislation (SB180), ACOs agreed to cap their costs to the growth rate of the state general fund, rather than to health care cost inflation.
- This provided affordability and budget predictability for the state, and incentives to the ACOs to innovate and implement strategies to contain costs.

Utah ACOs save money and maintain quality – Increase state value

- $44.4M has been placed in the stabilization account since SFY 2014. Additional dollars should be added this fall as state budget close is finalized.
- Medicaid ACOs have maintained clinical quality scores and consistently received high member satisfaction scores – outperforming most commercial insurance plans.

<table>
<thead>
<tr>
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<tbody>
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<td>Actual Appropriation Increase</td>
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<td>General Fund Growth Rate</td>
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<td>Milliman Medical Index (MMI)</td>
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</table>
A lack of appropriate ongoing funding above the historically funded 2% minimum threatens the ongoing viability of the ACO model in Utah

- UDOH must provide actuarially certified rates to CMS on an annual basis to ensure they meet a range between the CMS acceptable upper and lower bounds.

- Recently rates could not be certified initially because actual medical expense experience exceeded the funding available. Therefore an actuarial technique was used to certify the rates. The technique increases estimated ACO savings to a very high level, giving the appearance that funding is not needed. However, this only compounds the structural funding deficit, delaying funding needs to future rate certifications.

- Now is the time to appropriately tackle the growing funding deficit while the Utah economy and general fund growth is strong.

Request from Medicaid ACOs

- Ensure a minimum annual increase of 3.5% and evaluate whether the general fund growth rate provides an opportunity to increase this percentage up to 5% to reduce the cumulative systemic funding deficit.
## Request for Funding Increase

### Projected Fiscal Note

<table>
<thead>
<tr>
<th>Billing Code Reimbursement</th>
<th>Current Rates</th>
<th>Current Costs*</th>
<th>Proposed Rates/unit**</th>
<th>1 year projection of 100% ACO eligibles</th>
<th>Projected Additional Funding 2020</th>
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<tbody>
<tr>
<td>G0299 RN (per 15 min) (usually 2 units) 15 min/unit</td>
<td>$22.72</td>
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*Based on data from UAHC conglomeration of members.

**Request 3.5% increase on codes per year, for next five years (2020-2025)

### Total Additional Funding Needed

$4,470,491.01

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**UTAH ASSOCIATION FOR HOME CARE**

Matt Hansen, President & Board Chair
Beth Noyce, Executive Director
Ed Dieringer, Government Outreach Chair
Clay Watson, Vice President
**Request for Waiver Funding Increase**

**Projected Fiscal Note**

<table>
<thead>
<tr>
<th>Waiver Support Services Code</th>
<th>Reimbursement</th>
<th>Current Rates</th>
<th>Current Costs*</th>
<th>Proposed Rates/unit**</th>
<th>Projected Additional Funding Needed (multiplied by 20,000 units)</th>
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<tbody>
<tr>
<td>S5125-New Choice Waiver</td>
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<td>$ 22.56</td>
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*based on data from UAHC conglomeration of members.

**Request 3.5% increase on codes per year, for next five years (2020-2025)**

**Total Additional Funding Needed (estimate)**

$ 4,403,000.00
## Medicaid Physical Therapy Reimbursement

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### Scenario: Therapy for Knee Replacement

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**Total Reimbursement**

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**Follow Up Treatment / Visits CPTs**

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**Total Reimbursement**

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**Total Reimbursement**

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6/14/18

Dear MCAC Committee Members:

The Utah Music Therapy Association is exploring ways to make it possible for music therapists in Utah to become approved medicaid providers. Clients and facilities across the state are requesting better access to this service. Here is some information to help provide more insight into this important issue.

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Individuals who complete one of the 70+ approved college music therapy curricula, including 1200 hours of clinical training, are eligible to sit for the national examination offered by the Certification Board for Music Therapists (CBMT). Music therapists who successfully complete the independently administered examination hold the music therapist-board certified credential (MT-BC). Please visit www.musictherapy.org for more info on populations, domain areas, and how music therapy works.

With over 60 years of clinical history in the U.S., Music Therapy currently receives national and state recognition in the following ways:

- In the states of **Arizona, Colorado, Idaho, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Pennsylvania, Texas, and Wisconsin** music therapy has been a covered service under **Medicaid** and other disability waiver programs (i.e. Autism, PACE, Developmental Disabilities, Traumatic Brain Injury). The State of Idaho for example covers music therapy for both adults and children with developmental delays when they are on the program called Family Directed Services (for children) or Self Directed Services (for adults). In these programs, clients receive a budget from the state, then submit to the state which therapies they will be using the money for. Music therapy is normally used to address communication, social skills, emotional expression and awareness goals for Medicaid clients.

- In addition to waiver program examples listed above, other states have utilized state and county agency funds to cover the provision of music therapy interventions in a variety of settings. These states include: **California, Georgia, Hawaii, Nevada, Ohio, South Dakota, Virginia, and Washington**.

- Music therapists are already able to bill using existing **CPT codes** that overlap skills that can be addressed in other therapies such as physical and speech.

- The **United States Code** lists music therapy as a disease prevention and health promotion service and as a supportive service under Title 42: The Public Health and Welfare; Chapter 35: Programs For Older Americans; Subchapters I and III.

- Music therapy is listed on the **U.S. General Services Administration (GSA)** schedule under PROFESSIONAL AND ALLIED HEALTHCARE STAFFING SERVICES:
Music therapists are eligible to apply for the National Provider Identifier system for billing under taxonomy code 225A00000X, which is included in the category of “Respiratory, Developmental, Rehabilitative and Restorative Service Providers”.

Music therapy has a Procedure Code of 93.84 in the International Classification of Diseases-9th Revision Manual (ICD-9) used in reimbursement.

CMS recognizes music therapy for Medicare reimbursement in Partial Hospitalization Programs (PHP). Music therapy is included under the Healthcare Common Procedure Coding System (HCPCS) Code G0176 for billing purposes.

CMS recognizes music therapy on the revised Minimum Data Set (MDS) 3.0 assessment tool utilized for Medicare and Medicaid billing in skilled and residential nursing facilities.

Music therapy is a related service under IDEA and can be included on IEPs if found necessary for a child to benefit from his/her special education program. The U.S. Department of Education continues to provide policy guidance regarding recognition of music therapy as a related service under IDEA, most recently in a June 2010 document titled, “Questions and Answers on Individualized Education Programs (IEPs), Evaluations, and Reevaluations.”

In addition, state certification for music therapists which will help protect music therapy as a profession and is a step towards licensure has been approved in Connecticut, Georgia, New York, Nevada, North Dakota, Oklahoma, Oregon, Rhode Island, Utah, and Wisconsin.

Music therapy is a cost-effective and efficient. Board Certified Music Therapists are able to address multiple domains in one session i.e., communication, motor, and cognitive skills as well as offer group therapy to target multiple clients’ needs in a session. Music therapy also deals with the behaviors and psychosocial issues that often present barriers to meeting almost all other needs of the client. The cost savings realized by these interventions demonstrate one way to effectively utilize taxpayers’ money, which we know is always a primary concern. Reimbursement for music therapy is generally comparable to physical, occupational and speech therapy rates. A list of research studies can be provided upon request.

We hope this information is helpful as you consider the best method for including music therapy in Utah’s Medicaid program and thank you for your consideration and attention to this important matter. We welcome your questions and look forward to future opportunities to discuss the benefits of music therapy for the residents of Utah.

Sincerely,

Judy Simpson, MT-BC
Managed Healthcare Professional (MHP)
AMTA Director of Government Relations
Utahans receiving services through one of several Medicaid Waivers or the EPAS program have the option—or—in some cases—the requirement to receive services in a Self-Administered Services (SAS) model, rather than from a typical service provider agency. The SAS model allows an individual, or their representative, to hire their own employees, rather than hiring a service provider agency. The individual then selects a Fiscal Management Service Provider who assists them with:

**Employer Enrollment Services including**
- Obtaining a Federal Employer Identification Number (EIN)
- Appointment of Agent
- Authorization of tax information disclosure
- IRS Forms 2678, 8821, SS-4

**Employee Enrollment Services including**
- Processing fingerprints and background screening
- Determining and setting wage rate
- Copy identification
- Completion of the I-9 and W-4
- eVerify
- Informing employees of training requirements and processes
- Direct Deposit
- Process time cards and payroll
- W-2s
- Annual background screening reminder letter and processing

Fiscal Intermediaries do not receive an enhanced rate when a program participant employs multiple employees. The FMS receives the same Per-member Per-month rate for a program participant with one employee as they do for a program participant with fifteen employees.

The 2016 Utah State Legislature appropriated $250,000 to increase FMS service rates. This appropriation was only applied to the three DSPD Waiver programs. The resulting disparity in FMS rates has left customers with little choice in FMS providers, and a troubling decision for Fiscal Intermediary agencies. New unfunded federal EVV mandates have exacerbated an already tenuous situation. We are asking the MCAC to prioritize an effort to achieve parity within the Fiscal Intermediary and Waiver systems.

### FMS Rate Increases for Non-DSPD Programs

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<th>Agency</th>
<th>Fiscal Year</th>
<th>Program</th>
<th>Units (YTD)</th>
<th>Estimated Units</th>
<th>Unit Rate</th>
<th>Current Estimated Costs (State Funds)</th>
<th>Estimated Cost with New Rate (State Funds)</th>
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2010 Utahans with special care needs utilize Self-Administered Services.

Utah contracts with three (3) Fiscal Intermediary Providers:

- Acumen
- Leonard Consulting
- Morning Sun

The National average rate for FMS or FI Services is $98.10

Utah’s rates are highly disparate; between $48.00 and $95.24

2017 Analysis by the Department of Health:
PA Enrollment under Utah Medicaid as Rendering Providers

Physician assistants practice medicine as members of physician-led teams. As dedicated healthcare professionals, PAs are committed to the wellbeing of their patients. When considering methods to increase access to care in a cost-effective manner, it is imperative that PAs not be overlooked as policies and regulations are promulgated.

PAs must be recognized as enrolled rendering providers in Utah’s Medicaid program. The following reasons demonstrate why Utah Medicaid must amend its regulations and policies to reflect the role of PAs in Medicaid.

- **PA enrollment is about accountability**
  Utah PAs are hidden providers under the state’s Medicaid program, as services they perform are currently attributed to their collaborating physician. Claims submitted for services provided by PAs do not currently allow a PA’s name and NPI to be included to indicate who actually rendered the service. This system prevents patients, regulators, employers, and legislators from knowing which healthcare professional is accountable for a patient’s care.

- **PA enrollment is about transparency**
  Because of the fact that Utah PAs are hidden providers, inaccurate data is delivered to policymakers on workforce and network adequacy considerations. This can lead to an inefficient allocation of taxpayer resources.

- **More states are enrolling PAs in Medicaid**
  Forty-three states and DC require enrollment of PAs as rendering providers in the Medicaid program, authorizing them to use their own provider number on Medicaid claims to indicate that they have rendered the service. This number is expected to continue to grow.

- **PA enrollment in Medicaid may increase access to care**
  Enrollment of PAs in Medicaid ought to lead to the identification of PAs in provider directories. This clear identification of health professionals locally delivering care would make it easier for patients, especially those in underserved communities, to find care options, particularly in a time of worsening physician shortage.
• **No duplication of services or extra cost**
  The enrollment of PAs does not increase costs for the state Medicaid program or duplicate services. PAs are currently providing said services but billing under the physician’s provider number. Payment would continue to go to the employer.
1 in 4 Americans

Mental Health Peer Support Specialists

Peer Support Specialists use their own experience in living with a mental illness to help other individuals meet and achieve their own needs, wants and goals.\(^5\)

Why Mental Health Peer Support?

Mental health peer support specialist programs were originally designed to help people become *active mental health consumers* during the recovery movement in the early 2000s.\(^4\) Unlike other clinicians, we use our recovery story and our experience along with mental health resources. This helps us to reduce unnecessary hospitalization, help people in crisis, and assist clients in learning to manage their disorder.\(^1\)

Peer Roles

Mental Health Peer Support Specialists are required to have *the lived experience* with a mental health disorder. Walker and Bryant\(^6\) performed a meta-synthesis of studies in the US and Canada finding that:

- Clients often report that the peer is a role model.
- Clients find that peer support specialists are easier to talk to than other clinicians.
- Providers find that peer support workers help de-stigmatize mental illness.
- Non-peer staff experience learning from peer support workers.
- Peer support specialists often report that their job helps their own recovery.

The peer role brings with it some challenges:

- Peer support specialists report low pay and few hours.
- Mental Health Agencies do not hire CPSS because the reimbursement rate is so low
- Peers are not able to support themselves when working in the mental health field therefore many quit.
What Do Peer Support Specialists Do?

Peer Support Specialists work in residential, education and advocacy, crisis services, and psychiatric rehabilitation.3 There are many roles peer support specialists will fill2:

**Peer Bridger**—Are considered a Bridge for those in Jails, Prisons, and Psychiatric Units back into the community. SAMHSA and National Behavioral Health Council have reported a significantly lower rate of individuals returning and helps them find resources and provides support while they transition.

**Diplomat** — bridge staff, clients, and family by sharing one’s experience being in the position of the “patient”. Validate the seriousness and complexity of living and surviving a mental disorder.

**Mentor** —Help Peers Find Resources, Collaborating with Case Managers

**Support** — work with clients to set goals for a client to move forward with their life. Peers use their experience of fear, self-doubt, and risk taking to empathize with the client’s struggles.

**Advocate** — advocate for the client’s plans to recover even when the treatment team is unsupportive.

**Educator** — educate staff and peers. Lead recovery based groups.

**Whole Integrated Health Care**— this is a new grant that will be taking place for the first time in 2018 with CPSS working together with physical health doctors and clinicians to avoid the chronic disease that is often related to having a mental illness.

**ACT Teams**— members help the person address every aspect of their life, whether it be medication, therapy, social support, employment or housing. They are available 24/7 with a team of support that meet the individual wherever they are at in the community.

**Conclusion**

For some individuals who live with a serious mental illness, being able to tell your story is often the only defense one has against a barrage of unwanted psychiatric treatment. For others, the goals of living independently is desired, but hard to reach. And for many, it’s just nice to have the empathetic support.

Certified Peer Specialists provide a unique and key service of using the lived experience with Mental Health Conditions to **empower** other individuals with similar experiences to live more healthy, independent and meaningful lives.

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1. Adapted from: Fisher et. al Global Evidence for Peer Support
June 15, 2018

Medical Care Advisory Council
Martha Hughes Cannon Building
288 N. 1460 W.
Salt Lake City, UT

RE: Certified Peer Support Specialist Medicaid Reimbursement Rate

Dear Medical Care Advisory Committee,

The Department of Human Services (DHS) and Division of Substance Abuse and Mental Health (DSAMH) strongly recommend that the Medical Care Advisory Committee (MCAC) endorse an increase for the Medicaid reimbursement rate for Peer Support Services (H0038) to $13.64/15 min. Endorsement of Peer Support Services (PSS) is compatible with the advisory role of MCAC, as PSS have evolved into a critical element in the health care delivery for individuals receiving treatment for mental health and substance use disorders. With workforce shortages in behavioral healthcare the role of Peer Support on treatment teams becomes increasingly important.

Research has demonstrated that PSS have resulted in reduced inpatient service use, improved relationship with providers, better engagement with care, higher levels of empowerment, higher levels of patient activation, and higher levels of helpfulness for recovery.\textsuperscript{1,2,3} PSS support recovery and assist individuals gain employment, education, housing and maintain social relations\textsuperscript{2}. PSS can reduce cost of care by reducing psychiatric rehospitalizations\textsuperscript{3,4} and increasing the use of primary care over emergency services\textsuperscript{5}.

In addition to PSS cost effectiveness, the demand for PSS has increased steadily in the Utah Public Health system; PSS services increased by 7.7\% between FY15 and FY16, and by 6.2\% between FY16 and FY17. The percentage of Certified Peer Support Specialists (CPSS) who are employed has increased steadily from 32\% (January 2016) to 51\% (January 2017). There are 98 CPSSs and 44 Family Resource Facilitators currently providing services to individuals in treatment at the Utah Local Authorities. This exceeds the DSAMH Strategic Plan Goal 3.1 - Promote and establish Peer Support Services, Increase CPSS employed by 10\%.
Medical Care Advisory Council
RE: Certified Peer Support Specialist Medicaid Reimbursement Rate
6/15/18 – Page Two

In contrast, note that the current Utah Medicaid reimbursement rate of $8.19/15 min is dramatically lower than nearby states:

<table>
<thead>
<tr>
<th>State</th>
<th>PSS Reimbursement rate/15 minutes</th>
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<tbody>
<tr>
<td>Utah</td>
<td>$8.19</td>
</tr>
<tr>
<td>Idaho</td>
<td>$13.63</td>
</tr>
<tr>
<td>Nebraska</td>
<td>$11.50</td>
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<tr>
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<tr>
<td>Washington</td>
<td>$12.30</td>
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The recommended increase to $13.64/15 min (from $8.19/15 min) would make the rate equivalent to the Medicaid reimbursement rate for Targeted Case Management (TCM). Certified PSS and TCM have comparable requirements as both involve application to DSAMH, 40 hours of training, and passing a DSAMH exam with a score of 70 percent or above. Both positions also have experience requirements. TCM requires a high school diploma and 400 hours experience in human services or related field. CPSS requires lived mental health and/or substance use disorder experience and sustained recovery (typically at least one year).

DHS has goals that complement the Governor’s Office of Management and Budget’s strategies for SUCCESS. Increasing the reimbursement rate and the use of Peer Support Services will meet GOMB goals, as Peer Support Specialists assist individuals meet behavioral needs, and strengthen connections to education, employment, housing, and natural and informal supports.

Sincerely,

Ann Silverberg Williamson, Executive Director
Department of Human Services

Doug Thomas, Director
Division of Substance Abuse and Mental Health

Medical Care Advisory Committee  
State of Utah  
Ladies and gentlemen,

The Utah Behavioral Health Planning and Advisory Council (UBHPAC) strongly endorses an increase for the Medicaid reimbursement rate for Peer Support Services (PSS) to $13.64/15 minute.

The need for such an increase has been discussed multiple times over the last several months in our monthly council and council subcommittee meetings. At our last meeting held on June 7, 2018, our council unanimously voted to support the increase.

Our members include individuals who live with serious mental illness and have experienced firsthand the benefits of involvement of a Certified Peer Support Specialist (CPSS). Seeking help—especially the first time—from a mental health service provider can be an extremely intimidating experience. In fact, it’s been observed that some leave untreated and discouraged, which can lead to more frustration, pain, and then more severe problems down the road that cost greater amounts to treat.

The experiences of our members also indicate that the involvement of CPSSs between therapy sessions helps make the therapeutic process more effective and efficient. Individuals who can speak candidly of their personal challenges with a peer who is in recovery from mental illness helps promote hope. The combination of therapeutic sessions guided by a mental health therapist and recovery support from a CPSS is a powerful synergistic combination.

However, while the benefits of CPSS involvement are evident, we understand that the supply of CPSS applicants is not keeping up with the increased demand. We hear that low Medicaid reimbursement rates are a key factor. It appears that a meaningful increase in the reimbursement rate would facilitate the needed expansion of CPSS services.

We would be very pleased to provide testimony or other support for this increase.

Very truly yours,

Owen R. Ashton  
Chair, Utah Behavioral Health Planning and Advisory Council
Recipients Providers

Total Percent Change 2008-2017 Salt Lake County

Total Percent Change 2008-2017 Davis County
* Rural South Eastern Utah includes San Juan, Carbon, Grand, Emery, Sevier, Wayne, Kane,
Total Percent Change 2008-2017

- Recipients
  - Average Annual Percentage Growth: 238%

Average Annual Percentage Growth S

- Recipients
  - Average Annual Percentage Growth: 11%

Average Annual Percentage Growth中の

- Recipients
  - Average Annual Percentage Growth: 11%
and Garfield Counties
<table>
<thead>
<tr>
<th>Location</th>
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<tbody>
<tr>
<td>Statewide</td>
<td>48%</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>4%</td>
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<tr>
<td>Davis County</td>
<td>5%</td>
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</table>
Waiver for Individuals Age 65 and Older (Aging Waiver)


A repeated measures ANOVA determined that after two weeks of music therapy, symptoms of depression and agitation were significantly reduced. Multivariate analyses confirmed a relationship between music therapy and change in neuropsychiatric symptoms associated with dementia. Results suggest widespread use of music therapy in long-term care settings may be effective in reducing symptoms of depression and agitation.

New Choices Waiver


This review reveals three ways in which music influences the lives of community-dwelling older adults with dementia: 1) reduced agitation, 2) improved cognition, 3) enhanced social well-being. Music is a non-pharmacological alternative to improving quality of life for persons with dementia and a means to empower caregivers in new ways to provide care.

Physical Disabilities Waiver


Rhythmic Auditory Stimulation (RAS) is a technique where music is used as an external cue for organizing movement. RAS has been found to increase the efficacy of physical therapy because of the effect music and rhythm have on the central nervous system. This study observed the effects of RAS on ambulatory children with cerebral palsy who were receiving gait training. A paired-sample t-test demonstrated that participants receiving RAS from a therapist made more improvements in stride length, velocity, and cadence than the self-study group and the control group. Results suggest that music therapy can improve mobility for children and adults with physical disabilities such as cerebral palsy.
Acquired Brain Injury Waiver


Neurologic music therapy (NMT) is a systematic treatment method to improve sensorimotor, language, and cognitive domains of functioning via music. The effects of NMT in cognitive rehabilitation report promising results in improving executive function along with improvement in emotional adjustment and decreasing depressions and anxiety following TBI.

Medically Complex Children’s Waiver


Patterns of behavior used in speech and communication are also used in making music. This allows music to be used as a tool to develop communication skills, even in individuals who are nonverbal. Children with severe disabilities and complex medical needs often lose opportunities to develop social skills because of environmental and physical constraints. In this study, improvisational music therapy is used to give these children the opportunity to develop communication skills in an adaptive way. Music therapy was found to be helpful in practicing reciprocal interactions, allowing clients to exert control over their environments, and in motivating clients to participate in interacting with others.

Community Supports Waiver for Individuals with Intellectual Disabilities


This pilot study investigated the use of music therapy to increase three specific prosocial behaviors in adults with disabilities attending a day habilitation program. The social skills addressed were (a) initiating conversation, (b) participating in reciprocal exchanges, and (c) expressing emotions. Participants who engaged in music therapy demonstrated an increase in prosocial behaviors, suggesting that participation in music therapy increased social skill development in adults with disabilities.

State Autism Plan


Nine quantitative studies were included. Music and non-music treatments were measured. It was concluded in each case that clients treated with music improved significantly compared to non-music treatment.
Results of the 2017 Utah Music Therapy Poll

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program (American Music Therapy Association, 2018).

Out of the 95 Board Certified Music Therapists in Utah, 63 are practicing, with 56 of those holding the State Certification designation.

Music therapists assess emotional well-being, physical health, social functioning, communication abilities, and cognitive skills through musical responses; design music sessions for individuals and groups based on client needs using music improvisation, receptive music listening, song writing, lyric discussion, music and imagery, music performance, and learning through music; participate in interdisciplinary treatment planning, ongoing evaluation, and follow up (American Music Therapy Association, 2018).

Utah MT-BCs work in these settings:
Hospice...............................35%
Mental Health Facility...33%
Elder Care Facility...........31%
Private Pay Clients........31%
Schools.................................27%
Medical....................................25%

Populations served by Utah MT-BCs:
Aids, Dementia, Autism Spectrum, Behavioral Disorders, Cancer, Chronic Pain, Developmentally Disabled, Early Childhood, Eating Disorders, Older Adults, Forensic, Hospice/Palliative Care, Intellectually Disabled, Medical, Mental Health, Neurologically Impaired, Physical/Sensory Impairment, PTSD, Substance Abuse, Wellness

Music Therapy is happening in ALL Utah counties
22 companies in Utah employ full time MT-BCs.
69 companies in Utah contract with MT-BCs.
153 individuals hired the services of an MT-BC.

An estimated 22,560 people participated in either group or individual music therapy sessions.

Samples of facilities with music therapy programs:
Employment status of Utah music therapists:
  - Full time salaried employees: 15%
  - Full time hourly employees: 19%
  - Employed part time: 12%
  - Self-Employed: 46%
  - Combination of employed and self employed: 21%

Average salary for a full-time music therapist in Utah: $40,000/year

Education
Those who wish to become music therapists must earn a bachelor’s degree or higher in music therapy from an American Music Therapy Association (AMTA) approved program and have at minimum the entry level credential, MT-BC to ethically practice as a music therapist. The curriculum includes coursework in music, music therapy, biology, psychology, social and behavioral sciences, and general studies. Clinical skills are developed through 1200 hours of required fieldwork, including an internship in healthcare and/or education facilities. Once the music therapy degree is earned and internship is completed, the student is eligible to sit for a board certification exam to earn the entry level credential, MT-BC, (music therapist, board certified) from the credentialing body, the Certification Board for Music Therapists. (American Music Therapy Association, 2018).

Utah State University is the only school in Utah that offers a BS in Music Therapy. The program began in 1978, and USU currently employs two full time faculty and five MT-BC adjunct faculty. An average of 10 students graduate each year, with a high job success rate. However, many graduates choose to work outside of Utah due to more prevalent employment opportunities.

There are currently 5 clinical internship sites in the state of Utah, with the ability to serve up to 14 interns at any given time.

Resources
American Music Therapy Association: www.musictherapy.org
Board Certification for Music Therapists: www.cbmt.org
Utah Association of Music Therapists: www.uamt.org
Utah Medicaid Physical Therapy Access

Physical Therapists in the state of Utah receive the lowest reimbursement for the care of Medicaid patients in the Western United States. The Utah Medicaid Treatment rate for Physical Therapy has been relatively flat for the past 35 years. During the past 20 years the Physical Therapy treatment rate has been adjusted 2 times. In 2004 the rate was increased to $20.06 and in 2008 it was raised by $0.82 to $20.88 where it has remained.

- $20.88 is the total reimbursement for a Physical Therapy Treatment (which generally lasts 45 to 60 minutes).
- $20.88 is approximately 25% of what Medicare pays and 20% of the average collected from private insurance for a Physical Therapy Treatment.
- The Utah Medicaid Treatment rate covers less than 25% of the average cost of a Physical Therapy Treatment.
- Physical Therapists often limit or decline taking Medicaid patients due to the inability to cover costs.
- Utah Medicaid currently uses a unique Utah Medicaid billing code that is inclusive of all treatment elements rather than the standard CPT codes used for billing specific procedures and modalities.
- Using CPT codes for billing P.T. Treatment would allow Medicaid to manage costs through the standardized values that are applied to codes.
- CPT codes for billing P.T. Treatment could ease administrative burden on providers because it is the gold standard of defining care and billing third parties.

Provider Limitations

Low Medicaid reimbursement rates for physical therapy services cause some providers to limit the number of Medicaid patients they will see, creating limited access to physical therapy for these patients.

For example, our analysis of health care claims data indicates that among individual with back pain, privately insured patients were 20% more likely than Medicaid beneficiaries to have PT.

Back pain is the most common non-cancer pain condition seen in health care, and the most common diagnosis for which opioid pain medication is prescribed.

Recent guidelines from the CDC and other organizations emphasize the need for non-drug pain management alternatives, like physical therapy, as a strategy to reduce opioid prescribing.

Limiting access to physical therapy for Medicaid beneficiaries through low reimbursement may increase the risk that opioid pain management will be used instead.