

---

---

COMPENDIUM OF BUDGET INFORMATION  
FOR THE  
2005 GENERAL SESSION

JOINT APPROPRIATIONS SUBCOMMITTEE FOR  
HEALTH AND HUMAN SERVICES

OFFICE OF THE LEGISLATIVE FISCAL ANALYST  
SPENCER PRATT  
DECEMBER 10, 2004

---

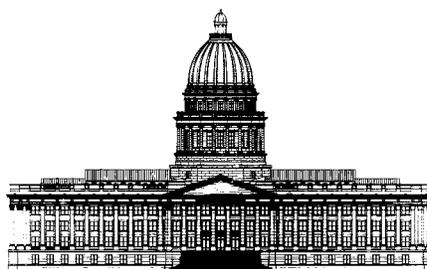
---



---

---

UTAH STATE LEGISLATURE  
COMPENDIUM OF BUDGET INFORMATION  
FOR THE  
2005 GENERAL SESSION



JOHN E. MASSEY, DIRECTOR

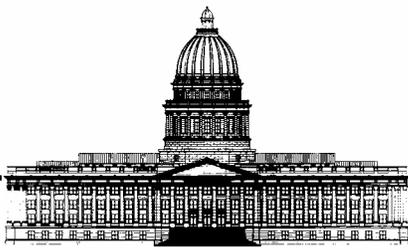
OFFICE OF THE LEGISLATIVE FISCAL ANALYST  
W310 STATE CAPITOL COMPLEX  
SALT LAKE CITY, UTAH 84114-5310

801-538-1034  
[WWW.LE.UTAH.GOV](http://WWW.LE.UTAH.GOV)

---

---





JOHN E. MASSEY  
LEGISLATIVE FISCAL ANALYST

## OFFICE OF THE LEGISLATIVE FISCAL ANALYST

---

W310 STATE CAPITOL COMPLEX • P.O. BOX 145310  
SALT LAKE CITY, UTAH 84114-5310 • WWW.LE.STATE.UT.US/LFA  
PHONE: (801) 538-1034 • FAX: (801) 538-1692

December 1, 2004

Appropriations Subcommittee for  
Health and Human Services  
Utah State Capitol  
Salt Lake City, UT 84114

Dear Subcommittee Members:

I am pleased to present to you the first edition of the Utah Legislature's Compendium of Budget Information (COBI). I hope that it provides useful and thorough information upon which you can base your policy and budget decisions.

COBI is one part of a new three-pronged approach to staff budget analysis authorized by the Executive Appropriations Committee last spring. It is designed as a reference document from which you may garner details on Utah state government activities within your subcommittee's jurisdiction. It includes program descriptions, references to statutory authority, accountability information, and, of course, budget data. COBI sets a baseline against which you can evaluate budgets proposed during the 2005 General Session.

Parts two and three of the new budget format – Budget Briefs and Issue Briefs – will be available throughout the 2005 General Session beginning in January. Both are succinct, decision oriented papers that build on COBI, presenting future budgets rather than COBI's *status quo*. Budget Briefs will follow the structure of state government documenting proposals for current year supplemental and future year budget action. Issue Briefs will cut across "silos" to discuss subjects that impact the state independent of program structure.

If I or my staff can assist you further regarding COBI specifically, the new budget format generally, or any other matter, please do not hesitate to contact me at (801) 538-1034.

Sincerely,

John E. Massey  
Legislative Fiscal Analyst



**TABLE OF CONTENTS**

**INTRODUCTION.....III**

**CHAPTER 1 UTAH DEPARTMENT OF HEALTH ..... 1-1**

**CHAPTER 2 EXECUTIVE DIRECTOR’S OFFICE..... 2-1**

EXECUTIVE DIRECTOR’S OFFICE..... 2-4

PROGRAM OPERATIONS ..... 2-6

OFFICE OF THE MEDICAL EXAMINER ..... 2-7

BIOTERRORISM GRANTS ..... 2-8

CENTER FOR HEALTH DATA ..... 2-10

**CHAPTER 3 HEALTH SYSTEMS IMPROVEMENT ..... 3-1**

DIRECTOR’S OFFICE..... 3-5

EMERGENCY MEDICAL SERVICES ..... 3-6

CHILD CARE LICENSING ..... 3-10

HEALTH FACILITY LICENSURE, CERTIFICATION, AND RESIDENT ASSESSMENT..... 3-12

PRIMARY CARE GRANTS..... 3-13

**CHAPTER 4 WORKFORCE FINANCIAL ASSISTANCE PROGRAM ..... 4-1**

**CHAPTER 5 EPIDEMIOLOGY AND LABORATORY SERVICES ..... 5-1**

DIRECTOR’S OFFICE..... 5-4

CHEMICAL AND ENVIRONMENTAL SERVICES ..... 5-5

FORENSIC TOXICOLOGY..... 5-6

LABORATORY IMPROVEMENT ..... 5-7

MICROBIOLOGY ..... 5-8

COMMUNICABLE DISEASE CONTROL ..... 5-10

EPIDEMIOLOGY ..... 5-15

**CHAPTER 6 COMMUNITY AND FAMILY HEALTH SERVICES..... 6-1**

DIRECTOR’S OFFICE..... 6-4

HEALTH PROMOTION ..... 6-5

MATERNAL AND CHILD HEALTH ..... 6-17

CHILDREN WITH SPECIAL HEALTH CARE NEEDS ..... 6-24

**CHAPTER 7 HEALTH CARE FINANCING ..... 7-1**

DIRECTOR’S OFFICE..... 7-5

FINANCIAL SERVICES..... 7-5

MANAGED HEALTH CARE..... 7-7

MEDICAL CLAIMS ..... 7-8

ELIGIBILITY SERVICES ..... 7-9

COVERAGE AND REIMBURSEMENT..... 7-11

CONTRACTS ..... 7-12

**CHAPTER 8 MEDICAL ASSISTANCE..... 8-1**

MEDICAID BASE PROGRAM..... 8-5

TITLE XIX FUNDING FOR HUMAN SERVICES ..... 8-15

MEDICAL/DENTAL CLINICS ..... 8-16

**CHAPTER 9 CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) ..... 9-1**

**CHAPTER 10 LOCAL HEALTH DEPARTMENTS..... 10-1**

---

---

**GLOSSARY ..... A**  
    APPENDIX 1: BUDGETING TERMS..... A  
    APPENDIX 2: GLOSSARY OF HEALTH TERMS AND ACRONYMS ..... D  
    APPENDIX 3: DEFINITIONS OF MEDICAID CATEGORIES OF SERVICE..... V

**INDEX .....AA**

## INTRODUCTION

**Format**

During the 2004 Interim the Office of the Legislative Fiscal Analyst proposed a new budget analysis format to the Executive Appropriations Committee, which the committee unanimously approved. Budget analyses will now consist of three parts:

- **Compendium of Budget Information (COBI).** The document you are currently reading, the COBI will provide detailed information at a program level. It will be a resource for decision-makers desiring further detail or background information beyond the summary provided in the Budget Analysis. It will not contain recommendations.
- **Issue Briefs.** These relatively short documents (no more than a few pages) will discuss issues that transcend line items or perhaps even departments. For example, if the Analyst wished to present a concern with law enforcement, an Issue Brief may be the best format. The Analyst will prepare Issue Briefs just prior to the 2005 General Session.
- **Budget Briefs.** Another relatively short document, the budget brief will be used to highlight issues, recommendations, performance measures, and line item-level budget tables. The purpose of this document is to bring issues to the forefront and discuss the Analyst's recommendations. The Analyst will prepare Budget Briefs just prior to the 2005 General Session.

**Process**

The Office of the Legislative Fiscal Analyst (LFA) – a non-partisan office – serves both chambers of the Legislature by making independent budgetary recommendations, determining the fiscal impact of proposed legislation, and preparing appropriations bills. Appropriations subcommittees review LFA's recommendations, vote upon, and report to the Executive Appropriations Committee proposed budgets for programs within their respective jurisdictions. The Executive Appropriations Committee, and ultimately the Legislature as a whole, considers multiple appropriation acts that, in turn, determine the final annual budget for each program of state government.

**Timing**

Utah does not budget on the calendar year, but on what is termed a Fiscal Year, which is the twelve-month period from July 1 to June 30 of the following year. A Fiscal Year is usually abbreviated FY, with the number which follows designating the year which includes the second six months. The current fiscal year is FY 2005, which will end June 30, 2005. The next fiscal year for which the Legislature is determining the budget is FY 2006, which will include the period of time from July 1, 2005 to June 30, 2006. However, the Legislature can also make supplemental changes to the already established budget for FY 2005.

**Sources**

In allocating funds for governmental purposes, appropriations subcommittee may use funding from several sources to complete the full appropriation to each. The following funding sources have been most prevalently used by the subcommittee:

- General Fund
- School Funds
- Transportation Funds
- Federal Funds
- Dedicated Credits
- Restricted Funds
- Other Funds

A glossary of terms – included at the end of this document – defines these funding sources as well as other terms commonly used in Utah state budgeting.

**CHAPTER 1 UTAH DEPARTMENT OF HEALTH**

<b>Function</b>	<p>The Utah Department of Health's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.</p> <p>Local Health Departments (LHDs) cover all areas of the state and provide local public health services. The State utilizes the local health departments to administer many of the services required by state law.</p>
<b>Statutory Authority</b>	<p>The Utah Department of Health is governed by the Utah Health Code, Title 26 of the Utah Code.</p> <ul style="list-style-type: none"><li>➤ UCA 26-1 authorizes and establishes the Department; authorizes the Health Advisory Council; and outlines the powers and duties of the department.</li><li>➤ UCA 26-18 creates the Medical Assistance Act, the joint federal/state program that provides healthcare services to select population, commonly known as “Medicaid”.</li><li>➤ UCA 26-23 grants enforcement authority and penalty provisions to the department.</li><li>➤ UCA 26-25 limits the usage of confidential medical information obtained by the department.</li><li>➤ UCA 26-26 requires institutions to obtain the department’s authorization to obtain impounded animals for scientific and educational activities.</li></ul>

**Funding Detail**

The Department of Health utilizes significant funding from the state General Fund and Federal Funds. Additional sources of funding include dedicated credits, transfers, and various restricted funds.

<b>Health</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	193,861,600	229,149,800	233,410,500	263,684,500	285,751,300
General Fund, One-time	866,300	(10,487,700)	0	(36,917,800)	1,345,200
Federal Funds	711,888,902	802,557,659	907,792,332	1,063,467,378	1,166,397,900
Dedicated Credits Revenue	66,450,520	103,809,290	85,923,291	99,305,499	110,190,400
GFR - Cigarette Tax Rest	250,000	250,000	2,868,400	3,131,500	3,131,500
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
GFR - Medicaid Restricted	9,141,000	4,217,200	1,573,000	0	0
GFR - Nursing Facility	6,022,400	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	0	5,347,300	10,100,000
GFR - State Lab Drug Testing Account	149,400	267,900	270,800	277,600	293,600
GFR - Tobacco Settlement	9,498,900	11,549,500	11,558,500	13,064,900	13,155,200
Organ Donation Contribution Fund	0	0	113,000	113,000	113,000
Transfers	90,494,456	88,619,395	107,499,890	110,532,622	117,061,500
Beginning Nonlapsing	3,542,183	8,062,582	2,040,019	3,802,269	2,383,700
Closing Nonlapsing	(8,062,581)	(3,913,026)	(3,802,270)	(3,747,798)	(1,098,000)
Lapsing Balance	(628,995)	129,721	(6,249,780)	(979,554)	0
<b>Total</b>	<b>\$1,083,574,085</b>	<b>\$1,234,312,321</b>	<b>\$1,343,097,682</b>	<b>\$1,521,181,416</b>	<b>\$1,708,925,300</b>
<b>Line Items</b>					
Executive Director's Operations	12,151,209	13,089,501	17,404,808	24,385,919	26,959,100
Veterans' Nursing Home	1,491,280	1,515,468	0	0	0
Health Systems Improvement	11,233,488	12,704,072	12,549,638	12,651,077	13,020,500
Workforce Financial Assistance	600,283	723,447	566,299	430,299	994,900
Epidemiology & Lab Services	13,890,950	15,112,371	14,701,088	15,259,670	15,053,100
Community & Family Health	80,816,137	85,305,254	93,136,967	94,064,434	98,346,300
Health Care Financing	67,722,683	78,860,943	72,941,682	64,274,904	71,563,100
Medical Assistance	872,041,299	994,770,779	1,100,162,664	1,274,428,494	1,444,238,200
Children's Health Ins Prog	23,626,756	30,144,786	29,548,836	33,674,019	36,708,900
Local Health Departments	0	2,085,700	2,085,700	2,012,600	2,041,200
<b>Total</b>	<b>\$1,083,574,085</b>	<b>\$1,234,312,321</b>	<b>\$1,343,097,682</b>	<b>\$1,521,181,416</b>	<b>\$1,708,925,300</b>
<b>Categories of Expenditure</b>					
Personal Services	60,566,487	64,854,353	66,376,469	70,420,394	73,938,900
In-State Travel	565,192	593,425	657,077	609,646	924,800
Out of State Travel	435,684	472,132	531,098	539,009	868,500
Current Expense	38,023,547	41,706,907	43,324,250	48,220,204	44,621,800
DP Current Expense	6,178,544	5,844,982	6,244,917	7,108,762	6,051,900
DP Capital Outlay	184,335	359,670	53,109	722,219	0
Capital Outlay	231,111	398,027	375,314	399,465	292,500
Other Charges/Pass Thru	977,389,185	1,120,082,825	1,225,535,448	1,393,161,717	1,582,226,900
<b>Total</b>	<b>\$1,083,574,085</b>	<b>\$1,234,312,321</b>	<b>\$1,343,097,682</b>	<b>\$1,521,181,416</b>	<b>\$1,708,925,300</b>
<b>Other Data</b>					
Total FTE	1,233.5	1,257.7	1,244.6	1,308.9	1,301.4
Vehicles	36	41	52	52	52

Table 1-1

**CHAPTER 2 EXECUTIVE DIRECTOR'S OFFICE**

<b>Function</b>	The Utah Executive Director's Office (EDO) includes those functions of the Department of Health that provide overall direction of policy, management, and administrative support to the divisions, offices, and programs of the Department. This organizational category also includes the Office of the Medical Examiner, Bioterrorism Grants, and the Center for Health Data.
<b>Statutory Authority</b>	<p>The Utah Department of Health is governed by the Utah Health Code, Title 26 of the Utah Code.</p> <ul style="list-style-type: none"><li>➤ UCA 26-1-8 through 26-1-17 details the qualifications and powers of the executive director of the department.</li><li>➤ UCA 26-2 creates the Vital Statistics Act which is the State's repository of birth and death certificates.</li><li>➤ UCA 26-3 empowers the department to collect and maintain health data and utilize that data for analytical purposes.</li><li>➤ UCA 26-33a creates the Utah Health Data Authority Act and the Health Data Committee which uses the data collected through 26-3.</li><li>➤ UCA 26-4 establishes the Medical Examiner Act, which outlines procedures taken when dealing with various deaths in the State.</li><li>➤ UCA 26-18a creates the Kurt Oscarson Children's Organ Transplant Coordinating Committee with the purpose of providing financial assistance to children facing organ transplants.</li><li>➤ UCA 26-18b creates the Organ Donation Contribution Fund which promotes and supports organ donations through a statewide registry and donor awareness education.</li><li>➤ UCA 26-28 establishes criteria for organ donations and how those affect the Medical Examiner.</li></ul>

**Accountability** The Executive Director’s Office has outlined the following performance measures:

<b>Performance Data Summary - Executive Director's Office</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
<b>Medical Examiner</b> - proper certification of acuse and manner of death	Full/partial autopsies	Output	1,235	1,312	1,378
<b>Bio Terror Preparedness</b> - Build statewide public health infrastructure in preparation for bioterror attack	Develop 24/7 capacity to track urgent infectious disease cases or outbreak of disease with LHDs	Output	12	12	12
Prepare Utah hospitals with BT decontamination/ protective equipment and training	Number of hospitals prepared for bioterror attack	Output	42	42	42
<b>Center for Health Data</b> - Manage, analyze, and provide appropriate access to strategic information reosurces	Number of health status and health system indicators tracked and e-published	Output	100	114	135

**Table 2-1**

**Funding Detail**

The Department utilizes significant funding from the state General Fund and Federal Funds. Additional sources of funding include dedicated credits, transfers, and various restricted funds. Federal funds support the entire Bioterrorism program, although the level of funding is projected to decrease in the upcoming years.

<b>Executive Director's Operations</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	7,154,500	5,530,300	5,963,100	5,388,200	5,519,900
General Fund, One-time	505,700	31,400	0	4,500	33,900
Federal Funds	2,913,028	4,950,137	9,657,921	16,483,149	18,478,400
Dedicated Credits Revenue	1,198,590	1,338,631	1,665,042	2,256,882	2,567,000
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
Organ Donation Contribution Fund	0	0	113,000	113,000	113,000
Transfers	640,728	607,852	350,036	71,938	0
Beginning Nonlapsing	0	585,719	345,450	324,936	554,800
Closing Nonlapsing	(324,936)	(345,450)	(324,936)	(236,422)	(407,900)
Lapsing Balance	(36,401)	290,912	(464,805)	(120,264)	0
<b>Total</b>	<b>\$12,151,209</b>	<b>\$13,089,501</b>	<b>\$17,404,808</b>	<b>\$24,385,919</b>	<b>\$26,959,100</b>
<b>Programs</b>					
Executive Director	4,211,308	2,912,882	1,834,107	1,833,551	2,032,300
Program Operations	3,279,580	3,426,696	3,240,372	3,378,430	3,484,600
Medical Examiner	1,565,265	1,833,958	1,920,356	1,957,937	1,926,200
Bio Terrorism Grants	0	525,488	4,946,158	12,237,308	14,670,400
Center for Health Data	3,095,056	4,390,477	5,463,815	4,978,693	4,845,600
<b>Total</b>	<b>\$12,151,209</b>	<b>\$13,089,501</b>	<b>\$17,404,808</b>	<b>\$24,385,919</b>	<b>\$26,959,100</b>
<b>Categories of Expenditure</b>					
Personal Services	7,760,629	8,895,164	9,520,074	10,852,651	12,583,800
In-State Travel	30,746	36,305	56,494	64,273	239,100
Out of State Travel	44,064	40,551	105,393	90,090	169,200
Current Expense	1,603,967	2,430,647	2,370,999	4,258,666	6,135,100
DP Current Expense	672,198	762,820	787,283	1,025,338	702,200
DP Capital Outlay	60,254	91,163	18,436	236,944	0
Capital Outlay	13,900	0	234,975	163,506	225,000
Other Charges/Pass Thru	1,965,451	832,851	4,311,154	7,694,451	6,904,700
<b>Total</b>	<b>\$12,151,209</b>	<b>\$13,089,501</b>	<b>\$17,404,808</b>	<b>\$24,385,919</b>	<b>\$26,959,100</b>
<b>Other Data</b>					
Total FTE	140.8	144.9	160.4	209.2	208.4
Vehicles	4	5	5	5	5

Table 2-2

**Special Funding**

As shown in Table 2-2, a portion of the funding for this division comes from two restricted accounts, as detailed in the following table.

Restricted Funds Summary - Executive Director's Operations				
Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2004 Balance
Kurt Oscarson Children's Organ Transplant Trust Account	26-18a-4	Voluntary contributions on individual income tax return (see UCA 59-10-550)	Provide financial assistance for initial medical expenses of children who need organ transplants; obtain the assistance of volunteer and public service organization; and fund activities as the committee designates for the purpose of educating the public about the need for organ donors.	\$218,911
Organ Donation Contribution Fund	26-18b-101	Voluntary donations collected with motor vehicle registrations and drivers' license or identification card applications or renewals (see UCA 53-3-214.7).	Grants to organizations that: promote and support organ donation; assist in maintaining and operating a statewide organ donation registry; and provide donor awareness education.	\$55,690

Table 2-3

**EXECUTIVE DIRECTOR'S OFFICE**

**Function**

The Office of the Executive Director is responsible for the overall direction of policy and management of the Utah Department of Health. The following administrative support functions also report to this office:

- Legal Counsel – Provides legal counsel and support, drafts administrative rules, and conducts administrative hearings. Also coordinates the Department's legislative affairs.
- Human Resources Management and Employee Development – Responsible for providing personnel support services throughout the Department.
- Policy Support – Facilitates public health strategic and operational planning and coordinates issues and programs of local health departments with the Department of Health.
- Public Information – Directs the release of public information to the media.

*Kurt Oscarson Organ Transplant Account*

The Kurt Oscarson Children's Organ Transplant Account was established in 1992 to assist families with some of the ancillary expenses involved with an organ transplant. The account does not pay for transplants. The account is funded through a check off on the Utah State Income Tax Form. Collections from FY 1993 through FY 2004 have totaled \$844,422, averaging approximately \$94,494 over the past three years. Expenditures began in FY

1997, and since that time, include \$332,912 for administration and promotion expenditures and \$292,699 in interest-free loans. The total revenue, less the expenditures, leaves a balance in the account of \$218,911.

The five-member coordinating committee, established in UCA 26-18a, may award the financial assistance to eligible families. The committee establishes terms of repayment, which may include a waiver of repayment. The total number of recipients who have received assistance since FY 1997 is 70. In addition to the financial assistance, the committee has approved expenditures for marketing and public awareness campaigns, and for membership dues to Intermountain Organ Recovery. The code requires the committee to make an annual report to the Appropriations Subcommittee.

*Organ Donation  
Contribution Fund*

The 2002 Legislature approved the Organ Donation Contribution Fund in an effort to promote and support organ donation, assist in maintaining an organ donation registry, and provide donor awareness education. The fund receives revenue from voluntary donations collected with motor vehicle registrations and driver licenses. The FY 2004 expected amount of revenue was \$113,000, which reflects the amount appropriated. Actual FY 2004 collections were \$61,781. The Department's expenses (as authorized in 26-18b-(1)(c) were \$20,662 resulting in an ending fund balance of \$55,690 as of June 30, 2004.

Funding Detail

<b>Executive Director</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	3,134,000	1,115,400	932,900	865,500	914,700
General Fund, One-time	87,600	(115,400)	0	2,900	4,000
Federal Funds	1,067,181	1,524,198	797,942	863,816	900,600
Dedicated Credits Revenue	109	63,985	105,240	5,541	0
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
Organ Donation Contribution Fund	0	0	113,000	113,000	113,000
Transfers	60,482	298,582	0	0	0
Lapsing Balance	(238,064)	(73,883)	(214,975)	(117,206)	0
<b>Total</b>	<b>\$4,211,308</b>	<b>\$2,912,882</b>	<b>\$1,834,107</b>	<b>\$1,833,551</b>	<b>\$2,032,300</b>
<b>Categories of Expenditure</b>					
Personal Services	1,807,164	1,760,301	1,496,877	1,177,161	1,527,700
In-State Travel	6,856	8,953	4,921	1,965	5,800
Out of State Travel	11,422	8,166	1,134	1,188	12,800
Current Expense	291,392	396,179	225,519	519,922	390,800
DP Current Expense	69,886	63,573	29,656	21,315	55,200
DP Capital Outlay	0	3,798	0	0	0
Other Charges/Pass Thru	2,024,588	671,912	76,000	112,000	40,000
<b>Total</b>	<b>\$4,211,308</b>	<b>\$2,912,882</b>	<b>\$1,834,107</b>	<b>\$1,833,551</b>	<b>\$2,032,300</b>
<b>Other Data</b>					
Total FTE	24.5	20.6	19.4	15.3	15.3

Table 2-4

PROGRAM OPERATIONS

Function

The following administrative support functions are organized into Program Operations and report to the Executive Director:

- Office of Fiscal Operations – Directs the following functions:
  1. Budget – manages the preparation of the Department’s annual appropriations request and monitors expenditures within the appropriated budget.
  2. Finance – Provides purchasing, accounting, payroll, and financial information services.
  3. Financial Audit – Performs financial audits of contracts with outside agencies as well as internal audit activities.
- Information Technology – Provides computer and communication technology support.
- Employee Support Services – Provides administrative support for office function, building, equipment, and grounds.

## Funding Detail

Program Operations					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	1,496,800	1,553,400	1,845,900	1,586,800	1,606,900
General Fund, One-time	(300)	56,500	0	(4,900)	11,300
Federal Funds	1,412,362	1,396,869	1,497,210	1,762,204	1,670,200
Dedicated Credits Revenue	2,913	4,299	146,284	46,081	196,200
Transfers	190,852	174,263	65,066	71,938	0
Lapsing Balance	176,953	241,365	(314,088)	(83,693)	0
<b>Total</b>	<b>\$3,279,580</b>	<b>\$3,426,696</b>	<b>\$3,240,372</b>	<b>\$3,378,430</b>	<b>\$3,484,600</b>
<b>Categories of Expenditure</b>					
Personal Services	2,510,660	2,710,364	2,576,145	2,688,220	2,733,000
In-State Travel	10,647	10,685	18,826	16,356	19,400
Out of State Travel	13,066	4,107	2,624	7,678	10,700
Current Expense	310,134	328,985	270,890	403,143	294,000
DP Current Expense	374,651	285,190	353,418	263,033	427,500
DP Capital Outlay	46,522	87,365	18,436	0	0
Capital Outlay	13,900	0	0	0	0
Other Charges/Pass Thru	0	0	33	0	0
<b>Total</b>	<b>\$3,279,580</b>	<b>\$3,426,696</b>	<b>\$3,240,372</b>	<b>\$3,378,430</b>	<b>\$3,484,600</b>
<b>Other Data</b>					
Total FTE	45.5	52.2	42.4	42.8	43.0
Vehicles	1	1	1	1	1

Table 2-5

## OFFICE OF THE MEDICAL EXAMINER

## Function

The Office of the Medical Examiner is responsible for the investigation and certification of sudden and unexpected deaths that occur within the borders of the State. The specific circumstances surrounding any given death which place it under the jurisdiction of the OME are specified in 26-4-7. Given that any resident or visitor to Utah may potentially die in circumstances defined in the Medical Examiners Act, the OME serves a population of approximately 2.3 million, not including visitors to the State.

Staff pathologists perform the majority of the examinations performed by the OME and all of the autopsies. Contracted physicians in local communities examine approximately 150 cases each year or approximately 6.5 percent of all exams performed. These physicians conduct external examinations only. Other OME personnel assist in examinations and maintain morgue operations 24 hours per day. Investigators (both employed and contracted) gather information needed to understand how a death happened. For the past several years, the appropriation has included funding to pay staff costs for their on-call coverage of the office.

The OME pays for transportation of bodies under its jurisdiction. A contracted transportation service is used along the Wasatch Front; funeral homes provide all other transportation.

The following table lists the number of cases reported to, and investigated and certified by, the Office of the Medical Examiner for the past three years, separated according to manner of death. The table includes inquiries received where it was determined that the death did not fall under the jurisdiction of the Medical Examiner.

MEDICAL EXAMINER CASES						
	<u>FY 2002</u>	<u>% of Cases</u>	<u>FY 2003</u>	<u>% of Cases</u>	<u>FY 2004</u>	<u>% of Cases</u>
Natural Causes	2,117	66.09%	2,087	64.08%	2,210	65.62%
Accidents	413	12.89%	485	14.89%	412	12.23%
Suicides	347	10.83%	352	10.81%	336	9.98%
Undetermined	254	7.93%	264	8.11%	356	10.57%
Homicides	72	2.25%	69	2.12%	54	1.60%
Inquiries	1,631		1,629		1,607	
<b>Total</b>	<b>4,834</b>	100.00%	<b>4,886</b>	100.00%	<b>4,975</b>	100.00%

Table 2-6

**Funding Detail**

Medical Examiner					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	1,322,100	1,619,700	1,778,200	1,770,400	1,825,500
General Fund, One-time	99,800	167,800	0	4,300	9,600
Dedicated Credits Revenue	72,384	66,470	88,936	85,759	91,100
Lapsing Balance	70,981	(20,012)	53,220	97,478	0
<b>Total</b>	<b>\$1,565,265</b>	<b>\$1,833,958</b>	<b>\$1,920,356</b>	<b>\$1,957,937</b>	<b>\$1,926,200</b>
<b>Categories of Expenditure</b>					
Personal Services	1,112,600	1,317,622	1,371,481	1,399,989	1,381,100
In-State Travel	3,093	5,414	3,292	3,021	3,500
Out of State Travel	5,789	1,626	0	1,211	0
Current Expense	435,406	476,358	537,618	543,184	534,300
DP Current Expense	8,377	31,966	7,965	10,532	7,300
Other Charges/Pass Thru	0	972	0	0	0
<b>Total</b>	<b>\$1,565,265</b>	<b>\$1,833,958</b>	<b>\$1,920,356</b>	<b>\$1,957,937</b>	<b>\$1,926,200</b>
<b>Other Data</b>					
Total FTE	17.9	19.2	19.2	19.6	19.6
Vehicles	3	4	4	4	4

Table 2-7

**BIOTERRORISM GRANTS**

**Function**

In response to the September 11, 2001 terrorist attacks and the ensuing anthrax scare, the federal government has begun funding a nationwide program for bioterrorism preparedness. In FY 2003, the Utah Department of Health received \$12.3 million in federal grants from the Center for Disease Control (CDC) for public health preparedness and response for bioterrorism.

For FY 2004, the Department received an additional \$8,547,996 in grants. The grant is broken down into seven focus areas as follows:

- Preparedness planning and readiness assessment
- Surveillance and Epidemiology Capacity
- Laboratory Capacity – Biological Agents
- Laboratory Capacity – Chemical Agents
- Health Alert Network – Communication and Information Technology
- Communicating Health Risks and Health Information Dissemination
- Education and Training

In addition to the CDC Bioterrorism grant, the Health Resources and Services Administration (HRSA) Hospital Preparedness Bioterrorism grant was \$1.1 million in FY 2003 and \$4.4 million in FY 2004. This grant is designated for hospitals to increase training, education, and supplies. This grant is broken into the following priority areas:

- Administration
- Regional Surge Capacity
- Emerging Medical Services
- Links to Public Health Departments
- Education and Preparedness Training
- Terrorism Preparedness Exercises

Both the CDC Bioterrorism grant and the HRSA Hospital Preparedness grant are projected to go through FY 2005. Note: Most of the FTEs associated with this grant are “AL” positions, indicating that they are temporary and are available only while there is funding from the grant. When the grant funding ends, the positions are eliminated.

Funding Detail

Bio Terrorism Grants					
Sources of Finance	2001 Actual	2002 Actual	2003 Actual	2004 Actual	2005 Appropriated
Federal Funds	0	525,488	4,946,158	12,237,308	14,670,400
<b>Total</b>	<b>\$0</b>	<b>\$525,488</b>	<b>\$4,946,158</b>	<b>\$12,237,308</b>	<b>\$14,670,400</b>
Categories of Expenditure					
Personal Services	0	228,191	1,091,569	2,282,886	3,524,800
In-State Travel	0	210	15,247	27,296	195,800
Out of State Travel	0	6,646	66,522	57,619	109,400
Current Expense	0	259,887	351,771	1,707,910	4,110,500
DP Current Expense	0	2,140	140,029	447,917	3,000
DP Capital Outlay	0	0	0	236,944	0
Capital Outlay	0	0	234,975	163,506	225,000
Other Charges/Pass Thru	0	28,414	3,046,045	7,313,230	6,501,900
<b>Total</b>	<b>\$0</b>	<b>\$525,488</b>	<b>\$4,946,158</b>	<b>\$12,237,308</b>	<b>\$14,670,400</b>
Other Data					
Total FTE	0.0	0.0	15.4	60.3	60.3

Table 2-8

CENTER FOR HEALTH DATA

Function

The Center for Health Data manages, analyzes, and provides appropriate access to strategic information resources that support Utah public health. The operating units of the Center are the Offices of Health Care Statistics, Public Health Assessment, Vital Records and Statistics, and the Utah Statewide Immunization Information System. The mission of the Center is to (1) provide statistical and epidemiological expertise to the Department so that high quality data are collected, analyzed, and interpreted for surveillance, planning, program evaluation, and policy development; (2) register, preserve, and certify vital records; (3) provide information for immunization coordination; and (4) disseminate health data to improve health care access, quality, and cost.

This mission is accomplished through the following functions:

- Registration, preservation, and certification of the public’s vital records;
- Collection, tabulation, analysis, and publication of vital statistics and other health status and health system statistical reports;
- Providing health indicators to business and the public over the internet as an e-government service;
- Providing electronic access to childhood immunization records for physicians;

- Providing training and consultation on the intelligent use of data for planning and carrying out public health measures;
- Promoting patient safety initiatives in concert with Utah hospitals;
- Reporting managed care performance measures and enrollee satisfaction;
- Collecting and reporting of statewide hospitalization, surgery, and emergency department encounter data;
- Collecting and reporting of managed care organizations’ performance measures and HMO enrollee satisfactions;
- Promoting and coordinating of statewide hospital patient safety initiatives using available hospital data.

The following table shows the historical trends of vital records generated and maintained by this office.

VITAL RECORDS CERTIFICATE ACTIVITY BY FISCAL YEAR					
	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Births	48,147	48,763	49,409	50,816	51,884
Deaths	12,495	12,822	13,382	13,522	14,008
Fetal Deaths	246	247	273	294	282
Induced Abortions	3,024	3,380	3,594	3,618	3,277
Marriages	24,448	24,474	24,981	24,182	22,294
Divorces	9,218	8,192	9,607	7,172	9,114
Ancillary Records	5,453	5,591	5,403	5,047	4,609
Other New Records	2,108	1,793	2,019	2,378	2,033
<b>Total</b>	<b>105,139</b>	<b>105,262</b>	<b>108,668</b>	<b>107,029</b>	<b>107,501</b>
Certificate Copies Issued	79,343	84,779	89,795	95,940	88,234
Fees Collected	\$718,911	\$724,612	\$806,234	\$913,884	\$1,081,821

Table 2-9

This program received supplemental funding in FY 1995 in the amount of \$337,000 for a health status survey. The funding was designated as non-lapsing by intent language. Previously, this survey has been done on a five-year cycle. An appropriation of \$400,000 (\$320,000 one-time; \$80,000 ongoing) was approved in FY 2001 for the next survey. This funding was also designated as non-lapsing. With this ongoing funding, the survey is more of an ongoing, continual process, which provides more timely, relevant information.

The survey results in a number of reports, among them: Health Insurance Coverage, Injuries in Utah, Health Status in Utah, Chronic Conditions in Utah, Socioeconomic Status and Health, Limitations of Activities, Interpersonal Violence, Health Care Access and Utilization, Lifestyle Factors, and the Medical Outcomes Study.

## Funding Detail

<b>Center for Health Data</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	1,201,600	1,241,800	1,406,100	1,165,500	1,172,800
General Fund, One-time	318,600	(77,500)	0	2,200	9,000
Federal Funds	433,485	1,503,582	2,416,611	1,619,821	1,237,200
Dedicated Credits Revenue	1,123,184	1,203,877	1,324,582	2,119,501	2,279,700
Transfers	389,394	135,007	284,970	0	0
Beginning Nonlapsing	0	585,719	345,450	324,936	554,800
Closing Nonlapsing	(324,936)	(345,450)	(324,936)	(236,422)	(407,900)
Lapsing Balance	(46,271)	143,442	11,038	(16,843)	0
<b>Total</b>	<b>\$3,095,056</b>	<b>\$4,390,477</b>	<b>\$5,463,815</b>	<b>\$4,978,693</b>	<b>\$4,845,600</b>
<b>Categories of Expenditure</b>					
Personal Services	2,330,205	2,878,686	2,984,002	3,304,395	3,417,200
In-State Travel	10,150	11,043	14,208	15,635	14,600
Out of State Travel	13,787	20,006	35,113	22,394	36,300
Current Expense	567,035	969,238	985,201	1,084,507	805,500
DP Current Expense	219,284	379,951	256,215	282,541	209,200
DP Capital Outlay	13,732	0	0	0	0
Other Charges/Pass Thru	(59,137)	131,553	1,189,076	269,221	362,800
<b>Total</b>	<b>\$3,095,056</b>	<b>\$4,390,477</b>	<b>\$5,463,815</b>	<b>\$4,978,693</b>	<b>\$4,845,600</b>
<b>Other Data</b>					
Total FTE	52.8	52.9	64.1	71.2	70.2

Table 2-10

**CHAPTER 3 HEALTH SYSTEMS IMPROVEMENT**

<b>Function</b>	<p>The Division of Health Systems Improvement assures and improves the quality of the Utah health care system. Its mission is fulfilled through the examination, analysis, and actions to improve service availability, accessibility, acceptability, continuity, quality, and cost.</p> <p>The Division includes the Director's office, the Office of Primary Care and Rural Health, the Office of Child Care Licensing, the Bureau of Emergency Medical Services, and the Bureau of Health Facility Licensing, Certification, and Resident Assessment. Through the two bureaus, Health Systems Improvement directs the regulation and oversight of the health care industry. Division-wide improvement strategies include training, certification, licensing, inspection, pre-admission screenings for all Utah Medicaid recipients seeking nursing home or institutional care, and promoting primary care services to underserved population. The Division additionally supports the Patient Safety Initiative and the Workforce Financial Assistance Program.</p>
<b>Statutory Authority</b>	<p>The Division of Health Systems Improvement is governed by the Utah Health Code, Title 26 of the Utah Code.</p> <ul style="list-style-type: none"> <li>➤ UCA 26-6a sets up criteria for testing and workers' compensation for emergency medical services providers who are exposed to various diseases.</li> <li>➤ UCA 26-8a creates the State Emergency Medical Services Committee, establishes the Statewide Trauma System, and outlines the criteria for emergency medical service personnel.</li> <li>➤ UCA 26-9 outlines the Department's efforts in relation to health services in rural areas of the State.</li> <li>➤ UCA 26-21 outlines the necessary requirements for state licensing of various health care facilities.</li> <li>➤ UCA 26-21a requires the department to license facilities using diagnostic mammography.</li> <li>➤ UCA 26-39 details the licensing requirements for child care providers.</li> </ul>
<b>Intent Language</b>	<p>The Legislature included several items of intent language for the Division of Health Systems Improvement in the FY 2005 Appropriations Act. Most of these deal with nonlapsing funding.</p> <p>In Item 112, S.B. 1, 2004 General Session, the Legislature stated that plan review fees and civil money penalties in the Bureau of Health Facility Licensing, Certification, and Resident Assessment and all funding for Primary Care Grants be considered nonlapsing. It also put restrictions on uses of the funding for the Primary Care Grants Program.</p>

**Accountability** The Division of Health Systems Improvement has outlined the following performance measures:

<b>Performance Data Summary - Health Systems Improvement</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
<b>EMS</b> - 100% of all licensed EMS provider agencies will receive funds from the EMS Grants Program.	Number of grants awarded to licensed EMS provider agencies.	Output	145	144	145
Conduct and complete all re-licensure and re-designation quality assurance reviews 30 days before the expiration date for 90% of the 38 licensed and designated agencies whose license or designation expires this year.	Completed re-license or re-designation certificate mailed to the agency.	Output	38 agencies	38 agencies	34 agencies
<b>Child Care Licensing</b>	Child Care Licenses	Output	2,680	2,680	2,700
	# of Bur. Of Criminal Invest. inquiries	Output	12,835	12,835	13,000
	Child Care Surveys	Output	2,557	2,557	2,680
<b>HFL,C, &amp; RA</b> - Medicare/Medicaid Provider Report Card	This information was initially developed to assist the general public in selecting a nursing home. The information is designed to aid the public by comparing nursing homes. We have expanded the process to include Intermediate Care Facilities for the Mentally Retarded/Developmentally Delayed (ICF/MR).	Output	100% Average every 12 months	100% Average every 12 months	100% Average every 12 months
Complaint Investigations	Conduct on-site complaint investigations within Medicare/Medicaid certified providers within designated time frames. 1. Immedicate Jeopardy Complaints 2. Non-Immedidate Jeopardy Complaints	Output	1. within 2 days; 2. within 10 working days	1. 1.6 days; 2. 6.6 days (averages)	1. within 2 days; 2. within 10 working days

**Table 3-1a**

<b>Performance Data Summary - Health Systems Improvement</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
<b>Primary Care Grants -</b> Award grants to agencies and organizations in order to increase access to appropriate, high quality, cost-effective primary health care to targeted Utah low-income individuals and families who do not have health insurance, have limited health insurances, or cannot qualify for public assistance.	Number of grants awarded to agencies and organizations providing primary health care to targeted populations.	Output	18 grants	24 grants	18 grants

**Table 3-1b**

**Funding Detail**

The Division's funding comes from three main sources - the state General Fund, Federal Funds, and dedicated credits.

<b>Health Systems Improvement</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	4,103,200	4,777,100	3,987,200	4,014,500	4,146,700
General Fund, One-time	20,800	220,200	0	9,000	130,400
Federal Funds	2,855,667	3,568,551	4,180,414	4,328,255	4,415,300
Dedicated Credits Revenue	2,481,011	2,574,463	3,812,456	3,959,797	4,100,700
GFR - Medicaid Restricted	499,800	5,600	0	0	0
Transfers	1,230,228	1,296,189	156,027	222,183	140,000
Beginning Nonlapsing	1,505,518	1,507,954	1,274,983	845,431	407,400
Closing Nonlapsing	(1,507,953)	(1,274,983)	(845,431)	(724,929)	(320,000)
Lapsing Balance	45,217	28,998	(16,011)	(3,160)	0
<b>Total</b>	<b>\$11,233,488</b>	<b>\$12,704,072</b>	<b>\$12,549,638</b>	<b>\$12,651,077</b>	<b>\$13,020,500</b>
<b>Programs</b>					
Director's Office	351,563	929,569	819,194	748,273	1,113,800
Emergency Medical Services	3,967,514	4,507,538	5,245,983	4,953,277	4,706,100
Child Care Licensing	2,929,154	3,057,153	3,004,179	2,043,614	3,046,200
Health Facility Licensure, Certification, anc	2,926,861	2,932,180	2,914,942	4,279,256	3,450,400
Primary Care Grants	1,058,396	1,277,632	565,340	626,657	704,000
<b>Total</b>	<b>\$11,233,488</b>	<b>\$12,704,072</b>	<b>\$12,549,638</b>	<b>\$12,651,077</b>	<b>\$13,020,500</b>
<b>Categories of Expenditure</b>					
Personal Services	6,843,608	7,147,792	6,947,717	7,038,781	7,282,200
In-State Travel	175,371	185,322	216,521	190,340	212,400
Out of State Travel	60,660	85,300	80,115	82,257	108,500
Current Expense	2,039,786	2,618,838	2,853,210	2,785,694	2,837,600
DP Current Expense	261,237	210,053	167,804	261,606	288,400
DP Capital Outlay	11,032	5,984	0	0	0
Capital Outlay	0	7,000	5,874	10,529	0
Other Charges/Pass Thru	1,841,794	2,443,783	2,278,397	2,281,870	2,291,400
<b>Total</b>	<b>\$11,233,488</b>	<b>\$12,704,072</b>	<b>\$12,549,638</b>	<b>\$12,651,077</b>	<b>\$13,020,500</b>
<b>Other Data</b>					
Total FTE	142.2	143.0	136.2	130.4	130.9
Vehicles	15	17	22	22	22

**Table 3-2**

**DIRECTOR'S OFFICE****Function**

The administrative function of the Division of Health Systems Improvement includes planning and budget analysis, coordination of intradivisional activities, oversight of the three bureaus and one office, identification and implementation of information systems improvement, patient safety initiative, and division liaison with other public and private agencies and organizations.

**Funding Detail**

<b>Director's Office</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	240,400	245,100	172,000	215,800	220,300
General Fund, One-time	100	(96,800)	0	600	1,600
Federal Funds	0	605,529	601,892	579,364	891,900
Dedicated Credits Revenue	113	(88)	0	(1,129)	0
Beginning Nonlapsing	0	121,240	0	0	0
Closing Nonlapsing	(121,240)	0	0	0	0
Lapsing Balance	232,190	54,588	45,302	(46,362)	0
<b>Total</b>	<b>\$351,563</b>	<b>\$929,569</b>	<b>\$819,194</b>	<b>\$748,273</b>	<b>\$1,113,800</b>
<b>Categories of Expenditure</b>					
Personal Services	252,706	471,668	357,560	339,038	350,500
In-State Travel	321	2,929	1,999	579	9,200
Out of State Travel	2,834	5,732	8,901	7,157	16,900
Current Expense	27,364	322,345	409,955	313,873	498,800
DP Current Expense	41,882	11,636	5,779	9,292	43,500
Capital Outlay	0	0	0	10,529	0
Other Charges/Pass Thru	26,456	115,259	35,000	67,805	194,900
<b>Total</b>	<b>\$351,563</b>	<b>\$929,569</b>	<b>\$819,194</b>	<b>\$748,273</b>	<b>\$1,113,800</b>
<b>Other Data</b>					
Total FTE	4.0	4.0	6.9	6.2	6.2

**Table 3-3**

---

**EMERGENCY MEDICAL SERVICES****Function**

The Bureau of Emergency Medical Services is a leadership team functioning as a resource and providing assurance of a quality emergency medical system in the State. The Bureau of Emergency Medical Services has as its mission to promote a statewide system of emergency and trauma care to reduce morbidity and mortality, through prevention, awareness, and quality intervention.

The Bureau implements this mission by:

- Listening to its constituents and helping them meet their needs.
- Providing information, technical assistance and consultation to providers of emergency medical services to enhance the provision of quality emergency care.
- Assuring compliance by emergency medical providers to rules and regulations that promote quality emergency care.
- Promoting the highest standards possible for the statewide provision of emergency medical services, taking into consideration available resources, utilizing available resources and investigating alternative funding sources.
- Establishing an infrastructure to provide administrative support that will continually seek to improve, streamline, and find the most cost-effective way to meet the needs throughout the State.
- Recognizing Bureau personnel as valuable team members and empowering them to make decisions to facilitate their performance, provide good customer service, and to seek additional training for the attainment of Bureau goals.
- Encouraging EMS involvement and coordination with existing and new injury prevention and health promotional activities.
- Promoting and supporting programs and activities that address the physical and mental health and safety of EMS personnel.

***EMS Grants Program***

The portion of the surcharge that is allocated to EMS has restrictions on its usage established in the Utah Code. In the past, six percent of the monies have been allocated for administration of the grants program. In the July 2002 Special Session, the Legislature removed the six percent cap for grant funds available for staff support, administrative services, and trauma system development. This allowed for the replacement of \$250,000 in General Funds for trauma system development funds with EMS grant funds. After administration and trauma system development, the Bureau then allocates 15 percent of the remaining balance to emergency medical training programs developed for high school students, 42 ½ percent for block grants for emergency medical services at the county level, determined by population, and the remaining 42 ½ percent as competitive grants distributed to applicants

based on the rules established by the Emergency Medical Services Committee.

*EMT Certification*

Emergency Medical Technicians must be certified to meet a statewide standard for emergency medical service provision. The following two charts show the number of certifications and re-certifications and examinations given from 1997 to 2004. The number of EMT certifications has grown fairly steadily from 1997 when there were 1,501 certifications through 2004 when there were 2,361.

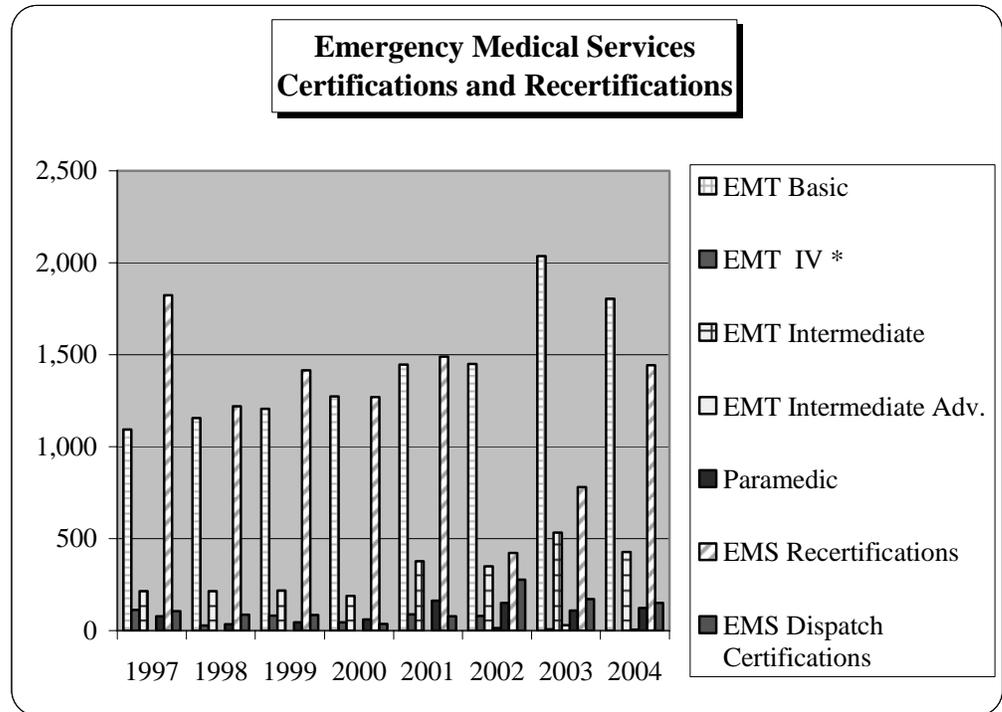


Figure 3-1

\* The EMT IV program was dropped during FY 2003.

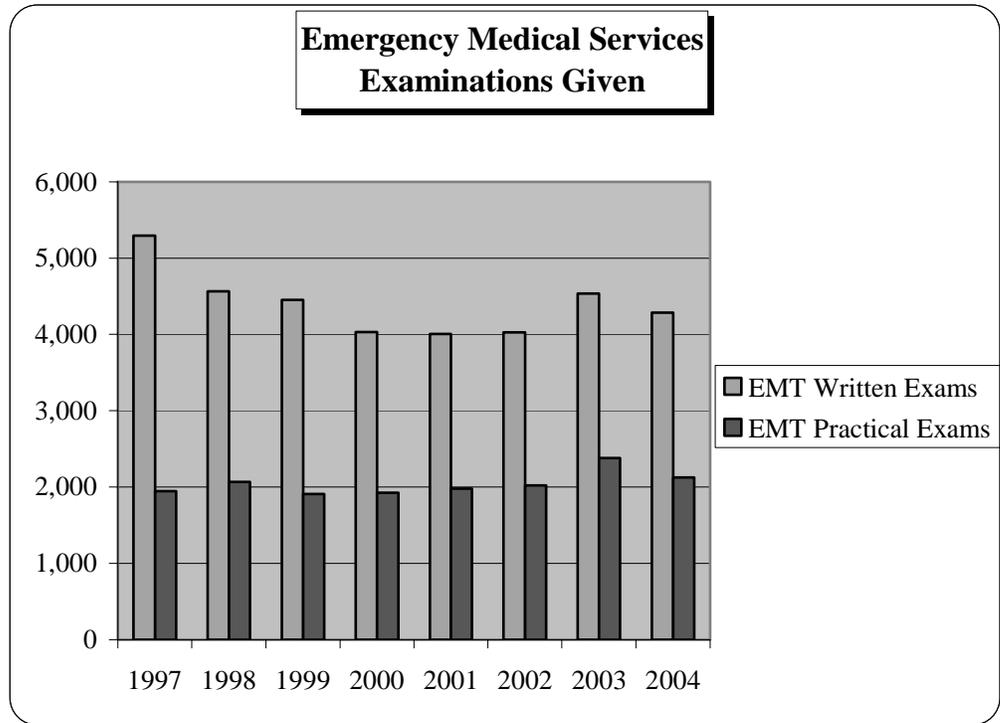


Figure 3-2

To assist EMTs in gaining certification or recertification, courses are available. The following chart shows the number of those course offerings. In 1997, there were 116 course offerings; in 2004, there were 164.

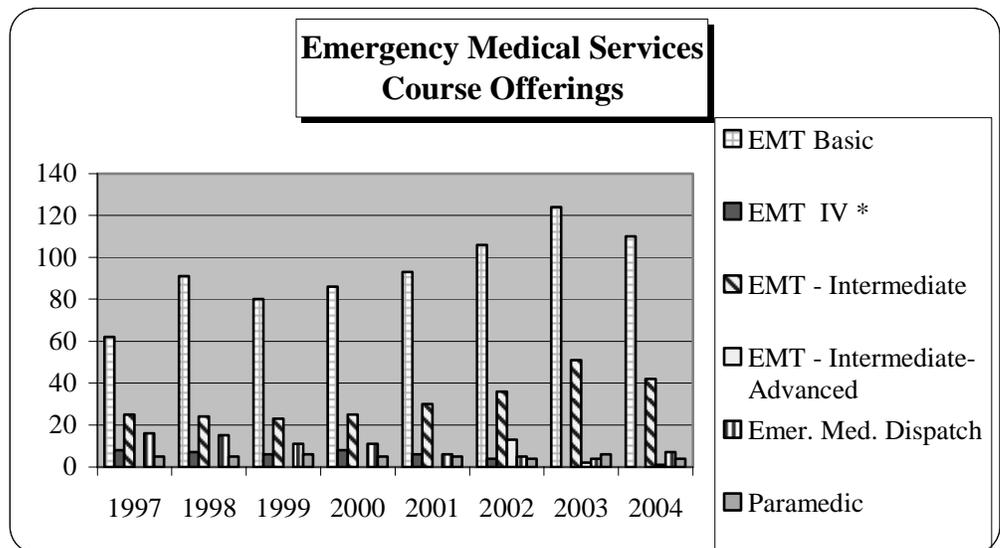


Figure 3-3

\* The EMT IV program was dropped during FY 2003.

## Funding Detail

<b>Emergency Medical Services</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	1,240,000	1,279,000	901,500	886,000	956,300
General Fund, One-time	24,000	(82,900)	0	8,300	9,200
Federal Funds	130,874	493,410	1,094,758	1,012,864	575,200
Dedicated Credits Revenue	2,358,238	2,417,935	2,501,661	2,752,489	2,942,300
Transfers	240,987	350,195	156,280	222,183	140,000
Beginning Nonlapsing	1,120,034	1,105,000	1,015,817	471,965	165,500
Closing Nonlapsing	(1,104,931)	(1,015,817)	(471,965)	(357,095)	(82,400)
Lapsing Balance	(41,688)	(39,285)	47,932	(43,429)	0
<b>Total</b>	<b>\$3,967,514</b>	<b>\$4,507,538</b>	<b>\$5,245,983</b>	<b>\$4,953,277</b>	<b>\$4,706,100</b>
<b>Categories of Expenditure</b>					
Personal Services	1,208,373	1,284,611	1,341,452	1,187,672	1,325,500
In-State Travel	59,380	59,765	89,784	61,884	95,600
Out of State Travel	25,798	27,814	32,919	32,365	18,700
Current Expense	918,062	1,355,234	1,543,021	1,504,435	1,195,200
DP Current Expense	58,475	52,161	53,574	74,906	38,600
DP Capital Outlay	11,032	5,984	0	0	0
Capital Outlay	0	7,000	5,874	0	0
Other Charges/Pass Thru	1,686,394	1,714,969	2,179,359	2,092,015	2,032,500
<b>Total</b>	<b>\$3,967,514</b>	<b>\$4,507,538</b>	<b>\$5,245,983</b>	<b>\$4,953,277</b>	<b>\$4,706,100</b>
<b>Other Data</b>					
Total FTE	29.4	29.6	30.1	26.8	27.3
Vehicles	4	4	6	6	6

Table 3-4

---

**CHILD CARE LICENSING****Function**

The Office of Child Care Licensing is responsible for ensuring and protecting the health and safety of children through inspection of child care facilities, enforcing rules governing child care facilities and providing education and information to the public. The Office of Child Care implements this mission by inspecting child care facilities to ensure compliance to state rules.

The categories with the largest numbers of facilities include Residential Certificate (1,339), Licensed Family Child Care Providers (763), Child Care Centers (268), Licensed Family Group Child Care providers (240) and Hourly Child Care Centers (74).

A provider/facility may be issued a deficiency if it is found to be in violation of state rules. Enforcement activities and sanctions follow adjudicative proceedings. A major activity of rule writing and rule revision is completed under the direction of the Child Care Licensing Advisory Committee, which has legislative authority.

As a result of legislation passed during the 1997 Legislative General Session, the responsibility of licensing child care providers was added to Office of Child Care. In addition, Licensing also was given the responsibility of licensing hourly care providers. To accommodate this additional responsibility, Licensing has updated the state rules with input from the Child Care Licensing Advisory Committee, and has centralized the licensing function and redistributed personnel to address case load equity. In 2003, licensing adopted the issuance of two-year licenses to reduce paperwork submission from licensed child care providers. The following chart shows the number and types of child care facilities. It should be noted that a significant driver of the workload in the child care licensing area is the turnover. Over the course of 2004, there were 814 facilities which closed, while another 1,061 new facilities were opened. On July 1, 2004, the Bureau of Licensing was reorganized and the function of child care licensure was transferred under the direction of the directors office, which included a name change to Office of Child Care Licensing.

In 2004, Licensing processed 12,835 MIS and BCI checks on child care providers with 151 hits.

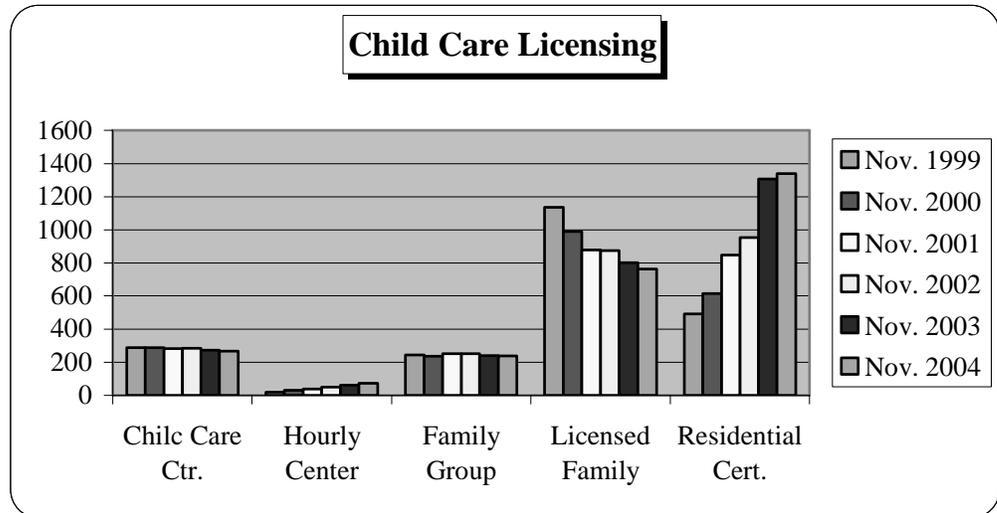


Figure 3-4

Funding Detail

Child Care Licensing					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	1,791,600	1,841,300	1,849,200	995,000	1,872,100
General Fund, One-time	(2,600)	(59,600)	0	0	15,700
Dedicated Credits Revenue	105,402	95,537	1,189,717	965,007	1,158,400
Transfers	984,986	945,994	(253)	0	0
Beginning Nonlapsing	218,519	160,400	81,441	0	0
Closing Nonlapsing	(160,439)	(81,441)	(77,596)	0	0
Lapsing Balance	(8,314)	154,963	(38,330)	83,607	0
<b>Total</b>	<b>\$2,929,154</b>	<b>\$3,057,153</b>	<b>\$3,004,179</b>	<b>\$2,043,614</b>	<b>\$3,046,200</b>
<b>Categories of Expenditure</b>					
Personal Services	2,551,620	2,637,375	2,658,513	1,738,334	2,688,500
In-State Travel	43,039	47,155	49,007	36,062	44,300
Out of State Travel	5,946	5,564	204	778	2,000
Current Expense	279,353	311,622	266,148	228,402	281,400
DP Current Expense	49,196	55,437	30,307	40,038	30,000
<b>Total</b>	<b>\$2,929,154</b>	<b>\$3,057,153</b>	<b>\$3,004,179</b>	<b>\$2,043,614</b>	<b>\$3,046,200</b>
<b>Other Data</b>					
Total FTE	52.8	53.9	52.8	49.9	49.9
Vehicles	7	8	10	10	10

Table 3-5

---

**HEALTH FACILITY LICENSURE, CERTIFICATION, AND RESIDENT ASSESSMENT****Function**

Effective July 1, 2004 the Division of Health Systems Improvement implemented a merger between the Bureau of Licensing and the Bureau of Program Certification and Resident Assessment to form a single organizational unit. This unit has the responsibility for both licensing and certification activities for all health care providers within the State of Utah. The name of the newly combined organization is the Bureau of Health Facility Licensing, Certification and Resident Assessment; this title provides a more accurate description of the Bureau's overall duties and responsibilities.

The merger will allow for more coordinated oversight of all health care providers and allow for greater State presence to ensure continued compliance for all Medicare/Medicaid certified entities. Along with an increased coordination within the provider community the bureau also increases its ability of implementing state authorized sanctions against a specific provider identified as being out of compliance with Medicare/Medicaid program requirements.

The bureau licenses over 700 health care providers, and certified over 350 providers for Medicare/Medicaid participation. These include hospitals, nursing homes, institutions for mentally retarded and the mentally ill, home health agencies, and many other provider types. In addition to survey inspections, follow-up inspections and complaint investigations are performed. The bureau performs pre-admission/continued stay reviews for over 4,700 Medicaid recipients in Utah nursing homes and facilities for the mentally retarded/mentally ill.

The bureau is responsible for managing two federal grants: Title 18 (Medicare) Certification Grant, and Title 19 (Medicaid) Certification. These grants are funded at different matching rates. Title 18 Certification is matched at 100 percent and Title 19 is matched at either 75 percent or 50 percent Federal Financial Participation (FFP). In addition, the bureau participates in the regular Title 19 program. This program is matched at 90 percent, 75 percent or 50 percent FFP. Overall, the average match rate is 87.5 percent federal and 12.5 percent state.

Another program the bureau manages is performing reviews of building plans for new construction of health care facilities. Due to the fact that construction and reviews often span multiple fiscal years, the Legislature has approved the designation of plan review fees as non-lapsing.

## Funding Detail

<b>Health Facility Licensure, Certification, and Resident Assessment</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	588,500	604,000	496,000	1,318,800	498,600
General Fund, One-time	(500)	(69,000)	0	0	3,600
Federal Funds	2,449,462	2,469,612	2,483,764	2,736,027	2,948,200
Dedicated Credits Revenue	9,537	61,079	121,078	243,430	0
Beginning Nonlapsing	0	9,508	70,616	263,197	185,600
Closing Nonlapsing	(9,537)	(70,616)	(185,601)	(285,222)	(185,600)
Lapsing Balance	(110,601)	(72,403)	(70,915)	3,024	0
<b>Total</b>	<b>\$2,926,861</b>	<b>\$2,932,180</b>	<b>\$2,914,942</b>	<b>\$4,279,256</b>	<b>\$3,450,400</b>
<b>Categories of Expenditure</b>					
Personal Services	2,527,055	2,553,691	2,577,800	3,763,349	2,895,600
In-State Travel	64,356	73,607	75,676	91,761	63,200
Out of State Travel	21,298	43,924	38,091	41,957	70,900
Current Expense	230,299	176,327	146,385	245,531	245,100
DP Current Expense	83,853	84,631	76,990	136,658	175,600
<b>Total</b>	<b>\$2,926,861</b>	<b>\$2,932,180</b>	<b>\$2,914,942</b>	<b>\$4,279,256</b>	<b>\$3,450,400</b>
<b>Other Data</b>					
Total FTE	49.0	48.0	46.0	47.0	47.0
Vehicles	4	5	6	6	6

Table 3-6

## PRIMARY CARE GRANTS

## Function

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

The office also serves as the federally-funded State Office of Rural Health and Primary Care Office, and is the lead agency in working with the federal National Health Service Corps in recruiting and retaining health care professionals to work in medically underserved areas of Utah. The office manages the federal Medicare Rural Hospital Flexibility Grant Program that assists in strengthening rural health by: 1) allowing small hospitals the flexibility to reconfigure operations and be licensed as critical access hospitals, 2) offering cost-based reimbursement for Medicare acute inpatient and outpatient services, 3) encouraging the development of rural-centric health networks, and 4) offering grants to help implement a critical access hospital program in the context of broader initiatives to strengthen the rural health care infrastructure. The federal Small Rural Hospital Improvement Grant Program assists small rural hospitals to help them: 1) pay for costs related to the implementation of PPS, 2) comply with provisions of HIPAA and 3) reduce medical errors and support quality improvement

The State Primary Care Grants Program for Medically Underserved Populations makes grants to public and nonprofit entities for the cost of operation of providing primary health care services to medically underserved populations. The program strives to decrease the number of individuals without access to appropriate, high quality, post-effective primary health care by making these grants to qualified provider organizations. The program targets Utah's low-income populations, who have no health insurance, or whose health insurance does not cover primary health care services and do not qualify for Medicare, Medicaid, CHIP, or other government insurance programs. The scope of this program includes populations in medically underserved areas, including the working poor, individuals with chronic diseases, children of low income families, the homeless, Native Americans, seasonal and migrant farm workers, and other disadvantaged groups.

The 1996 and 1997 Legislatures approved \$350,000 from Mineral Lease Funds for a State Primary Care Grants Program for Medically Underserved Populations. The 1998 Legislature increased the funding to \$500,000. This amount was also appropriated in 1999 for FY 2000 and FY 2001, but the source of the funding switched in FY 2001 to the Medicaid Restricted Account. Since FY 2002, the funding for the State Primary Care Grants Program has been from the General Fund. Intent language has been included each year with the funding, designating it as nonlapsing.

The history of the State Primary Care Grants Program, along with the number of individuals receiving services funded by the grants is included in the following table:

PRIMARY CARE GRANTS HISTORY								
	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>
<b>Rural Projects:</b>								
New	1	0	3	5	3	2	0	7
Continuation	3	2	5	3	5	6	9	6
Individuals served	425	861	1,699	3,093	1,932	2,503	2,652	1,778
Funds	\$79,599	\$71,940	\$191,798	\$218,700	\$228,700	\$223,850	\$205,700	\$232,200
<b>Urban Projects:</b>								
New	1	3	0	0	0	5	1	6
Continuation	4	4	4	4	6	6	7	7
Individuals served	2,020	3,352	3,117	3,298	1,768	3,178	3,693	5,923
Funds	\$300,750	\$404,218	\$304,594	\$251,300	\$251,300	\$346,300	\$363,599	\$453,500
<b>Total Projects</b>								
Rural	4	2	8	8	8	8	9	13
Urban	5	7	4	4	6	11	8	13
Individuals served	2,445	4,213	4,816	6,391	3,700	5,681	6,345	7,701
Funds	\$380,349	\$476,158	\$496,392	\$470,000	\$480,000	\$570,150	\$569,299	\$685,700

Table 3-7

## Funding Detail

Primary Care Grants					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	242,700	807,700	568,500	598,900	599,400
General Fund, One-time	(200)	528,500	0	100	100,300
Federal Funds	275,331	0	0	0	0
Dedicated Credits Revenue	7,721	0	0	0	0
GFR - Medicaid Restricted	499,800	5,600	0	0	0
Transfers	4,255	0	0	0	0
Beginning Nonlapsing	166,965	111,806	107,109	110,269	56,300
Closing Nonlapsing	(111,806)	(107,109)	(110,269)	(82,612)	(52,000)
Lapsing Balance	(26,370)	(68,865)	0	0	0
<b>Total</b>	<b>\$1,058,396</b>	<b>\$1,277,632</b>	<b>\$565,340</b>	<b>\$626,657</b>	<b>\$704,000</b>
<b>Categories of Expenditure</b>					
Personal Services	303,854	200,447	12,392	10,388	22,100
In-State Travel	8,275	1,866	55	54	100
Out of State Travel	4,784	2,266	0	0	0
Current Expense	584,708	453,310	487,701	493,453	617,100
DP Current Expense	27,831	6,188	1,154	712	700
Other Charges/Pass Thru	128,944	613,555	64,038	122,050	64,000
<b>Total</b>	<b>\$1,058,396</b>	<b>\$1,277,632</b>	<b>\$565,340</b>	<b>\$626,657</b>	<b>\$704,000</b>
<b>Other Data</b>					
Total FTE	7.0	7.5	0.5	0.6	0.6

Table 3-8



**CHAPTER 4 WORKFORCE FINANCIAL ASSISTANCE PROGRAM**

**Function** The Legislature established the Workforce Financial Assistance Program during the 2002 Legislative General Session by consolidating the Physicians and Physician Assistants Grant and Scholarship Program, the Nurse Education Financial Assistance Program, and the Special Population Health Care Provider Financial Assistance Program. The purpose of the combined Workforce Financial Assistance Program is to increase the number of health care professionals (physicians, physician assistants, nurses, dentists, mental health therapists, or other health care professionals) in underserved areas in the State through loan repayment grants and scholarships in return for providing professional services for an obligated period of time serving medically underserved populations in the state. Funding for this program is designated as nonlapsing and is appropriated as a separate line item, in accordance with UCA 26-46-102(4).

**Statutory Authority** The Workforce Financial Assistance Program is governed by Title 26, Chapter 46 of the Utah Code.

- UCA 26-46 creates the Utah Health Care Workforce Financial Assistance Program Advisory Committee and establishes the department’s authority to administer the program.

**Accountability** The Workforce Financial Assistance Program has outlined the following performance measure:

<b>Performance Data Summary - Workforce Financial Assistance</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005 Target</b>
			<b>Target</b>	<b>Observed</b>	
Award grants to health care professionals to increase access to appropriate high quality, cost-effective primary health care services to targeted Utah medically underserved, low-income populations.	Number of grants awarded to health care professionals providing primary health care services to targeted populations.	Output	50 grants	51 grants	50 grants

**Table 4-1**

Of those individuals that have completed their service obligation, 83 percent have either remained in their original service areas or within the same county where their service obligation began. Placements have been made in 26 of Utah's 29 counties, allowing those communities the opportunity for more comprehensive primary health care. Over the course of its existence, the program has provided funding to secure the obligation of a total of 862 years of service.

The following table represents the number of grants approved classified by healthcare profession.

HEALTH CARE WORKFORCE FINANCIAL ASSISTANCE PROGRAM								
	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Physician	3	4	3	11	10	3	13	4
Physician Assistant	3	1	1	3	0	1	2	0
Nurse	17	25	13	23	14	0	19	5
Mental Health Therapist	0	1	3	4	1	1	16	2
Dentist	0	1	2	1	1	0	1	1
Total Number of Grants	23	32	22	42	26	5	51	12
Funds	\$600,000	\$595,000	\$585,000	\$568,000	\$530,500	\$528,800	\$510,300	\$419,700

Table 4-2

**Funding Detail**

The Financial Assistance Program’s funding comes from the state General Fund, including nonlapsing General Fund appropriations.

Workforce Financial Assistance					
Sources of Finance	2001 Actual	2002 Actual	2003 Actual	2004 Actual	2005 Appropriated
General Fund	563,200	565,600	528,800	419,300	419,700
General Fund, One-time	0	(37,900)	0	100	200
Federal Funds	20,698	55,227	63,071	43,676	0
Beginning Nonlapsing	1,309,216	1,292,831	1,152,361	1,177,932	945,100
Closing Nonlapsing	(1,292,831)	(1,152,361)	(1,177,933)	(1,210,709)	(370,100)
Lapsing Balance	0	50	0	0	0
<b>Total</b>	<b>\$600,283</b>	<b>\$723,447</b>	<b>\$566,299</b>	<b>\$430,299</b>	<b>\$994,900</b>
<b>Categories of Expenditure</b>					
Personal Services	63,907	31,070	21,440	19,357	15,400
In-State Travel	1,884	958	2,864	516	2,900
Current Expense	531,548	691,184	541,060	409,897	975,900
DP Current Expense	2,944	235	935	529	700
<b>Total</b>	<b>\$600,283</b>	<b>\$723,447</b>	<b>\$566,299</b>	<b>\$430,299</b>	<b>\$994,900</b>
<b>Other Data</b>					
Total FTE	1.5	0.0	0.4	0.3	0.3

Table 4-3

**CHAPTER 5 EPIDEMIOLOGY AND LABORATORY SERVICES**

<b>Function</b>	The Division of Epidemiology and Laboratory Services encompasses a director's office, three programs within the State Health Laboratory and two programs associated with community health services.
<b>Statutory Authority</b>	<p>The Division of Epidemiology and Laboratory Services is governed by the Utah Health Code, Title 26 of the Utah Code.</p> <ul style="list-style-type: none"><li>➤ UCA 26-6 and 26-6b are established to define, control, and treat various communicable diseases.</li><li>➤ UCA 26-15 outlines the Department's efforts, in conjunction with those of local health departments, in relation to general sanitation, including those dealing with the Indoor Clean Air Act.</li><li>➤ UCA 26-15a outlines the Department's efforts, in conjunction with those of local health departments, in relation to food safety.</li><li>➤ UCA 26-23b outlines the procedures to be taken during a public health emergency.</li></ul>

**Accountability** The Division of Epidemiology and Laboratory Services has outlined the following performance measures:

<b>Performance Data Summary - Epidemiology and Laboratory Services</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
<b>Laboratory Testing</b> - Total testing for Microbiology and Chem & Env Services	Number of tests performed: is a measure of work load and customers served	Output	582,000	571,399	580,000
<b>Forensic Toxicology</b> - Average turn around time for testing	This is the average number of days required to move samples through the lab each month.	Output	21 days	24 days	21 days
<b>Communicable Disease Control</b> - Chlamydia Incidence	Reduce the proportion of adolescents & young adults attending STD clinics with chlydmia trachomatis infections to 3%	Output	3%	6.49%	3%
AIDS Drug Assistance Pgm.	Track number of individuals who receive HIV drugs annually	Output	n/a	327	350
<b>Epidemiology</b> - Case count and rate of WNV (human) (count/rate)	Evaluate the occurrence of WNV over time to ensure adequate management	Output	<1,500 cases (calendar year)	9 cases *	<1,500 cases (calendar year)
Inspections of licensed food establishments	To determine the ratio of food inspectors to licensed food establishments	Output	1 per 300 restaurants	1 per 290 restaurants	1 per 300 restaurants

\* data as of Sept. 30, 2004

**Table 5-1**

**Funding Detail**

The Division's funding comes from three main sources - the state General Fund, Federal Funds, and dedicated credits.

<b>Epidemiology &amp; Lab Services</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	4,611,900	4,696,800	4,218,000	4,037,800	4,188,600
General Fund, One-time	302,700	(302,300)	0	9,200	28,400
Federal Funds	6,616,566	7,659,618	7,822,114	7,981,803	7,586,600
Dedicated Credits Revenue	1,658,907	2,126,604	2,680,984	2,456,542	2,948,900
GFR - State Lab Drug Testing Account	149,400	267,900	270,800	277,600	293,600
Transfers	773,129	548,077	41,495	503,473	7,000
Beginning Nonlapsing	203,892	413,800	313,800	313,800	0
Closing Nonlapsing	(413,800)	(313,800)	(313,800)	(313,800)	0
Lapsing Balance	(11,744)	15,672	(332,305)	(6,748)	0
<b>Total</b>	<b>\$13,890,950</b>	<b>\$15,112,371</b>	<b>\$14,701,088</b>	<b>\$15,259,670</b>	<b>\$15,053,100</b>
<b>Programs</b>					
Director's Office	1,705,834	1,418,070	1,029,687	555,076	476,900
Chemical and Environmental Services	1,950,790	2,246,033	2,405,496	1,727,781	2,544,000
Laboratory Improvement	919,752	932,143	911,711	847,787	996,800
Microbiology	1,910,466	2,016,253	1,519,046	1,696,549	1,808,400
Communicable Disease Control	4,931,429	5,468,051	6,840,978	6,899,855	6,744,900
Food Safety and Environmental Health	457,697	237,227	0	0	0
Epidemiology	2,014,982	2,794,594	1,994,170	2,651,820	2,482,100
Forensic Toxicology	0	0	0	880,802	0
<b>Total</b>	<b>\$13,890,950</b>	<b>\$15,112,371</b>	<b>\$14,701,088</b>	<b>\$15,259,670</b>	<b>\$15,053,100</b>
<b>Categories of Expenditure</b>					
Personal Services	6,431,693	6,849,282	6,895,631	7,169,310	7,700,700
In-State Travel	35,198	33,403	23,566	25,021	40,800
Out of State Travel	79,395	95,427	98,345	120,266	129,200
Current Expense	3,978,929	5,095,473	5,644,501	5,637,598	5,348,000
DP Current Expense	330,467	169,327	211,192	359,698	252,800
DP Capital Outlay	0	193,176	0	291,961	0
Capital Outlay	212,011	386,363	134,465	225,430	67,500
Other Charges/Pass Thru	2,823,257	2,289,920	1,693,388	1,430,386	1,514,100
<b>Total</b>	<b>\$13,890,950</b>	<b>\$15,112,371</b>	<b>\$14,701,088</b>	<b>\$15,259,670</b>	<b>\$15,053,100</b>
<b>Other Data</b>					
Total FTE	131.5	142.1	129.3	142.7	140.7
Vehicles	3	3	3	3	3

Table 5-2

**Special Funding**

As shown in Table 5-2, a portion of the funding for this division comes from the State Laboratory Drug Testing Account, as detailed in the following table.

Restricted Funds Summary - Epidemiology and Laboratory Services				
Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2004 Balance
GFR-State Laboratory Drug Testing Account	26-1-34	Portion of fees generated from the reinstatement of certain licenses. See 53-3-106(5)	To perform drug and alcohol analysis tests for state and local law enforcement agencies.	\$58,209

Table 5-3

**DIRECTOR'S OFFICE**

**Function**

The Division of Epidemiology and Laboratory Services was formed during FY 1996 with the consolidation of other divisions within the Department. This program provides administration of public health and environmental health programs. These programs include environmental testing and toxicology, laboratory licensure, microbiology, communicable disease control, and epidemiology.

**Funding Detail**

Director's Office					
	2001 Actual	2002 Actual	2003 Actual	2004 Actual	2005 Appropriated
<b>Sources of Finance</b>					
General Fund	611,600	635,000	481,300	469,700	473,700
General Fund, One-time	13,600	(80,000)	0	1,200	3,200
Federal Funds	930,032	537,676	470,840	0	0
Dedicated Credits Revenue	18,401	37,055	9,445	0	0
Transfers	750	0	0	0	0
Beginning Nonlapsing	203,892	413,800	313,800	313,800	0
Closing Nonlapsing	(413,800)	(313,800)	(313,800)	(313,800)	0
Lapsing Balance	341,359	188,339	68,102	84,176	0
<b>Total</b>	<b>\$1,705,834</b>	<b>\$1,418,070</b>	<b>\$1,029,687</b>	<b>\$555,076</b>	<b>\$476,900</b>
<b>Categories of Expenditure</b>					
Personal Services	465,292	411,950	334,894	299,454	362,900
In-State Travel	1,311	2,150	238	559	200
Out of State Travel	2,669	4,114	2,223	(410)	5,000
Current Expense	123,935	183,240	87,117	102,092	86,500
DP Current Expense	98,167	27,456	18,470	34,516	22,300
Capital Outlay	124,294	282,590	115,905	118,865	0
Other Charges/Pass Thru	890,166	506,570	470,840	0	0
<b>Total</b>	<b>\$1,705,834</b>	<b>\$1,418,070</b>	<b>\$1,029,687</b>	<b>\$555,076</b>	<b>\$476,900</b>
<b>Other Data</b>					
Total FTE	8.0	8.0	6.3	6.3	6.3
Vehicles	3	3	3	3	3

Table 5-4

**CHEMICAL AND ENVIRONMENTAL SERVICES**

**Function**

The Bureau of Chemical and Environmental Services provides testing of water, soil, and air to monitor the environment to assure compliance with health and safety standards, and to respond to emergencies such as chemical spills and contaminated drinking water. The tests, requested primarily by the Department of Environmental Quality and the Department of Natural Resources, assist those departments in assessing the safety of the environment.

New capacity has been developed to test for chemical agents and respond to chemical terrorism incidents as a result of federal funding from the Center for Disease Control and Prevention (CDC). The laboratory is now able to analyze for heavy metals and cyanide in chemical samples to determine exposure of these chemicals to humans. The bureau has been reorganized to include sample receiving activities for the environmental testing functions.

The bureau is also working on a BioMonitoring project funded by CDC in collaboration with epidemiologists in the Environmental Epidemiology program. The goal of this study is to provide the Office of Epidemiology with test results to assess human exposure to environmental chemicals.

During FY 2004, the division reorganized by moving the drug and alcohol analysis and testing functions from this program to a new “Forensic Toxicology” program. The FY 2004 expenditure data reflects this change.

The following table shows the laboratory workload for this bureau for the fiscal years 2001 through 2004.

<b>LABORATORY WORKLOAD (Tests)</b>				
	<b><u>FY 2001</u></b>	<b><u>FY 2002</u></b>	<b><u>FY 2003</u></b>	<b><u>FY 2004</u></b>
Inorganic Chemistry Section	121,520	102,867	112,886	85,397
Radiation Chemistry	325	333	251	350
Organic Chemistry	3,917	4,112	3,534	20,376
Environmental Microbiology		4,562	4,079	16,312
<b>Totals</b>	<b><u>125,762</u></b>	<b><u>111,874</u></b>	<b><u>120,750</u></b>	<b><u>122,435</u></b>

**Table 5-5**

## Funding Detail

Chemical and Environmental Services					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	1,374,300	1,418,800	1,517,300	1,459,900	1,730,200
General Fund, One-time	100	(48,700)	0	4,000	11,400
Dedicated Credits Revenue	406,520	415,034	586,667	694,941	508,800
GFR - State Lab Drug Testing Account	149,400	267,900	270,800	0	293,600
Transfers	79,743	100,039	0	0	0
Lapsing Balance	(59,273)	92,960	30,729	(431,060)	0
<b>Total</b>	<b>\$1,950,790</b>	<b>\$2,246,033</b>	<b>\$2,405,496</b>	<b>\$1,727,781</b>	<b>\$2,544,000</b>
<b>Categories of Expenditure</b>					
Personal Services	1,545,710	1,721,711	1,852,590	1,290,182	1,961,600
In-State Travel	520	960	851	123	800
Out of State Travel	1,585	6,632	9,561	12,926	5,000
Current Expense	382,533	433,414	502,419	345,751	491,100
DP Current Expense	20,442	15,816	28,837	42,034	18,000
Capital Outlay	0	67,500	11,238	36,765	67,500
<b>Total</b>	<b>\$1,950,790</b>	<b>\$2,246,033</b>	<b>\$2,405,496</b>	<b>\$1,727,781</b>	<b>\$2,544,000</b>
<b>Other Data</b>					
Total FTE	29.5	31.0	31.5	23.4	32.6

Table 5-6

## FORENSIC TOXICOLOGY

## Function

During FY 2004, the division created this program by moving the drug and alcohol analysis and testing functions from the Environmental Testing and Toxicology program. The Funding Detail reflects the beginning of expenditures in FY 2004. No appropriations were made for FY 2005.

The Bureau of Forensic Toxicology provides drug and alcohol analysis needed by law enforcement agencies to support driving under the influence violations, including automobile homicide. In addition, the bureau provided testing for drug, alcohol, and other poisons in autopsy specimens to assist the Office of the Medical Examiner in determining the cause and manner of death.

The number of tests for both law enforcement and the Medical Examiner show significant increases in FY 2004. This is due to the increase in samples from these agencies in addition to changes in laboratory analytical methods, such as screening multiple tissues for drugs.

LABORATORY WORKLOAD (Tests)				
	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Law Enforcement Toxicology	15,476	17,103	15,938	25,058
Medical Examiner Toxicology	6,903	8,198	8,171	9,079
<b>Totals</b>	<b>22,379</b>	<b>25,301</b>	<b>24,109</b>	<b>34,137</b>

Table 5-7

**Funding Detail**

Forensic Toxicology					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
Dedicated Credits Revenue	0	0	0	1,814	0
GFR - State Lab Drug Testing Account	0	0	0	277,600	0
Lapsing Balance	0	0	0	601,388	0
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$880,802</b>	<b>\$0</b>
<b>Categories of Expenditure</b>					
Personal Services	0	0	0	618,379	0
In-State Travel	0	0	0	219	0
Out of State Travel	0	0	0	1,096	0
Current Expense	0	0	0	183,961	0
DP Current Expense	0	0	0	7,347	0
Capital Outlay	0	0	0	69,800	0
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$880,802</b>	<b>\$0</b>
<b>Other Data</b>					
Total FTE	0.0	0.0	0.0	11.6	0.0

Table 5-8

**LABORATORY IMPROVEMENT**

**Function**

The Bureau of Laboratory Improvement sets and enforces standards for those laboratories that perform tests that impact public health.

The following table shows the total number of laboratory service units (certifications and inspections, safety, training, internal quality assurances, and other support functions for the laboratory) accomplished during the past four years.

LABORATORY WORKLOAD (Tests)				
	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Service Units				
Sample receiving	7,802	8,049	9,697	9,621
Environ. Labs drinking water	48	58	64	65
Environ. Labs water quality	60	68	70	75
Environ. Labs solid & haz. waste	56	97	65	66
Clinical Accreditation labs	103	106	112	110
Clinical Certification labs	217	215	199	200
Clinical PPM labs	252	270	278	273
Clinical Waived labs	425	440	470	521
Training Hours	2,092	672	1,275	756
<b>Totals</b>	<b>11,055</b>	<b>9,975</b>	<b>12,230</b>	<b>11,687</b>

Table 5-9

## Funding Detail

Laboratory Improvement					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	418,300	416,900	353,200	346,600	479,200
General Fund, One-time	313,700	(74,000)	0	1,000	4,800
Federal Funds	92,332	92,998	92,606	119,651	98,300
Dedicated Credits Revenue	295,979	522,507	395,171	451,626	414,500
Lapsing Balance	(200,559)	(26,262)	70,734	(71,090)	0
<b>Total</b>	<b>\$919,752</b>	<b>\$932,143</b>	<b>\$911,711</b>	<b>\$847,787</b>	<b>\$996,800</b>
<b>Categories of Expenditure</b>					
Personal Services	820,485	819,564	808,763	740,248	894,000
In-State Travel	3,502	2,867	3,576	3,745	3,000
Out of State Travel	11,705	18,238	25,384	18,048	25,200
Current Expense	73,051	78,638	66,789	65,140	68,500
DP Current Expense	11,009	12,836	7,199	20,606	6,100
<b>Total</b>	<b>\$919,752</b>	<b>\$932,143</b>	<b>\$911,711</b>	<b>\$847,787</b>	<b>\$996,800</b>
<b>Other Data</b>					
Total FTE	18.5	19.0	19.0	19.0	19.0

Table 5-10

## MICROBIOLOGY

### Function

The Bureau of Microbiology provides laboratory support services for local health departments; hospitals, clinics, labs, and physicians throughout Utah; the Utah Department of Agriculture; State Mosquito Abatement; the Department of Environmental Quality; the Division of Community and Family Health Services; and the State Medical Examiner. The areas of

support include newborn screening, HIV, sexually-transmitted diseases, agents of bioterrorism surveillance, arbovirus surveillance, virology, rabies testing, bacteriology, mycology, mycobacteriology, parasitology, as well as outbreak control (food and waterborne), and communicable disease outbreak support, i.e., influenza, pertussis.

The bureau works in close support with state epidemiology to provide test data for disease surveillance and statistics across the entire state.

The FTE count increased from FY 2003 to FY 2004 by two, as a result of a new federal grant from the CDC. This increase in staff has allowed the lab to prepare for West Nile, influenza, and other diseases.

The following table shows the bureau's workload for the past several years.

<b>LABORATORY WORKLOAD (Tests)</b>				
	<b><u>FY 2001</u></b>	<b><u>FY 2002</u></b>	<b><u>FY 2003</u></b>	<b><u>FY 2004</u></b>
Bacteriology Section	39,637	9,946	7,088	7,469
Virology Section	66,195	67,300	48,236	43,412
Immunology Section	52,975	55,545	24,020	21,618
Newborn Screening	493,617	540,750	520,655	468,598
Molecular Biology	469	4,064	4,349	9,916
<b>Totals</b>	<b><u>652,893</u></b>	<b><u>677,605</u></b>	<b><u>604,348</u></b>	<b><u>551,013</u></b>

**Table 5-11**

The drop in the number of tests from FY 2002 to FY 2003 reflects the loss of General Funds over the past year. Selected services were either reduced or eliminated if those services were available from other laboratories. The lab has shifted to providing more complex (and more costly and time-consuming) tests that are required for epidemiological investigations and disease prevention efforts.

## Funding Detail

Microbiology					
Sources of Finance	2001 Actual	2002 Actual	2003 Actual	2004 Actual	2005 Appropriated
General Fund	577,800	561,800	447,200	432,700	140,800
General Fund, One-time	(100)	(4,400)	0	700	800
Federal Funds	151,040	404,726	89,457	233,455	327,400
Dedicated Credits Revenue	937,890	1,149,063	1,316,736	1,221,416	1,339,400
Transfers	310,439	61,981	0	0	0
Lapsing Balance	(66,603)	(156,917)	(334,347)	(191,722)	0
<b>Total</b>	<b>\$1,910,466</b>	<b>\$2,016,253</b>	<b>\$1,519,046</b>	<b>\$1,696,549</b>	<b>\$1,808,400</b>
<b>Categories of Expenditure</b>					
Personal Services	989,300	1,026,536	835,823	836,166	946,900
In-State Travel	722	178	47	0	200
Out of State Travel	8,854	3,993	1,658	3,235	8,000
Current Expense	778,973	895,435	644,782	803,028	814,200
DP Current Expense	39,900	14,638	36,736	54,120	39,100
DP Capital Outlay	0	37,700	0	0	0
Capital Outlay	87,717	36,273	0	0	0
Other Charges/Pass Thru	5,000	1,500	0	0	0
<b>Total</b>	<b>\$1,910,466</b>	<b>\$2,016,253</b>	<b>\$1,519,046</b>	<b>\$1,696,549</b>	<b>\$1,808,400</b>
<b>Other Data</b>					
Total FTE	22.6	23.1	16.6	17.6	18.6

Table 5-12

## COMMUNICABLE DISEASE CONTROL

## Function

The Bureau of Communicable Disease Control focuses its efforts on providing technical assistance and capacity building expertise to the community and to local health departments in the areas of HIV disease prevention, counseling/testing services, surveillance, treatment and care; tuberculosis (TB); hepatitis C; sexually transmitted disease (STD) control and elimination; and refugee health assessment. Services include consultation, direct client programs and contract monitoring provided by bureau staff and through contracts with other governmental agencies, local health departments and community-based organizations. Funding sources include the Centers for Disease Control and Prevention (CDC), Health Resources Services Administration (HRSA), the Utah Department of Workforce Services, and the Office of Refugee Resettlement (ORR).

The mission of the bureau is to protect the public health by:

- documenting and analyzing the incidence and prevalence of HIV disease, Hepatitis C, TB, STDs, and refugee health concerns;
- assessing community-based needs for prevention and care services in refugee and high-risk populations;

- developing policies and implementing strategies to prevent, control, and treat individuals with HIV disease, Hepatitis C, TB, and STDs, and;
- assuring that policies and strategies are implemented to ensure the improved health of affected populations.

*HIV Prevention*

The goals of the HIV Prevention Program are to provide education and training programs which emphasize reduction and prevention for diverse populations, including individuals at high risk (men who have sex with men, youth, women, injecting drug users, and ethnic populations), and to provide confidential or anonymous HIV pre- and post-test counseling, testing and referral services to approximately 6,357 individuals at publicly-funded sites (local health departments). Counseling and testing efforts attempt to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV through “client-centered” pre-and post test counseling, and partner counseling and referral services. The program also provides information on services available in the community to those who test positive or to those that might be considered “high-risk” and have tested negative including those individuals in occupational exposures.

Table 5-13 shows the number of tests administered and individuals receiving counseling.

<u>Service Provided</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Confidential Tests	5,221	4,800	5,920	6,357
Anonymous Tests	379	328	306	251
EMS Reports	44	49	76	41
Partner Counseling				
Client	53	57	40	33
Partner	97	86	75	40

**Table 5-13**

*HIV/AIDS  
Surveillance Program*

Surveillance program activities include public health efforts to study HIV/AIDS incidence and prevalence within the state. HIV/AIDS data are analyzed by demographic factors, i.e. race, risk, age, and gender in order to determine infection trends and to formulate prevention strategies.

The incidence rate of new cases is shown in the Table 5-14.

<u>New AIDS Cases</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004 *</u>
HIV	47	41	60	101	52
AIDS	142	116	70	72	41
Total	189	157	130	173	93

\* Through June 2004

**Table 5-14**

*HIV/AIDS Treatment and Care Program*

The Surveillance Program also documents tuberculosis infection and disease in Utah. The program works closely with laboratories and health providers in order to encourage disease reporting to the department.

The goal of the Title II program is to provide for the development, organization, coordination, and operation of a more effective and cost-effective system for the delivery of essential services to individuals and families with HIV disease. Individuals and their families affected by HIV are provided essential health and support services if they are not covered or are under-insured by private health insurance and do not qualify for Medicaid, Medicare, or other state or local programs. These activities are accomplished primarily through supportive services, a home and community based care program, and an AIDS drug assistance program.

The home health program, established in 1990, provides the following services: homemaker, health aide, personal care, routine diagnostic tests administered in the home, and durable medical equipment.

The AIDS Drug Assistance Program (ADAP), established in 1987, assists people living with HIV/AIDS to access AIDS-related medications.

The Health Insurance Continuation Program pays all or part of a person's health insurance premium if the person has HIV disease and is eligible to COBRA their health benefits. A premium payment program assists individuals with HIV disease who are not eligible for other insurance coverage, to obtain insurance through the Utah Comprehensive Health Insurance Pool (HIP), by providing monthly premium payments, copays, and deductibles.

Supportive services provide individuals with HIV the following services: dental services, food vouchers, mental health counseling, transportation, eye exams and glasses, legal advocacy, emergency funding, nutrition services, substance abuse services, case management, and short-term housing.

Table 5-15 reflects the use of services by individuals who have been diagnosed with HIV. (Note: Supportive Services were formerly administered by a contractor. They are now administered directly by the Treatment and Care Program.)

<u>Services Received</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
ADAP	209	228	295	225	332
Home Health	11	14	13	21	22
Insurance Continuation	51	148	166	177	180
Supportive Services				778	777

Table 5-15

*Tuberculosis (TB) Control Program*

The goal of the Tuberculosis (TB) Control Program is to reduce the incidence of TB in Utah through prompt identification and treatment of active TB cases, and the investigation and treatment of those who may have been in contact

with someone with active TB. Medications, medical expertise, and public health nursing are provided at no charge to the client. The program also provides preventive treatment to those with TB infection that has not progressed to the disease.

<u>TB Cases</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004 *</u>
TB Cases	49	35	31	39	33
Drug-resistant cases	12	8	5	3	5

\* Through October 15, 2004.

Table 5-16

*Refugee Health Program*

The federally-funded Refugee Health Program provides health screening and follow-up to newly arriving refugees in the State. Health screening is essential to protect Utah's resident population from exposure to communicable diseases and related problems.

<u>Refugees</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004 *</u>
Total Refugees	1,085	861	374	491	411
Refugees with TB	4	5	4	1	0
Refugees receiving health screen	1,046	691	364	357	343

\* Through June 2004

Table 5-17

*Sexually Transmitted Disease (STD) Control Program*

The Sexually Transmitted Disease Control Program is responsible for the detection, treatment, and control of STDs diseases. The STD Control Program coordinates with local health departments, the federal government, and other states with STD cases, issues, and concerns. STDs can cause harmful, often irreversible health complications such as reproductive health problems, fetal and perinatal health problems, and cancer. Women are biologically more susceptible to infection and suffer more frequently and more seriously to STD complications than do men. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy, infertility, and chronic pelvic pain. Program efforts include screening, examination, diagnosis, education, case and data management, partner notification, technical assistance, and epidemiological studies, analysis, and research. Without appropriate investigation and control, community wide outbreaks can occur. Currently, the STD Control Program has expanded screening, treatment, and education into high risk youth detention centers, homeless youth populations, and substance abuse youth treatment centers. The majority of STD infections occur among persons 15-24 years of age. In the past two years, over 4,000 reportable STD cases have been reported to the bureau. Between FY 2001 and FY 2003, the incidence rate for the most reportable STD – Chlamydia – has increased over 100 percent. During this same time, gonorrhea has increased 102 percent. While females account for approximately 70 percent of all Chlamydia infections, the need to test males is of significant importance to control the spread of this disease.

<u>Number of Cases Identified</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004 Est.</u>
Syphilis (Primary & Secondary)	8	7	9	15
Gonorrhea	197	268	438	487
Chlamydia	2,114	3,351	4,208	3,745

Table 5-18

*Hepatitis C Program*

The Hepatitis C Program activities include efforts to prevent and control hepatitis C virus (HCV) that are integrated with HIV Prevention and STD Control Programs. The focus is on managing, networking, and building technical expertise and capacity within the programs to control the spread of HCV.

HCV is a reportable disease. The following table shows the number of reported infections from private physicians and labs.

	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004 Est.</u>
HCV reported	1,888	1,917	1,868	1,100
<small>* Through August 2004</small>				

Table 5-19

## Funding Detail

<b>Communicable Disease Control</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	689,700	699,800	671,100	594,400	609,900
General Fund, One-time	(200)	(33,000)	0	500	3,800
Federal Funds	3,951,100	4,509,897	5,895,647	5,705,983	5,572,500
Dedicated Credits Revenue	117	5	292,447	5,180	551,700
Transfers	290,302	281,233	0	501,604	7,000
Lapsing Balance	410	10,116	(18,216)	92,188	0
<b>Total</b>	<b>\$4,931,429</b>	<b>\$5,468,051</b>	<b>\$6,840,978</b>	<b>\$6,899,855</b>	<b>\$6,744,900</b>
<b>Categories of Expenditure</b>					
Personal Services	1,034,428	1,169,110	1,557,993	1,701,419	1,810,500
In-State Travel	9,890	10,612	10,144	13,573	18,500
Out of State Travel	21,472	26,334	23,588	43,610	43,500
Current Expense	2,378,279	2,798,680	4,115,521	3,910,873	3,654,000
DP Current Expense	87,970	31,021	48,102	81,989	71,800
Capital Outlay	0	0	7,322	0	0
Other Charges/Pass Thru	1,399,390	1,432,294	1,078,308	1,148,391	1,146,600
<b>Total</b>	<b>\$4,931,429</b>	<b>\$5,468,051</b>	<b>\$6,840,978</b>	<b>\$6,899,855</b>	<b>\$6,744,900</b>
<b>Other Data</b>					
Total FTE	21.5	23.8	29.0	33.5	33.5

Table 5-20

## EPIDEMIOLOGY

## Function

The Office of Epidemiology is responsible for the detection, investigation, and control of communicable and infectious diseases and for surveillance and investigation of health effects associated with environmental hazards. The office operates two programs: the Communicable Disease Epidemiology Program and the Environmental Epidemiology Program. The programs have adapted the *U.S. Healthy People 2010 Goals and Objectives*, and activities are established to meet the UDOH goals of protecting the public health, improving quality of life, preventing disease and premature death, and promoting healthy lifestyles for the residents of the State.

The Office is responsible for developing and operating surveillance systems to detect bioterrorism and for assuring epidemiological preparedness to respond to an accident of bioterrorism or the similar threat of pandemic disease.

*Communicable  
Disease Epidemiology  
Program*

The Communicable Disease Epidemiology Program (CDEP) conducts communicable disease surveillance and management. The responsibilities of CDEP include assisting with the identification, investigation, and management of communicable diseases and outbreaks. Epidemiological investigations are conducted in conjunction with local health departments to identify risk factors and implement appropriate control measures and prevention strategies. The program also responds rapidly to suspect and confirmed cases of diseases of

public health significance, aiding local health departments, healthcare workers, and the public in implementing control and prevention measures. In addition, the program provides consultation regarding communicable diseases to healthcare professionals, healthcare facilities, and a variety of local, state, and federal agencies, and acts as a liaison to the Centers for Disease Control and Prevention (CDC) for disease investigations in Utah.

The program conducts routine analyses of surveillance data, generating and evaluating daily reports. These reports incorporate statistical methods to interpret disease trends over time to identify clusters of disease that may indicate an outbreak. The program also develops surveillance reports that provide communicable disease trend data to the public, healthcare professionals, and local, state, and federal partners on a regular basis and as requested.

The program is responsible for maintaining the current National Electronic Telecommunication System for Surveillance (NETSS) and providing support to local health departments in using this system to store and manage communicable disease data. The program is also responsible for building, implementing, and maintaining the National Electronic Disease Surveillance System (NEDSS) in Utah as part of a national effort to improve mechanisms for disease reporting, public health surveillance, and disease control practices. NEDSS will replace NETSS, providing a web-based system for storing and managing communicable disease data, as well as a mechanism for allowing case management functions to be monitored and evaluated by local and state health department staff simultaneously. The program utilizes technology for statewide surveillance systems that will improve public health’s ability to detect bioterrorism and other large-scale events and enhance preparedness for responding to such events in coordination with local and federal agencies such as CDC.

As CDEP is a newly reorganized program, there is a mixture of measures which includes historical values, as well as new goals that will demonstrate success for the program in their initiation this year and measurement in subsequent years. Illustration of CDEP’s work to prevent, manage, and control communicable diseases, in collaboration with other programs and agencies as appropriate, is included in Table 5-21.

<u>Activities</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>
Hepatitis A infections	66	66	55	39
Salmonellosis	482	225	181	228
E. Coli infections	84	58	95	99
WNV (human)				1
WNV (mosquito poolshuman)				2
WNV (horses)				35
WNV (sentinel chickenshuman)				9
WNV (birds)				4

Table 5-21

*Environmental  
Epidemiology  
Program*

The Environmental Epidemiology Program (EEP) addresses environmental hazards and diseases in Utah. The mission of the program is to develop and support, in partnership with other public and private agencies nationally and in Utah, programs to prevent or reduce the potential for acute and chronic morbidity and mortality associated with environmental and occupational factors, including exposure to toxic substances, reproductive hazards, unsafe work environments, and agents responsible for debilitating diseases. The program conducts epidemiological investigations, cooperates with local, state, and federal agencies in problems related to hazardous substance exposure, and researches environmental and occupational health problems.

During calendar year 2003, 566 consultations and 1,696 investigations were conducted, and 4,084 person-hours of training were provided by EEP staff. For the first half of 2004, 545 consultations and 986 investigations were conducted and 3,292 person hours of training were provided. Investigations conducted include: burn injuries, releases of hazardous chemicals, comprehensive public health assessments of superfund hazardous waste sites, cancer cluster investigations in communities concerned about high cancer rates, sources of lead poisonings in children and adults, and exposure investigations of communities exposed to hazardous chemical releases.

The food safety and environmental health programs’ goal is to reduce premature death and disability due to the effects of secondhand smoke, contaminated food, and poor sanitation at public swimming pools, public lodging, schools, and many other public places. With the focus to decrease premature death and disability due to contaminated food served to the public, this program provides consultation to food and restaurant inspectors. This program also seeks to establish and maintain a consistent approach to environmental health regulation across the 12 local health districts in Utah.

The Utah Indoor Clean Air Act (UICCA) program is conducted jointly with the staff in the Bureau of Health Promotion. This program helps reduce morbidity and mortality attributable to one of the most preventable causes of premature death and disability – secondhand tobacco smoke.

The following table shows some of the functions performed by the Environmental Epidemiology Program.

<u>Activities</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>
Ratio of restaurant inspectors to licensed food establishments	1:292	1:229	1:220	1:277
Prevalence of children with Blood Lead levels >= 10 ug/dl	1.7%	1.3%	1.2%	1.7%
Incidence of work-related burns per 100,000 workforce	8.1	18.8	26.4	14.3

**Table 5-22**

## Funding Detail

Epidemiology					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	534,400	531,400	747,900	734,500	754,800
General Fund, One-time	(24,300)	(7,000)	0	1,800	4,400
Federal Funds	1,492,062	2,114,321	1,273,564	1,922,714	1,588,400
Dedicated Credits Revenue	0	2,929	80,518	81,565	134,500
Transfers	57,183	104,824	41,495	1,869	0
Lapsing Balance	(44,363)	48,120	(149,307)	(90,628)	0
<b>Total</b>	<b>\$2,014,982</b>	<b>\$2,794,594</b>	<b>\$1,994,170</b>	<b>\$2,651,820</b>	<b>\$2,482,100</b>
<b>Categories of Expenditure</b>					
Personal Services	1,357,602	1,483,022	1,505,568	1,683,462	1,724,800
In-State Travel	14,768	15,060	8,710	6,802	18,100
Out of State Travel	29,895	35,407	35,931	41,761	42,500
Current Expense	223,079	692,214	227,873	226,753	233,700
DP Current Expense	69,505	63,859	71,848	119,086	95,500
DP Capital Outlay	0	155,476	0	291,961	0
Other Charges/Pass Thru	320,133	349,556	144,240	281,995	367,500
<b>Total</b>	<b>\$2,014,982</b>	<b>\$2,794,594</b>	<b>\$1,994,170</b>	<b>\$2,651,820</b>	<b>\$2,482,100</b>
<b>Other Data</b>					
Total FTE	27.9	33.7	26.9	31.4	30.7

Table 5-23

**CHAPTER 6 COMMUNITY AND FAMILY HEALTH SERVICES****Function**

The Division of Community and Family Health Services assures that women, infants, children, and their families have access to comprehensive, coordinated, affordable, community-based quality health care. Division services are available to all citizens of the State according to their ability to pay, but primary clients are women, infants, and children who have special health care needs and are low income. The division coordinates efforts, identifies needs, prioritizes programs, and develops resources necessary to reduce illness, disability and death from:

- Adverse Pregnancy Outcomes
- Chronic Diseases
- Disabling Conditions
- Injury and Violence
- Vaccine-Preventable Infections

The division is organized into a Director's Office and three functional bureaus.

**Statutory Authority**

The Division of Community and Family Health is governed by various chapters of the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-5 defines chronic diseases and requires the department to establish programs to prevent, delay, and detect the onset of such diseases.
- UCA 26-7 authorizes the department to create programs to promote good health practices and reduce major risk factors that contribute to injury, sickness, death, and disability.
- UCA 26-9f creates the Utah Digital Health Services Commission which deals with telehealth issues.
- UCA 26-10 establishes "Family Health Services" including the metabolic testing of newborns.
- UCA 26-15 requires the department to adopt rules to implement the Utah Indoor Clean Air Act, a function carried out by the Tobacco Prevention Program in the area of Health Promotion.
- UCA 26-21a requires the department to create a program to reduce breast cancer mortality.
- UCA 26-38 is the Utah Indoor Clean Air Act, which restricts smoking in indoor public places, and establishes enforcement authority and penalties for noncompliance.
- UCA 26-42 establishes civil penalties for individuals and/or licensees that sell tobacco products to underage minors.

- UCA 26-43 requires the department to obtain information regarding tobacco products and the level of detectable compounds in them.

**Intent Language**

The Legislature included intent language in the FY 2005 Appropriations Act for the Division of Community and Family Health Services authorizing funding for alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs as nonlapsing.

**Accountability**

The following performance measures have been identified as key measures by the Division of Community and Family Health Services.

<b>Performance Data Summary - Community and Family Health Services</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
Decrease tobacco use among Utah youth	Tobacco use rate for Utah high school students	Outcome		7.3%	7.0%
Increase immunization rates among Utah Children	Utah 2 year olds who are fully immunized	Outcome	80.0%	78.8%	80.0%
Increase early prenatal care among Utah women	Baby Your Baby Hotline calls	Output	18,000	17,553	18,500
Increase early detection of hearing loss	Live births receiving newborn hearing screens	Output	98.5%	98.0%	98.5%
Increase early identification and treatment of developmental problems among Utah children	Children served by Baby Watch Early Intervention	Output		3,021	3,271

**Table 6-1**

**Funding Detail**

This division's primary source of revenue is Federal Funds – due to the significant funding levels for the Women, Infants, and Children (WIC) program. Other significant funding sources include the state General Fund, dedicated credits, transfers, and two restricted funds.

<b>Community &amp; Family Health</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	10,726,300	11,401,200	7,590,000	8,391,900	8,534,400
General Fund, One-time	89,100	(2,758,900)	0	9,900	26,000
Federal Funds	48,943,455	50,951,790	57,163,606	56,391,818	61,403,200
Dedicated Credits Revenue	15,149,264	16,022,679	15,907,105	18,270,659	14,410,300
GFR - Cigarette Tax Rest	250,000	250,000	2,868,400	3,131,500	3,131,500
GFR - Tobacco Settlement	3,998,900	6,053,700	6,061,700	6,061,700	6,149,000
Transfers	2,806,495	2,940,596	3,985,889	1,537,953	4,691,900
Beginning Nonlapsing	139,517	1,024,111	319,934	663,766	0
Closing Nonlapsing	(1,284,894)	(319,934)	(663,766)	(393,762)	0
Lapsing Balance	(2,000)	(259,988)	(95,901)	(1,000)	0
<b>Total</b>	<b>\$80,816,137</b>	<b>\$85,305,254</b>	<b>\$93,136,967</b>	<b>\$94,064,434</b>	<b>\$98,346,300</b>
<b>Programs</b>					
Director's Office	2,812,636	2,656,754	2,199,358	2,179,136	2,249,700
Health Promotion	12,556,755	15,164,367	18,879,781	19,067,324	18,903,100
Maternal and Child Health	47,575,253	47,473,004	50,612,187	49,842,465	53,226,000
Children with Special Health Care Needs	17,871,493	20,011,129	21,445,641	22,975,509	23,967,500
<b>Total</b>	<b>\$80,816,137</b>	<b>\$85,305,254</b>	<b>\$93,136,967</b>	<b>\$94,064,434</b>	<b>\$98,346,300</b>
<b>Categories of Expenditure</b>					
Personal Services	13,870,865	14,335,813	15,191,957	16,107,945	16,997,800
In-State Travel	219,175	225,800	239,195	218,358	315,100
Out of State Travel	201,723	191,834	211,299	202,066	250,800
Current Expense	13,177,923	14,411,230	19,369,568	23,388,581	20,070,200
DP Current Expense	1,438,187	748,609	922,023	1,082,990	1,056,900
DP Capital Outlay	0	0	6,373	17,922	0
Other Charges/Pass Thru	51,908,264	55,391,968	57,196,552	53,046,572	59,655,500
<b>Total</b>	<b>\$80,816,137</b>	<b>\$85,305,254</b>	<b>\$93,136,967</b>	<b>\$94,064,434</b>	<b>\$98,346,300</b>
<b>Other Data</b>					
Total FTE	280.6	290.4	285.6	301.1	295.2
Vehicles	6	7	8	8	8

**Table 6-2**

**Special Funding**

As shown in Table 6-2, a portion of the funding for this division comes from two restricted accounts, as detailed in Table 6-3.

<b>Restricted Funds Summary - Community and Family Health Services</b>				
<b>Fund/Account Name</b>	<b>Statutory Authority</b>	<b>Revenue Source</b>	<b>Prescribed Uses</b>	<b>FY 2004 Balance</b>
Tobacco Settlement Restricted Account	63-97-201	70% of all funds received by the state relative to the settlement agreement with the tobacco manufacturers. (The allocation drops to 55% on July 1, 2006 - see UCA 63-97-201(d))	Alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs . . . with a preference in funding given to tobacco-related programs.	\$5,246,730 (balance listed is total amount in account for all designated purposes)
Cigarette Tax Restricted Account	59-14-204(5)	\$250,000 from the increase in the cigarette tax effective July 1, 1998, and 58% of the revenue generated from the increase in the cigarette tax imposed during the 2002 General Session.	The share to the Department of Health is for tobacco prevention, reduction, cessation, and control programs.	\$2,731,768

**Table 6-3**

**DIRECTOR’S OFFICE**

**Function**

The Office of the Director of the Division of Community and Family Health Services (CFHS) leads and manages all the resources and programs of the division. The office consists of the Director, the administrative secretary, and the Financial Resources Program. The director oversees three bureaus, including Health Promotion, Maternal and Child Health, and Children with Special Health Care Needs.

The Center for Multicultural Health addresses health disparities among ethnic groups through health programs in the department and in the community. The Center aims to foster accessible and high-quality programs and policies that help all racial and ethnic minorities in Utah achieve optimal health, dignity, and independence. The center will accomplish this by increasing public and health professional awareness of persistent racial/ethnic disparities and developing effective health policies and culturally competent programs that lead to better access to quality health care services and improved health status. The Center for Multicultural Health is funded with state General Funds.

The Financial Resources program provides financial management for the division by managing budgets, contracts and grants; ensuring compliance with financial policies and regulations; ensuring the accuracy of all financial transactions; and providing billing services for public services.

Funding Detail

Director's Office					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	587,100	582,800	559,500	549,100	576,400
General Fund, One-time	(9,100)	(16,000)	0	1,600	3,800
Federal Funds	1,972,037	1,733,748	1,646,156	1,615,936	1,669,500
Dedicated Credits Revenue	264,599	373,494	503	0	0
Lapsing Balance	(2,000)	(17,288)	(6,801)	12,500	0
<b>Total</b>	<b>\$2,812,636</b>	<b>\$2,656,754</b>	<b>\$2,199,358</b>	<b>\$2,179,136</b>	<b>\$2,249,700</b>
<b>Categories of Expenditure</b>					
Personal Services	954,133	819,691	738,394	595,167	605,200
In-State Travel	1,003	753	1,007	971	1,300
Out of State Travel	9,806	5,794	2,895	410	2,500
Current Expense	300,789	355,494	56,914	59,737	68,400
DP Current Expense	77,456	27,934	13,670	12,291	14,800
Other Charges/Pass Thru	1,469,449	1,447,088	1,386,478	1,510,560	1,557,500
<b>Total</b>	<b>\$2,812,636</b>	<b>\$2,656,754</b>	<b>\$2,199,358</b>	<b>\$2,179,136</b>	<b>\$2,249,700</b>
<b>Other Data</b>					
Total FTE	20.0	14.4	12.6	8.7	8.7

Table 6-4

HEALTH PROMOTION

Function

The Bureau of Health Promotion includes more than 90 public health professionals focused on reducing premature death and disability due to heart disease, stroke, cancer, diabetes, arthritis, asthma, tobacco, injuries and violence, and lack of prenatal care. The bureau's programs systematically coordinate around common functions such as surveillance and information management, local health departments and other partner relations, media campaigns and related outreach, consumer research, and education of health care providers. Comprehensive population-based interventions are provided at the school, work, community and health care sites, and include primary, secondary, and tertiary prevention strategies.

Cancer Control Program

Cancer places a significant burden on the lives of many Utahns. Many cancer-related programs are categorical in nature; that is they are built around specific cancer sites (e.g. breast, prostate, lung, etc.) and risk factors (e.g. poor nutrition, use of tobacco, etc.) As a result, there is often lack of coordination and collaboration among these programs, efforts are duplicated, and opportunities for cancer prevention and control may be missed. The mission of the Utah Cancer Control Program is to reduce cancer incidence and mortality in Utah through collaborative efforts that provide services and programs directed toward comprehensive cancer prevention and control through the following:

- Maintaining the Utah Cancer Action Network (UCAN), a group of over 100 people from 60 organizations including hospitals, private clinics, government and community agencies, non-profit organizations and other groups who are working together to reduce cancer incidence and mortality for all Utahns.
- Implementing the goals and objectives of the State Cancer Plan written by the members of the UCAN in 2001.
- Sponsoring a meeting for 23 individuals representing primary care, urology, oncology, public health, the insurance industry, the Utah Cancer registry, medical ethics, and the American Cancer Society. The group unanimously opposed the development of statewide, population-based prostate cancer screening. It was agreed that the Department of Health would provide education for both the public and providers.

Breast cancer is the leading cause of cancer death for Utah women. In 2002, 220 Utah women died of breast cancer and 1,073 new cases of invasive breast cancer and 196 in situ were diagnosed. Late stage diagnosis is the primary predictor of poor survival and subsequent mortality.

The Cancer Control Program helps reduce morbidity and mortality from breast and cervical cancers by working with LHDs and other community providers statewide to:

- Provide low cost or free breast and cervical cancer screening (including mammograms) to medically underserved women
- Provide public and professional education about the need for early detection and availability of screening services
- Develop and use a statewide surveillance system to plan and evaluate screening and education efforts

The bureau provides approximately \$625,000 to the local health departments for Cancer Control programs.

*Heart Disease and Stroke Prevention Program (HDSPP)*

The goal of the Heart Disease and Stroke Prevention Program is to decrease premature death and disability due to heart disease and stroke through the following:

- Develop and Coordinate State Partnerships: The Alliance for Cardiovascular Health in Utah, with over 100 partners, has been organized to strengthen health systems for the primary, secondary, and tertiary prevention of heart disease principles that are designed to promote, influence, and assist the public in developing skills and making decisions for healthier choices.
- Assist communities, work-sites, schools, and health care sites in developing effective policies, environment supports and practices that are effective in promoting heart health and preventing heart disease

and stroke, such as the Gold Medal School Initiative, and enhancing infrastructures to make communities more physically active.

- Continue the 5-A-Day efforts, which promote the message to eat at least five servings of fruits and vegetables each day for better health. Since the program began, the proportion of children, adolescents, and adults who eat “5-A-Day” has increased significantly.
- Work with physicians and other care providers and managed care to enhance the primary and secondary prevention efforts of all providers to Utahns at highest risk for heart disease and stroke, especially for high blood pressure and cholesterol, and obesity.
- Increase the knowledge and awareness base of Utahns about the importance of preventing heart disease and stroke for every age group. Maintain a surveillance and evaluation program to monitor heart health and risk status of Utahns, and evaluate effectiveness of program interventions and strategies.
- Provide training and technical assistance to enhance knowledge, skills, and resources of community partners to affect and sustain policy and environmental changes.

Table 6-5 shows some of the outcome measurements associated with this program.

<b>FY 2004 Service</b>	<b>Outcomes</b>
Gold Medal School Initiative (Schools/Students)	138/65,669
Walk Your Child to School Day (Schools/Students)	110/42,000
Students participating in 5 a Day activities	73,140
Utahns receiving prevention messages from events or campaigns	
Direct prevention messages	154,492
Website education	89,000
Newsletters	138,950
Health professionals receiving education	1,037
Teachers, principals, superintendents, and school food service staff receiving school health information and/or training	1,631
Utahns taking action to decrease high levels	
Blood Pressure	89.8%
Cholesterol	91.3%
Percent decrease of adults eating 5-A-Day	19.5%
Percent increase of adolescents eating 5-A-Day	20.3%
Increase in adults getting adequate physical activity	53.3%

**Table 6-5**

*Diabetes Prevention and Control Program (DPCP)*

The Diabetes Prevention and Control Program is funded completely through federal funds. Its mission is to work in partnerships to improve the quality of life of all Utahns at risk for, or affected by, diabetes. Almost four percent (3.7%) of Utahns, or about 87,000 residents, including children, have been diagnosed with diabetes (Utah Health Status Survey 2002-2003). An estimated additional 35,000 residents have diabetes but are unaware of it. Indirectly, diabetes affects the entire population as it is a major cause of morbidity and mortality, placing a huge economic burden on the health care system. Diabetes accounts for over 9% of Utah hospital discharges. In 2002, there were 20,362 discharges for people with diabetes (any listed diagnosis), with charges amounting to over \$268 million. There are also costs related to outpatient treatment, lost productivity, disability, and family resources.

The changing demographics in Utah continue to lead to an increasing percentage of the population at risk. While Utah retains its position as one of the youngest states in the U.S., over one-fourth (26.9%) of the population is age 45 or older (2002 Baseline Projections, Governor's Office of Planning and Budget, UPED Model System/IBIS). About one in 16 Utahns is non-white (6.4%) (Total County Population by Race in Utah: 2002, U.S. Census Bureau, Population Division). There has been a particularly strong growth in the Hispanic constituent. As of 2002, one of 10 Utahns (9.7%) was of Hispanic ethnicity (2002 data reported in The Economic Report to the Governor [2004]). Over half (56.0%) of Utah adults are overweight or obese (BRFSS 2001-2003). The DPCP strives to improve awareness of the risks and treatment of diabetes and its complications (heart disease, end-stage kidney disease, blindness, amputations, hospitalizations and long-term reduction in activity). The DPCP recognizes that access to quality care, up-to-date information and education are important components of diabetes management.

The Diabetes Prevention and Control Program accomplished the following in FY 2004:

Health Communications:

Conducted the sixth phase of its public awareness campaign. The FY04 campaign focused on increasing awareness of the diabetes risk factors and symptoms; prevention and delay of type 2 diabetes; and diabetes care and control methods by Utahns with diabetes. Public Service Announcements (PSA) were aired on English and Spanish television and radio stations. Diabetes messages were distributed on posters, brochures, and a bus wrap. The bus wrap targeted Hispanics and Utahns with diabetes displaying the message "You are the Heart of Your Family, Control Your Diabetes, For Life".

The DPCP additionally updated and delivered its press kit and began collecting the number of stories aired on two local television stations and print media to be compared with future years.

Community-based Activities:

Contracted with six local health departments (Bear River, Southwest, Tooele, Davis, Utah and Weber-Morgan) and four Community Based Organizations (Wendover Resources Council, East Carbon Community Health Center, Midvale City and Mountainlands Community Health Center) to implement awareness activities in these counties/ districts. Diabetes coordinators distributed information to physicians, clinics, grocery stores, schools, pharmacies, libraries, worksites and many other locations and individuals. In addition, media messages were displayed in print and through the radio. Two of the Community Based Organizations are developing a lay-health worker program to educate Hispanics/Latinos with diabetes about self-management and risk reduction techniques. The Program contracted with the Association for Utah Community Health (AUCH) to benefit all nine of Utah's Community Health Centers (CHCs) involved in the Breakthrough Collaborative. The goal is to improve diabetes care for high risk/low-income populations through continuing implementation of a chronic care model. A "flip-chart" format Diabetes Education Manual with instructor notes was developed for the CHC staff to provide consistent and standardized education to the clients of the CHCs.

Training Programs:

Provided two days of training to non-medically trained staff from around the state. The content covered intermediate level diabetes topics such as foot screenings, type 2 diabetes in children, carbohydrate counting, and insulin dosing. Participants included medical assistants, AmeriCorps workers from Community Health Centers, local health department educators, and Native American clinics and programs.

Provided nine statewide professional training updates to primary care providers, community health centers, and other health care professionals involved in care of patients with diabetes using telemedicine. Diabetes Updates (professional education for clinicians who care for patients with diabetes) were held in person in three locations.

Managed the Utah Certification Program for Diabetes Self-Management Training Programs including the provision of continuing education opportunities. Technical assistance was also provided to those sites seeking American Diabetes Association Recognition. There are currently sixteen State programs with three in the application process. Updates and re-certification of certified programs was provided.

Monitoring Activities:

Contracted with seven health plans to collect hybrid HEDIS information (claims and chart reviews) for six enhanced comprehensive diabetes care measures: HbA1c testing, HbA1c levels, eye exams, LDL testing, LDL levels, and monitoring for nephropathy. The DPCP through it health plan partnership developed enhancements in the required HEDIS data by requiring that A1c and LCLc levels be reported rather than just those meeting or exceeding the

HEDIS benchmarks. Data are reported using specified reporting formats to make comparisons. The data are used to measure progress in and among the health plans and results are weighted to reflect the entire health plan population.

*Healthy Utah Program*

Healthy Utah is a work-site-based employee health promotion and prevention program available to more than 68,000 state and other public employees and their spouses covered by Public Employees Health Program. Healthy Utah’s mission is providing resources, incentives and skills: empowering people to achieve healthy lifestyles. Healthy Utah works in state agencies and with other public entities (local governments) to create healthy work environments that support healthy lifestyle behaviors. Healthy Utah offers physical assessments, personal health sessions, weight management and stress prevention classes. Seminars on a variety of health topics and group health promotion programs are also available free of charge. Healthy Utah also provides technical assistance to work sites interested in establishing wellness councils and integrating employee health promotion and prevention into daily business activities. Healthy Utah strives to increase employee productivity, decrease employee absenteeism and reduce the rapid escalation of health care costs.

The following table demonstrates some of the program’s accomplishments for FY 2004:

FY 2004 Service	Outcomes
State/Public employees and spouses who are registered members	23,940
Participants in assessment sessions	6,143
Participants in wellness seminars	5,565
Participants in personal health counseling sessions	380
Participants in health enhancement programs	2,617
Weight Management Class	198
Smoking cessation rebates completed	5
Physical activity rebates completed	7,040
Diabetes rebate participants	71
Average number of visits to the web site per day	7,221
Number of agencies with Wellness Council	6

**Table 6-6**

*Arthritis Program*

Arthritis affects at least one of every six Americans and is the leading cause of disability. Medical care for arthritis cost nearly \$22 billion in 1995. Total costs, including medical care and loss of productivity, exceeded \$82 billion in 1995. Costs will increase by the year 2020, when it is estimated that at least 60 million individuals will be affected. In Utah, one of five adults (22%, 342,000) has doctor-diagnosed arthritis and an additional 17 percent (259,000), who do not have doctor-diagnosed arthritis, have possible arthritis as indicated by chronic joint pain (2002 BRFSS). In Utah, arthritis is a

leading cause of disability, activity limitation, and poor health. Among adults with doctor-diagnosed arthritis, 34% (116,000) report activity limitation due to their arthritis and 28% (64,000) report their arthritis affects their work for pay (females = 35%, males = 19%). Adults with doctor-diagnosed arthritis were over two times more likely to report fair or poor health (24%) when compared to those without arthritis (10%). Self-management programs, such as physical activity and self-management education, can reduce the pain and disability in arthritis, yet less than 1% of the people with arthritis have participated in such programs.

With these facts in mind the Utah Department of Health, Bureau of Health Promotion, began The Utah Arthritis Program late in 1999. This program, fully funded by the Centers for Disease Control and Prevention, is focused on 1) increasing community awareness; 2) measuring arthritis trends; 3) improving clinical practice; and 4) promoting supportive health systems and policies. The mission of the Utah Arthritis Control Program is to improve the quality of life for people affected by arthritis.

Significant progress has been made towards each of these areas.

Increasing Community Awareness: A broad-based arthritis television, radio, and written material campaign was conducted. This broad-based campaign has reached an estimated 40% of the Utah population, or 800,000 individuals. Additionally, the Utah Arthritis Report was distributed and has been utilized to educate professionals and others about these conditions.

Bus-stop posters were placed in 10 locations, seen by an estimated 17,000 people per day. They were placed for 180 days.

Nearly 1,000 people attended free community arthritis seminars, held at The Orthopedic Specialty Hospital (TOSH). Nearly 25 percent of these participants have gone on to enroll in more intensive, evidence based arthritis self-management courses (see improving clinical practice below).

Measuring Arthritis Trends: Utah's Arthritis Report was completed and distributed to key partners, constituencies, decision makers etc. Also, this report was released on the Utah Arthritis web page. Also, two arthritis "BRFSS Briefs", describing arthritis and co-existing conditions were produced and distributed to key partners, stakeholders, and medical professionals.

Improving Clinical Practice: Effective interventions have been identified and partnerships with medical providers, health plans, and clinics have been established. One important partnership is with The Orthopedic Specialty Hospital and is described in the awareness section above. Also, partial funding is provided for a position at the Arthritis Foundation. In addition to working on community awareness issues, this individual conducts arthritis self help education classes and trains instructors of those classes. During the past year approximately 5,800 individuals have received training, information, or services related to these efforts.

Promoting Supportive Health System and Policies: As noted above, the partnership with Intermountain Health Care, through TOSH, has provided free arthritis seminars to persons in the Salt Lake City area. This partnership has further supported referrals into more intensive, evidence-based arthritis management programs. It has accomplished this through the IHC network and through partnership with the Arthritis Foundation.

#### *Asthma Program*

Asthma is the leading cause of school days missed within the United States. It is estimated that there are more than 15 million people with asthma in the United States, including 5 million children.

Nationwide, the number of asthma cases in children under five years of age has increased more than 160 percent between 1980 and 1994, and 74 percent among children ages 5-14. Although Utah's growth rate has not been this dramatic, more than 8,500 additional children under the age of 17 were reported to have asthma from 1996 to 2001, bringing the current level to 36,300. In total, there are over 120,000 Utahns of all ages suffering with asthma, representing 5.3 percent of the population. In 2002, there were 1,443 hospitalizations for asthma, with children under the age of 20 accounting for 49 percent of those visits. Costs for the hospitalizations amounted to over \$8.3 million.

Although medical management is at the forefront of treatment for asthma, public health has an important role in the assessment of the problem. The Utah Asthma Program was developed in 2002 with CDC funding to begin efforts to address asthma from a public health perspective. The Utah Asthma Program has developed an asthma surveillance system to measure the burden created by this chronic illness to Utah residents. A Utah Asthma Task Force, comprised of public and private organizations, assessed the state of asthma prevention and care in Utah and designed a strategic plan that provides direction for future program interventions. As funding from CDC was specifically designed for statewide planning, partnership development, and surveillance efforts, infrastructure development services have been provided. With the development of the state Asthma Plan, action workgroups have been convened to address some of the most pressing needs identified by the Asthma Task Force. School and provider resource development, a data needs assessment, risk factor identification and a public awareness campaign will be some of the first projects implemented.

#### *Genomics Program*

The Genomics Program began in July 2003 with funding from the CDC, and is designed to develop the department's capacity for planning and integrating the use of genomic information in public health policy and programs, particularly in chronic disease programs. Of particular importance is enhanced coordination within State core public health specialties (such as epidemiology, laboratory activities, and environmental health) and facilitation of the effective application of new knowledge about gene-environment interactions, and crosscutting family history information to chronic disease opportunities. During its first year of operation, training was provided to over 100 public health professionals on the relevance of genomics to their public health role. A subcommittee of the State Genetics Advisory Committee was

convened to update the chronic disease section of the State Genetics Plan. Members of the committee consist of medical geneticists, genetic counselors, representatives of non-profit agencies and local health department health promotion specialists.

*Violence and Injury  
Prevention Program  
(VIPP)*

The mission of the Violence and Injury Prevention Program is to reduce the occurrence of fatal and non-fatal injuries among Utah residents. Injury is a significant public health problem and a leading cause of premature death and disability. It is the leading cause of death for people age 1-44 and the leading cause of years of potential life lost in Utah. During the four-year period of 1999-2002, injuries resulted in 4,373 deaths (48.3 per 100,000 persons). For that same period, there were 49,593 injury-related hospitalizations, with total charges of \$619 million and 790,764 emergency department visits at a cost of \$736 million. These figures do not include the costs associated with long-term disability, lost income, or injuries treated in clinics, doctor's offices, schools, and worksites.

To accomplish its mission, VIPP collaborates with many partners including other UDOH programs, state and local agencies, local health departments, private business, nonprofit community organizations, health care providers and others.

The VIPP conducts and/or provides significant support to the following projects and activities: Motor Vehicle Seat Belt and Child Booster Seat Campaigns, Youth Suicide Study, Suicide Prevention Task Force, Child Fatality Review Committee, Intimate Partner Violence Death Review Team, Rape and Sexual Assault Prevention Project, Domestic Violence Prevention Project, Traumatic Brain Injury Surveillance Project, Adolescent Pedestrian Safety Project, Utah Safe Kids Campaign, and others. The VIPP contracts with all local health departments - providing funding and technical support for local injury prevention programs that address adult seat belt and child care seat use, bicycle safety and helmet use, pedestrian safety, school playground safety, fall prevention, community and family violence prevention, etc.

*Baby Your Baby  
Program (BYB)*

The BYB Outreach Program strives to improve the health of families in Utah through programs such as Baby your Baby, Check your Health, Children's Health Insurance Program (CHIP), and the Primary Care Network (PCN). The program provides hotline services, develops education strategies, and program coordination. The hotline provides information and referral services to more than 60,000 callers each year for BYB, Check Your Health, Immunization hotline, CHIP, and other division programs. The outreach program establishes public-private partnerships to promote healthy lifestyles, reduce health risks, and increase access to health care. This is accomplished through public service announcements and other television programs, radio and printed materials which address Department goals dealing with early prenatal care, birth defects, SIDS, folic acid, child passenger safety, vaccine-preventable infections, injury and violence, dental disease, and other important maternal and child health issues.

Service	FY 2000	FY 2001	FY 2002	FY 2003
Number of hotline callers served	45,365	50,029	73,648	62,800

Table 6-7

*Tobacco Prevention and Control Program (TPCP)*

The TPCP provides technical expertise, and coordination at state and community levels to prevent and reduce tobacco use in Utah. The data indicate that Utah’s anti-tobacco efforts are starting to pay off. Tobacco use rates among adults and youth are on a downward trend, more smokers are making a serious attempt to quit, tobacco consumption is down, and fewer retailers are selling tobacco products to minors. Despite these successes, the need to address tobacco use in Utah remains high. More than 190,000 Utahns continue to use tobacco. Tobacco use costs taxpayers an estimated \$93 million in smoking-related Medicaid expenditures. In addition, the state incurs an estimated \$587 million in annual smoking-attributable medical and productivity costs. Research indicates that since the advent of the Master Settlement Agreement, the tobacco industry has spent more money than ever on marketing and promoting their products. In Utah alone, the tobacco industry spent an estimated \$90.8 million in product marketing in 2001—more than 10 times what Utah spends on anti-tobacco programming. The program’s efforts in fighting tobacco are paying off, but there is more to be done to protect citizens from the disability, disease, and death caused by tobacco use.

The goals of this program are to:

- Promote quitting among adults and youth
- Prevent initiation of tobacco use among young people
- Eliminate nonsmokers’ exposure to secondhand smoke
- Identify and eliminate disparities in tobacco use among populations groups

The program receives state, federal, and private funds. Ninety-five percent of state funds are passed through to local health departments, community prevention and cessation programs, the Truth media campaign, and other services. An independent evaluation contractor assists in measuring the impact of funded programs.

*Anti-Tobacco Projects Funded by Senate Bill 15, 2000 General Session*

The TPCP and its partners attack the problem of tobacco use with proven program components. Anti-tobacco programs and services include:

Statewide and Community-Based Services to Help Smokers Quit - Tobacco cessation counseling is one of the most effective interventions in preventive medicine. Quitting smoking at any age provides health benefits and increases life expectancy for former smokers. More than 81.5 percent of Utah’s report that they want to quit. To help smokers quit successfully, the TPCP offers the Utah Tobacco Quit Line and Utah QuitNet ([www.utahquitnet.com](http://www.utahquitnet.com)), Medicaid coverage of tobacco cessation services for pregnant women and for the

cessation medication Zyban, local health department tobacco quitting programs for pregnant women, local school and community based teen cessation programs, and community-based adult cessation programs, and Medicaid coverage.

“The TRUTH” Public Awareness Campaign – The TRUTH media campaign is multi-pronged, targeting prevention and quitting among mainstream and high risk youth, adults, pregnant women, Native Americans, Hispanics and Latinos, college students, rural populations, and work sites through a mix of media including radio, TV, and outdoor advertising. Most Utah residents are directly or indirectly impacted by the campaign. The TPCP evaluates the reach and impact of the media campaign with annual surveys of 1,500 randomly selected Utah teens, and adult smokers and non-smokers. Some campaign components include:

- "I Did It" quit smoking TV campaign to promote Utah Quit Line and QuitNet services
- "Truth About Tobacco" youth ads
- Advertisements addressing pregnant women and secondhand smoke
- Events promoting tobacco-free communities

Prevention Partnerships with Local Health Districts, Schools, and Communities - Evidence-based school programs promote strong "no tobacco use" attitudes among students, increase students' knowledge of the dangers of tobacco, and teach students skills to resist peer influences. School programs are most effective when they are part of comprehensive school tobacco policies that include enforcement of rules against tobacco use, tobacco prevention education for students in all grades, access to cessation services, and involvement of families and communities in tobacco prevention. TPCP prevention services included:

- Collaboration with select school districts to strengthen and better enforce school tobacco policies.
- Evidence-based anti-tobacco curricula for students in grades 4 to 8.
- Truth from Youth Anti-Tobacco Advertising Contest.
- Anti-tobacco activities and presentations in schools and communities across Utah.

Youth Access to Tobacco - Utah law prohibits tobacco sales to minors under the age of 19. Local health departments collaborate with retailers and law enforcement to ensure compliance with youth access laws through retailer education, retailer recognition, and compliance checks.

The following table lists some of the outcomes and accomplishments of the TPCP during FY 2003.

FY 2004 Service	Outcomes
% Decrease in Adult tobacco use*	15.0%
% Decrease in Youth tobacco use*	39.0%
Number of Utahns who called the Quit Line	10,000
Number of Utahns who used Quit Line referral or local cessation programs	3,523
Anti-tobacco awareness campaign:	
% of Adults recalling anti-tobacco ads	90.0%
% of Youth recalling anti-tobacco ads	90.0%
Number of students receiving classroom tobacco prevention education	15,000
% Decrease of tobacco sales to youth (since 2001)	50.0%
* since beginning of MSA funding	

Table 6-8

*Other Funding through Senate Bill 15, 2000 General Session*

Originally, Senate Bill 15 allocated \$4.0 million to the Health Department for programs addressing tobacco education, prevention, and cessation. The bill’s language also provided additional funding (\$2 million) in the event that the lawsuit from the outside law firm was settled. That suit was settled and the Legislature approved increasing the funding from the Tobacco Settlement Account to \$6 million, but reduced the division’s General Fund appropriation by a corresponding \$2 million.

In addition to the Tobacco Settlement Account’s funding for the TPCP, other allocations include \$7 million to cover the State’s share of the costs for the Children’s Health Insurance Program (CHIP); \$1.49 million to the Courts and the Department of Human Services to expand the drug court program; \$510,000 to the Board of Pardons, the Department of Corrections, and the Department of Human Services for a drug board pilot program; and \$4 million to the University of Utah Health Sciences Center. Utah Code requires that each of the state agencies that receive funding from the Tobacco Settlement funds shall provide an annual report on the program and activities funded to both the Health and Human Services Interim Committee and the Health and Human Services Joint Appropriations Subcommittee (63-97-201(6)).

## Funding Detail

<b>Health Promotion</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	1,540,100	1,557,400	325,200	(664,500)	352,500
General Fund, One-time	99,600	(2,169,000)	0	900	1,000
Federal Funds	5,814,228	6,470,150	8,349,347	7,545,833	8,006,000
Dedicated Credits Revenue	875,473	1,214,670	1,234,893	1,497,979	1,031,600
GFR - Cigarette Tax Rest	250,000	250,000	2,868,400	3,131,500	3,131,500
GFR - Tobacco Settlement	3,998,900	5,058,500	5,066,500	5,066,500	5,153,800
Transfers	1,002,565	1,063,970	1,397,273	1,255,008	1,226,700
Beginning Nonlapsing	0	1,024,111	319,934	663,766	0
Closing Nonlapsing	(1,024,111)	(319,934)	(663,766)	(393,762)	0
Lapsing Balance	0	1,014,500	(18,000)	964,100	0
<b>Total</b>	<b>\$12,556,755</b>	<b>\$15,164,367</b>	<b>\$18,879,781</b>	<b>\$19,067,324</b>	<b>\$18,903,100</b>
<b>Categories of Expenditure</b>					
Personal Services	3,870,457	4,348,506	4,558,030	4,778,145	5,035,300
In-State Travel	44,951	58,884	82,847	77,916	104,400
Out of State Travel	82,463	85,849	87,529	103,779	115,500
Current Expense	5,129,144	5,923,270	8,449,880	9,431,202	8,417,600
DP Current Expense	127,007	141,627	166,252	158,146	111,900
DP Capital Outlay	0	0	0	7,089	0
Other Charges/Pass Thru	3,302,733	4,606,231	5,535,243	4,511,047	5,118,400
<b>Total</b>	<b>\$12,556,755</b>	<b>\$15,164,367</b>	<b>\$18,879,781</b>	<b>\$19,067,324</b>	<b>\$18,903,100</b>
<b>Other Data</b>					
Total FTE	87.7	95.3	96.0	99.9	97.5
Vehicles	2	3	3	3	3

Table 6-9

## MATERNAL AND CHILD HEALTH

## Function

The Maternal and Child Health Bureau works to improve the health of mothers, children and their families through various activities that support the Department's mission. The Bureau takes on a leadership role for most maternal and child health issues, such as prenatal care, planning for a healthy pregnancy, child health, immunizations, oral health, nutrition education and analysis of data to determine priorities and establish program plans to address those areas that need additional work. Bureau programs focus on various public health functions, such as surveillance and analysis of data related to maternal behaviors before, during and after pregnancy, and factors associated with poor pregnancy outcomes, such as prematurity; review of maternal, fetal and infant deaths; promoting access to health services; media campaigns and other means of outreach; education of the public and health care providers; collaborative efforts with local health departments, community health centers and the private provider community, as well as community-based organizations and schools. The Bureau includes six programs that work to achieve the Bureau's goal: Reproductive Health; Child, Adolescent and School Health; Data Resources; Immunizations; Oral Health; and Women,

Infants and Children (WIC) Programs. The Maternal and Child Health Bureau provides leadership for many maternal and child health efforts in the state through these programs, grant opportunities and involvement at a national level to learn from other states' programs.

*Reproductive Health Program (RHP)*

The mission of the Reproductive Health Program (RHP) is to improve the health of women of childbearing age and their infants by reducing preventable illness, disability and death related to pregnancy, birth and infancy through the promotion of healthy lifestyles and optimal health care. The various components of the RHP include the Prenatal/Family Planning, the WeeCare, the Pregnancy Risk Assessment Monitoring System (PRAMS), the Baby Your Baby (BYB) by Phone and the Perinatal Mortality Review (PMR) component. The program creates and disseminates pertinent health education messages that are identified through the program's various data collection resources. These messages are distributed via presentations at schools, churches, health fairs, etc. as well as their Internet website ([www.health.utah.gov/rhp](http://www.health.utah.gov/rhp)), brochures, radio messages and poster displays.

The Prenatal Component of the program improves access to prenatal care through expedited eligibility to Medicaid, enhanced prenatal and delivery services within Medicaid, and by covering prenatal care for uninsured women. The family planning component assures access to family planning services in under served areas of the state, and also assures reproductive health services through technical assistance to local health departments, community health centers, and other providers. Contracts are maintained with these agencies for prenatal and family planning services.

The Wee Care Component offers nurse case management of moderate and high-risk PEHP pregnant participants throughout the state via telephone. Women are provided information that can help them reduce the risk of premature delivery and other pregnancy complications. They also enjoy follow-up contact throughout the pregnancy to assure that everything is going well, and that mother and infant have optimal healthy outcomes

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based surveillance system that queries a sample of Utah mothers about their experiences before, during and after pregnancy. PRAMS is intended to help answer questions that birth certificate data alone cannot answer. Data are used to provide important information that can guide policy interventions, and other efforts to improve care and outcomes for pregnant women and infants in Utah. An example of how PRAMS data are being used is to educate prenatal care providers about women's perceptions and experiences during.

The Baby-Your-Baby by Phone Component of the program has been implemented to provide a quick and easy Presumptive Eligibility determination by enrolling women who reside in Salt Lake County into Presumptive Eligibility via telephone. This program expedites early access to prenatal care for women who participate. This component is paid for with state general funding.

The Perinatal Mortality Review (PMR) Component of the program is a process aimed at identifying and examining the factors that contribute to perinatal deaths (fetal, infant, and maternal) through the systematic evaluation of individual cases. Through individual case review, the PMR coordinator, in conjunction with a committee of perinatal professionals, identifies contributing factors that may have led to the death. Information is obtained through medical records, public health records, autopsy reports, birth/death certificates and health care provider records. Committee members make recommendations based on findings that may lead to public health recommendations for changes that could improve the outcome of future cases.

*Child, Adolescent and  
School Health  
(CASH) Program*

The CASH Program provides a broad range of services related to child health and development, from birth through adolescence. The CASH Program administers several grants that seek to improve the system of services for children and promote health behaviors.

The CASH Program provides oversight, training and technical assistance for three home visiting nurse programs provided by public health nurses through the twelve local health departments. The CASH Program oversees the Title V-funded Prenatal-5 Nurse Home Visiting Program that provides nurse home visiting for pregnant women and at-risk children from birth to five years of age. The program provides training and technical assistance on the Medicaid-funded Early Childhood Targeted Case Management Service for children from birth to age four. Additionally, the program provides coordination, oversight and technical assistance for the Title V-funded Sudden Infant Death Syndrome (SIDS) Program for families that need grief and local services support after the unexpected loss of an infant. SIDS prevention materials and training are provided to local hospitals, community organizations, child care providers, and professional preparation programs.

The program administers the State Early Childhood Comprehensive Systems grant, funded with federal Title V funds, to improve the system of services for children from birth to age eight by coordinating efforts of statewide agencies and organizations to ensure children are ready to enter school healthy and ready to learn.

The Head Start-State Collaboration Office grant is designed to meet the increasingly complex and difficult challenges of improving long-term health outcomes for low-income children and their families and is funded with federal and state-match funds. The overall goal of this grant is to create and promote a statewide focus of interagency partnerships and linkages between Head Start and other early childhood service providers.

The Healthy Child Care America (HCCA) Project, funded with a Title V grant, develops, revises, and provides oversight for the implementation of Utah's Health and Safety Curriculum for Early Childhood Providers. Public health nurses and Child Care Resource and Referral agencies use this curriculum throughout the state to educate child care providers on practices that promote the overall health and safety of children in child care including reducing the incidence of SIDS. Utah's HCCA Project is also involved in

training child care health consultants (CCHCs) that provide direct consultation to child care providers on health and safety issues. CASH Program staff provide technical assistance, consultation, and training to child care providers, local health departments, the Bureau of Licensing, the Office of Child Care, and other programs on issues related to child care health and safety and on CCHC training and development.

The CASH Program provides oversight, with federal Title V funds, for the Abstinence Education Grant, Section 510 of Title V, to provide technical assistance, training, and consultation to the agencies that implement the Abstinence Education Only programs for youth from ages nine to fourteen. The goal of this grant is to promote abstinence from sexual activity before marriage.

Service	<u>FY 2003</u>
Child Health Services (well child care, care coordination, screening)	12,277
Prenatal - 5 Nurse Home Visit	7,954
Prenatal - 5 Nurse Home Visit # of children	3,986
Abstinence-only Education - adolescents and parents	37,930

Table 6-10

*Immunization Program (IMM)*

IMM promotes immunization as part of comprehensive health care across the life span – infants, children, adolescent, and adult. It provides services through technical assistance to local health departments (LHD), community health centers (CHC), managed care organizations (MCO), schools (public and private) and licensed day cares, and private providers. The program contracts with LHDs and CHCs to support infrastructure for outreach activities to at-risk and eligible populations. Special emphasis is placed on efforts to improve the immunization coverage for pre school-age children, especially those under two years of age.

The Vaccines for Children (VFC) component provides vaccine at no cost to eligible children ages 0-18 years who are uninsured, covered by Medicaid, under-insured, or American Indian. The vaccine is provided to 291 enrolled public and private medical providers statewide. An essential part of this program is technical assistance for vaccine management and accountability including doses administered and quality assurance, assessment, and audits. The VFC distribution system is now used, through an MOA with CHIP, to provide vaccine to children enrolled in CHIP which provides a substantial cost savings to the CHIP program and also provides the same provider services related to vaccine management and accountability.

The Disease Surveillance and Outbreak Control activities monitor the incidence of vaccine-preventable diseases and assist in addressing disease

outbreaks. A full time employee is supported in the Division of Epidemiology and Laboratory Services to monitor morbidity and mortality data.

The Population Based Assessment component provides technical assistance to school staff, school nurses, and school administrators. It further provides retrospective school entrance surveys and validation audits of all schools and licensed day care/Head Start centers. It also monitors second MMR levels of all school children through grade 12. There is a strong collaboration with Utah State Office of Education.

The Vaccine Adverse Event Reports System (VARES) component provides for a reporting system for adverse events following receipt of any U.S. licensed vaccine.

The Public and Professional Information and Education component involves activities and efforts to provide current immunization information, education, and training to the public and providers. It also supports the Every Child by Two public/private partnership and two local coalitions and media campaign working to increase immunization rates for children under two. This component maintains the Immunization Hotline.

The Immunization Registry component pertains to the Immunization program support of aspects of the development and maintenance of a population based immunization registry. This includes support of provider enrollment and historical data entry to increase provider utilization of Utah Statewide Immunization Information System.

The Perinatal Hepatitis B Prevention program promotes Hepatitis B immunization to prevent perinatal transmission. The program offers technical assistance and oversight of case management provided through local health departments, as well as Hepatitis B immunization for infants and household contacts. It also provides technical assistance, information and education resources on all forms of hepatitis: A, B, and C.

The Adolescent Immunization component supports activities to prevent vaccine preventable diseases in adolescents ages 11-21. This is accomplished through providing technical assistance, current information and education to the public and providers. College entrance immunization recommendations are also in place and collaboration with Youth Corrections.

The Adult Immunization component promotes the prevention of vaccine preventable diseases among adults with an emphasis on influenza and pneumococcal disease. It also supports the Utah Adult Immunization Coalition working to increase immunization rates for adults.

The WIC Linkage component promotes increased rates of immunization and the prevention of vaccine preventable diseases among WIC participants.

The Smallpox Vaccination and Pandemic Preparedness component provides support for Utah to achieve appropriate pandemic preparedness and response to bioterrorism agents statewide. Technical assistance and vaccine

management are provided to local health departments and communities statewide.

The IMM program provides vaccine to eligible children through a federal grant awarded credit line at the Centers of Disease Control. It also provides educational information and technical assistance to the entire population through grant awarded CDC funds.

*Data Resources Program*

The Data Resources Program (DRP) provides health data and information support to staff within MCH and CSHCN programs, local health departments, community-based health organizations, and citizens. The program is two-pronged in its approach as it aims to 1) increase access to health information and data, and 2) provide analytic consultation, data training, and web services.

DRP acts as a resource for MCH programs in identifying data sources and status of certain health indicators. The program also facilitates the coordination of multi-program projects, reports, and system integration. The program also plays an active role in designing web site and web-based applications for CFHS and ensures that they are in compliance with department and state web standards.

DRP provides the necessary activities related to all the MCH Bureau programs which deal with the documentation of data reporting by local health departments as part of the contract process. The DRP serves as the data resource component for all MCH Bureau programs since it is not feasible to hire an epidemiologist or data analyst for each individual program.

*Women, Infants and Children (WIC)*

WIC is a federally-funded program designed to provide supplemental food and nutritional education to pregnant, breast-feeding or postpartum women, infants and children up to five years of age. Included are individuals from low income families who are determined to be at nutritional risk because of inadequate nutrition, health care, or both. WIC is specifically designed to serve as an adjunct to good health care during critical periods of human growth and development.

Applicants must meet the following criteria to receive food:

1. A resident of the area or member of the population served by the 60 local clinics.
2. Income at or below 185 percent of the poverty guidelines established by the federal government.
3. Certified to be at nutritional need through a medical and/or nutritional assessment.

During FY 2004, the average monthly participation was 65,980.

*Oral Health Program (OHP)*

The Oral Health Program improves the oral health status of Utah residents by developing, implementing, and promoting effective prevention and dental access programs at both the state and local health department levels. OHP dental caries prevention methods such as community water fluoridation, fluoride mouth rinse programs, tooth sealant programs, and early childhood

interventions help reduce rates of dental caries among all populations. The evaluation and dissemination of statewide dental health surveys, Head Start data and other Utah specific dental health information by OHP provide important needs assessment information for state and local health departments. OHP activities which improve systems of outreach to and treatment care for Medicaid, CHIP, and low-income uninsured populations help us to assure access to appropriate oral health care services for these targeted populations.

In collaboration with the Utah Oral Health Coalition, the OHP has developed and maintains the Utah Oral Health Action Plan which emphasizes implementation of appropriate prevention and access strategies for target populations and promotes development of policies for better oral health and improved oral health systems statewide. Additionally, the OHP encourages and facilitates the formation of local oral health coalitions by conducting needs assessments and oral health surveys, providing technical consultation and reporting progress toward HP 2010 oral health objectives. The OHP collaborates with local health departments and community health centers and partners with many community public health and private practice dental and health professionals, stakeholders, and advocates to effectively implement programs which best serve the needs of local communities.

### Funding Detail

<b>Maternal and Child Health</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	2,574,000	2,569,100	244,400	1,158,100	210,800
General Fund, One-time	(400)	(320,100)	0	200	700
Federal Funds	34,423,820	34,569,127	37,741,238	37,306,240	41,138,600
Dedicated Credits Revenue	10,187,486	9,956,366	10,000,111	11,234,938	10,150,600
GFR - Tobacco Settlement	0	995,200	995,200	995,200	995,200
Transfers	511,613	1,007,011	1,670,438	96,787	730,100
Beginning Nonlapsing	139,517	0	0	0	0
Closing Nonlapsing	(260,783)	0	0	0	0
Lapsing Balance	0	(1,303,700)	(39,200)	(949,000)	0
<b>Total</b>	<b>\$47,575,253</b>	<b>\$47,473,004</b>	<b>\$50,612,187</b>	<b>\$49,842,465</b>	<b>\$53,226,000</b>
<b>Categories of Expenditure</b>					
Personal Services	3,075,664	2,672,905	2,897,344	3,351,238	3,733,700
In-State Travel	28,378	27,479	22,215	20,371	46,700
Out of State Travel	77,899	58,988	59,779	55,625	71,700
Current Expense	1,940,322	3,317,458	4,812,130	3,400,463	4,894,600
DP Current Expense	1,045,507	357,590	356,494	546,599	546,700
DP Capital Outlay	0	0	0	10,752	0
Other Charges/Pass Thru	41,407,483	41,038,584	42,464,225	42,457,417	43,932,600
<b>Total</b>	<b>\$47,575,253</b>	<b>\$47,473,004</b>	<b>\$50,612,187</b>	<b>\$49,842,465</b>	<b>\$53,226,000</b>
<b>Other Data</b>					
Total FTE	65.6	66.4	57.8	65.1	64.4
Vehicles	1	1	1	1	1

**Table 6-11**

**CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

**Function**

The Bureau of Children with Special Health Care Needs (CSHCN) encompasses ten programs serving special needs children. CSHCN programs reduce preventable death, disability, and illness due to chronic and disabling conditions by providing access to affordable high-quality health screening, specialty health care, and case management. Bureau programs provide “direct services” or “population based services”. These services are provided by bureau staff or through contractual agreement with community providers.

*Hearing, Speech, and Vision Services (HSVS)*

HSVS provides statewide screening, evaluation, and referral of infants and children with hearing, speech, and/or vision problems. Target populations are newborns, infants and preschoolers, children at risk, children in areas lacking alternative care and children whose parents request financial assistance. Pediatric hearing, speech, and vision services are provided throughout the state, from the main clinic in Salt Lake City, regional clinical facilities in Ogden, Cedar City, Vernal, Price, and Montezuma Creek, and 26 traveling clinic sites. HSVS works with local resources to provide referral to appropriate intervention services. Children identified with these disorders in early life have a much lower rate of subsequent chronic disability. Approximately 3,300 clinical visits are provided annually in addition to nearly 4,000 educational encounters.

<b>Service</b>	<b>FY 2001</b>	<b>FY 2002</b>	<b>FY 2003</b>	<b>FY 2004</b>
# patient encounters	3,817	3,023	3,514	3,305
# public health education efforts	4,335	3,455	2,200	3,935
# photo screens provided statewide	1,030	814	879	803
# recycled hearing aids provided	20	15	32	44

**Table 6-12**

*Neonatal Follow-up Program (NFP)*

The Neonatal Follow-up Program provides statewide multi-disciplinary screening services for the very low birth weight graduates of Utah newborn intensive care units. The services are offered through three satellites in Salt Lake City, Ogden, and Provo.

Compared to normal birth weight babies, low birth weight babies have a higher rate of health and growth problems, soft and hard neurological findings, learning and cognitive difficulties, hearing and vision deficits, behavioral disorders, difficulty maintaining attention, language delays, poor social skills, and school failure. In spite of advances in technology, pharmacology and better understanding of fetal and newborn physiology, the birth rate of very low birth weight babies and undesirable long-term outcomes remain unchanged. Undesirable long-term outcome is directly related to birth weight - the lower the birth weight, the higher the risk. Of the extremely low birth weight babies, 20 percent will have cerebral palsy, 25-30 percent will test in the mentally retarded range, and 45 percent will need special education

resources. The Neonatal Follow-up Program provides follow-up through two and one-half years of age and periodic screening by multi-disciplinary providers (neurologist, pediatrician, audiologist, speech pathologist, dietitian, psychologist, ophthalmologist, occupational/physical therapist, nurses and others as dictated by the child's condition).

Service	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Clinics	155	156	156	134	124
Patients	1,875	2,149	2,408	2,000	1,509
Patient encounters	11,645	12,431	9,382	6,202	6,258

Table 6-13

*Child Development Clinic (CDC)*

The Child Development Clinic Program provides multi-disciplinary medical and developmental assessment services for children birth to five years of age who have developmental disabilities or chronic illness associated with developmental delay. The program also offers consultative and case management services for children with multiple disabilities up to 18 years of age. Services are designed to:

- Recognize the need for early diagnosis and treatment;
- Provide timely detection of sensory, cognitive, and emotional disorders;
- Assist the family in identifying their child's strengths and weaknesses;
- Develop and monitor a written plan of services;
- Provide parents with support and information;
- Coordinate the delivery of services with local agencies; and
- Promote and develop appropriate community wide services for the prevention of disabilities.

In addition, the program provides general oversight to the new Utah Registry of Autism and Developmental Disabilities (URADD). The purpose of URADD is to find out how many people in Utah have autism spectrum disorders and developmental disabilities. URADD is part of a national project by the CDC. A key component of Utah's registry is to teach health care providers and teachers how to tell if a child has an autism spectrum disorder.

Service	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
# of Clinics	216	246	249	246	246
# of Children served	384	1,124	899	800	837
# of Patient encounters	3,092	4,247	6,710	7,121	7,444

Table 6-14

*Community Based  
Specialty Services  
(CBS)*

CBS administers Utah's Medicaid Waiver for Technology Dependent Children and the Utah Collaborative Medical Home Project. Administration and case management for Utah's Medicaid Waiver for Technology Dependent Children is provided by registered nurses. The waiver program targets technology dependent children statewide and provides access to Medicaid without regard to parental income. Medicaid covered services are available to eligible children in addition to "waiver" services including skilled nursing respite. Waiver care coordinators assess needs, authorize services and provide resources and referrals to support the entire family. The Medical Home Project provides technical assistance to pediatric and family practices statewide in setting up and implementing medical homes. Project activities include monthly phone conferences, site visits, newsletters and resource information. The project assists with the development of the Medical Home Website including module and resource development. The project's parent advocate oversees medical home family advocate training in Utah, provides representation on numerous committees, provides individual parent-to-parent support for CSHCN families needing assistance and oversees parent-to-parent support contracts. Projections are based on the new program organization.

*School Age and  
Specialty Services  
Program (SASS)*

The School Age and Specialty Services program provides services to children birth through eighteen, facilitating increased statewide access to medical and behavioral specialists. Children with special health care needs may be seen by neurology, cardiology, orthopedics, and genetics and also may receive evaluations for learning and behavioral disorders through the ABLE program component. Multidisciplinary clinics for conditions like cleft palate, spina bifida or osteogenesis imperfecta can be accessed through collaboration with the Primary Children's Medical Center or Shriners' Hospital for Children (in the greater Wasatch front). Itinerant site SASS clinics are conducted in collaboration with the local Health Departments and include Price, Moab, Blanding, as well as Ogden and Provo. General pediatric services are provided through contracts with the University of Utah Department of Pediatrics. SASS works with community medical providers, school districts, and other agencies to coordinate services. Additionally, the program includes activities in the areas of transition, medical home, SSI/disability, and cultural sensitivity.

*Fostering Healthy  
Children*

The mission of the Fostering Health Children Program is to ensure that the health care needs of children in the Utah Child Welfare System are met in a timely manner. The program was implemented in response to the Settlement Agreement the State made with the National Center for Youth Law in 1994. The settlement agreement requires the State to provide health, dental, and mental health care to all children in foster care custody on an on-going basis. DCFS contracts this service with the Department of Health to provide Administrative Case Management of all children entering Foster Care across the state. Registered nurses are utilized to:

- Manage the health, dental, and mental health care needs of children in Foster Care
- Assist the caseworker in addressing physical, dental, and mental health concerns for a child in state custody

- Provide input on the placement of a child with special health care needs
- Provide medical education and training to foster parents, families, and caseworkers
- Provide hospital, home and/or office visits for children with special needs with one on one health care education and training
- Increase the accessibility for health care by identifying providers willing to provide care
- Refer children with developmental delays noted on the Ages and Stages to Early Intervention

*Birth Defects and  
Genetics Program*

This program includes three major efforts: the Pregnancy RiskLine, the Center for Birth Defects Research, and the Utah Genetics Project.

The Pregnancy RiskLine provides information regarding exposure to drugs, chemicals, and infections in pregnancy and lactation and the possible effect on the developing fetus, breast-fed infant and mother that is often not easily accessible to health care practitioners or consumers. It is understandable that during pregnancy there is an increased sensitivity to the possibility of having a child with a birth defect. After an exposure and because of the poor quality of available information about fetal effects, women often feel their risk of having an affected child is higher than the actual risk posed by the exposure. These perceptions of heightened risk have too often led to terminations of otherwise wanted pregnancies, increased anxiety, demands for unnecessary and costly prenatal diagnostic procedures as well as for repeated screening and testing of the in-utero exposed infant and child. Unfortunately, medical, nursing, pharmacy, and other health-related schools usually do not provide courses in human or clinical teratology (the study of causes of birth defects), so practitioners are not prepared to assist their pregnant or lactating patients with these questions and concerns. Since it is common for pregnant and lactating women to be exposed to medications/drugs, chemicals, and infectious agents, misinformation can too often be transmitted. The Pregnancy Riskline was established to provide health care practitioners and consumers with accurate, up-to-date information regarding potential risks to a fetus or breast-fed infant in order to prevent unjustified anxiety leading to unnecessary abortions, costly prenatal and postnatal screening, diagnostics, and testing of an exposed fetus or infant. The program educates more than 9,000 callers each year and more than 1,000 health care practitioners, a total of over 10,000 encounters. Additionally, another 1,000 medical, pharmacy, nursing and health education students are educated each year.

The Birth Defect Network provides the basic infrastructure to monitor all infants and pregnancies affected by a birth defect in the State. For most birth defects, the cause is not known. Statewide monitoring for the occurrence of birth defects is critical to know background prevalence rates, to evaluate trends over time, perform cluster analysis and develop the framework for epidemiological investigations that may provide clues to identify causes.

This program provides the basic infrastructure to monitor all infants and pregnancies affected by a birth defect in the state of Utah. This program has been evolving since 1994 and became a full surveillance system in 1999, monitoring all major structural birth defects occurring in Utah. Two critical areas the Utah Birth Defect Network is involved with are primary and secondary prevention. Primary prevention, the ability to prevent birth defects from occurring, is dependent upon accurate data both for evaluation of potential prevention strategies and evaluation after implementation of a prevention project. Secondary prevention, minimizing secondary disabilities as a result of the primary birth defect, is critical for both the child and family to decrease social, financial and medical burden. The Utah Birth Defect Network also provides resource and referral information for parents of children with birth defects, as well as health care providers seeking accurate and up to date information about birth defects. Recently, the Utah Birth Defect Network was awarded a grant to make it one of seven Centers for Birth Defects Research and Prevention. This grant provides researchers the ability to investigate potential causes of birth defects as well as examining interventions for prevention.

Service	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004 est.</u>
Number of clients served by Pregnancy Riskline	10,422	10,503	10,891	10,618	11,000
Number of births screened by Birth Defects Network	47,331	47,915	49,140	49,834	50,000

Table 6-15

*Newborn Screening (NS)*

The Newborn Screening Program provides a statewide system for early identification and referral of newborns with certain metabolic, endocrine, or hematologic disorders that can produce long term mental or physical disabilities or death if not treated early. The disorders are: congenital hypothyroidism, galactosemia, hemoglobinopathy, and phenylketonuria (PKU). The kit needed to test for these disorders is normally part of the hospital delivery charge. The cost of the kit is \$31.00 with the fee revenue split between the State Health Laboratory and CSHCN.

*Baby Watch Early Intervention (BW/EI)*

BW/EI provides early intervention and developmental interventions statewide for young children with developmental delays and/or disabilities from birth to age three. Services include multi-disciplinary evaluation and assessment; service coordination; specialty and therapy services such as nursing, physical therapy, occupational therapy, speech therapy, special instruction, family support and other related services that build on family strengths and child potential. Services are available statewide through local service delivery personnel.

Service	<u>CY 2000</u>	<u>CY 2001</u>	<u>CY 2002</u>	<u>CY 2003</u>	<u>CY 2004 est.</u>
Children served w/ Indiv. Family Service Plan	2,263	2,463	2,527	2,382	2,400
Avg. number of encounters per child	36	36	36	36	36
Total encounters				90,972	86,400

Table 6-16

The 1997 Legislature authorized additional funding for this program to handle the increased number of requests for early intervention services. The amount added to the budget was \$1.5 million, with half of that funding coming from the General Fund and the other half coming from fees paid by the recipients, according to the sliding fee schedule which was also approved.

The 2000 Legislature allocated \$300,000 (General Fund) for growth in the BW/EI Program; the 2001 Legislature approved an additional \$600,000. The 2002 Legislature was unable to add any new funding for Early Intervention, however, the division was able to cover the additional growth with carry-forward federal funds. The 2003 Legislature approved an additional \$1 million. It now appears that that funding, together with the fee revenue and the division's tightening of eligibility will be sufficient to cover anticipated FY 2006 expenses.

Over the past several years, the BW/EI program has become better known throughout the State and the eligible population has also grown. The caseload in FY 1999 was 2,013, growing in FY 2000 to 2,263 in FY 2001 to 2,463 and in FY 2002 to 2,527. Due to the limited funding levels, eligibility criteria have reduced the FY 2003 caseload to 2,382.

*Child Health  
Advanced Records  
Management  
(CHARM)*

Accurate and timely data are essential for the State of Utah to provide appropriate health services to its citizens. Currently, data exists in an array of public and private health sectors and each database serves its own users and data is not shared across organizations or health programs. Services are often not coordinated and typically do not provide a network of care for families. As a result, many children do not receive critical follow-up. It is estimated that while nearly 95 percent of Utah's children receive newborn screening services, many are lost to follow-up.

The Child-Health Advanced Records Management (CHARM) Project is a coordinated, Department-wide effort to create an electronic virtual health profile for every child in Utah that allows real-time digital access and data sharing among appropriate health care programs and partners. The CHARM Vision is to become a shareable repository of child-specific public health information with secure role-based confidential access to a comprehensive set of integrated public health data accessible by people with a need to know, that promotes timely and efficient access to needed services, and supports program planning and evaluation. Integrating the state's health care databases provides

for immediate access to information that is stored in specific databases to track and monitor health status for children and their families.

CHARM integrates the programs targeted for early integration: Vital Records, Newborn Hearing Screening, and Utah's Immunization Registry.

The Newborn Dried Bloodspot Screening and Baby Watch/Early Intervention Programs, and Birth Defects Registry are also targeted for early integration (December '04 / January '05).

Web-based access to CHARM will provide secure role-based confidential access for appropriate health care partners outside the Department (December '04 / January '05).

Funding for this project has come from blending multiple funding streams including HRSA grants, CDC grants, and the MCH Block Grant.

Management of the funds is performed by an oversight committee (CHARM Governing Board) to ensure accountability and coordinated use.

### Funding Detail

<b>Children with Special Health Care Needs</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	6,025,100	6,691,900	6,460,900	7,349,200	7,394,700
General Fund, One-time	(1,000)	(253,800)	0	7,200	20,500
Federal Funds	6,733,370	8,178,765	9,426,865	9,923,809	10,589,100
Dedicated Credits Revenue	3,821,706	4,478,149	4,671,598	5,537,742	3,228,100
Transfers	1,292,317	869,615	918,178	186,158	2,735,100
Lapsing Balance	0	46,500	(31,900)	(28,600)	0
<b>Total</b>	<b>\$17,871,493</b>	<b>\$20,011,129</b>	<b>\$21,445,641</b>	<b>\$22,975,509</b>	<b>\$23,967,500</b>
<b>Categories of Expenditure</b>					
Personal Services	5,970,611	6,494,711	6,998,189	7,383,395	7,623,600
In-State Travel	144,843	138,684	133,126	119,100	162,700
Out of State Travel	31,555	41,203	61,096	42,252	61,100
Current Expense	5,807,668	4,815,008	6,050,644	10,497,179	6,689,600
DP Current Expense	188,217	221,458	385,607	365,954	383,500
DP Capital Outlay	0	0	6,373	81	0
Other Charges/Pass Thru	5,728,599	8,300,065	7,810,606	4,567,548	9,047,000
<b>Total</b>	<b>\$17,871,493</b>	<b>\$20,011,129</b>	<b>\$21,445,641</b>	<b>\$22,975,509</b>	<b>\$23,967,500</b>
<b>Other Data</b>					
Total FTE	107.2	114.3	119.3	127.5	124.6
Vehicles	3	3	4	4	4

**Table 6-17**

**CHAPTER 7 HEALTH CARE FINANCING**

<b>Function</b>	<p>The Division of Health Care Financing is the administrative agency for Utah's Medical Assistance Programs. The division administers state and federal funds, and contracts with providers. It also gathers and analyzes data, and pays for the provided services. There are seven bureaus and approximately 534 employees.</p> <p>Federal regulations provide for a wide variety of funding ratios ranging from 50 to 90 percent for different classes of positions and functions for this division. Overall, federal funding makes up approximately 55 percent of the division's budget.</p> <p>Federal law requires that the Medical Care Advisory Committee (MCAC) serve as an advisory board to the division. This committee consists of providers, Medicaid recipients, representatives from the Department of Human Services and the Department of Workforce Services, and members of the community. The committee advises the division on program content, policy, and priorities. The Committee is advisory and its decisions are not binding on the division.</p>
<b>Statutory Authority</b>	<p>The Division of Health Care Financing is governed by several chapters of the Utah Health Code, Title 26 of the Utah Code.</p> <ul style="list-style-type: none"><li>➤ UCA 26-18 establishes the Medical Assistance Program, commonly referred to as Medicaid and its administrative arm, the Division of Health Care Financing.</li><li>➤ UCA 26-19 authorizes the department to recover Medicaid benefits paid by the division from third parties, including estates and trusts.</li><li>➤ UCA 26-20 prohibits false Medicaid claims and establishes the Medicaid Fraud Unit.</li><li>➤ UCA 26-35a creates the Nursing Care Facilities Account and levies an assessment on the owners of nursing care facilities to generate seed money which draws down additional federal funds for the operation of those facilities.</li><li>➤ UCA 26-47 requires the department to create a Prescription Drug Assistance Program to assist individuals who need help in obtaining prescription drugs at a reduced cost or at no cost.</li></ul>
<b>Intent Language</b>	<p>The Legislature approved intent language in the FY 2005 Appropriations Act to have the Department of Health repeal the rules and portion of the state plan which requires nursing care facilities to charge their private pay residents the same rate or more that the Medicaid rate. Intent language for FY 2004 authorized eREP enhancement funding as nonlapsing.</p>

**Accountability**

The following performance measures have been identified as key measures by the Division of Health Care Financing.

<b>Performance Data Summary - Health Care Financing</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
<b>Medicaid Operations</b> - To provide improved access to customer service assistance	Customer phone call and abandonment rate	Output	270,000	295,698	315,000
	Wait time before reaching a customer service agent.	Output	8.5%	8.5%	7.0%
<b>Coverage &amp; Reimbursement</b> - Data and evidence-based decisions for requests for out of scope treatments	Utilizing Utah Medicaid's internal resources, bolstered by extensive outside expertise, the credibility of decisions is enhanced, thereby reducing the recurring challenges to approving or denying Medicaid coverage decisions. Reducing the number and length of challenges will allow more efficient and effective use of staff time, and will also reduce potential political overtones.	Output	96 seconds	94.8 seconds	89 seconds
			Initial research into evidence based medicine with contracting done during FY 2005. Accordingly, the target is to contract during FY 2005.	Based upon the research, contracting to augment the evidence based medicine approach was found to have sufficient justification to warrant an RFP.	Produce an RFP and award a contract to supplement our evidence based medicine approach.

**Table 7-1**

**Funding Detail**

This division's primary source of revenue is Federal Funds due to the matching monies available for the administration of the Medicaid program. Other significant funding sources include the state General Fund, dedicated credits, transfers, and one restricted funds.

<b>Health Care Financing</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	10,110,700	10,346,200	9,454,200	9,452,800	9,457,100
General Fund, One-time	(78,000)	(1,194,700)	0	396,800	104,000
Federal Funds	39,191,467	45,620,742	41,870,366	36,744,411	39,722,600
Dedicated Credits Revenue	4,129,854	7,287,569	10,500,816	2,810,081	10,771,000
GFR - Nursing Facility	1,631,900	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	0	0	300,000
Transfers	14,345,118	15,145,782	11,230,403	15,118,087	11,208,400
Beginning Nonlapsing	0	1,600,000	0	0	0
Closing Nonlapsing	(1,600,000)	0	0	(247,275)	0
Lapsing Balance	(8,356)	55,350	(114,103)	0	0
<b>Total</b>	<b>\$67,722,683</b>	<b>\$78,860,943</b>	<b>\$72,941,682</b>	<b>\$64,274,904</b>	<b>\$71,563,100</b>
<b>Programs</b>					
Director's Office	3,865,564	5,421,474	3,712,376	6,924,351	4,118,300
Financial Services	9,299,628	9,965,813	10,794,546	7,796,646	7,403,900
Managed Health Care	2,607,904	2,450,496	2,377,838	2,428,709	2,464,800
Medical Claims	2,627,083	2,948,167	2,812,658	3,508,541	3,152,200
Eligibility Services	14,311,200	13,804,574	15,057,063	16,045,344	15,527,300
Coverage and Reimbursement	3,229,998	3,317,523	3,039,806	3,030,104	3,068,800
Contracts	30,972,158	40,104,927	35,147,395	24,541,209	35,827,800
Utah Medical Assistance	809,148	847,969	0	0	0
<b>Total</b>	<b>\$67,722,683</b>	<b>\$78,860,943</b>	<b>\$72,941,682</b>	<b>\$64,274,904</b>	<b>\$71,563,100</b>
<b>Categories of Expenditure</b>					
Personal Services	22,809,568	24,229,648	24,275,311	25,362,446	25,548,100
In-State Travel	91,957	83,527	72,618	77,478	73,200
Out of State Travel	46,381	45,583	24,519	43,052	25,700
Current Expense	14,507,282	13,815,986	11,077,919	10,684,628	8,294,900
DP Current Expense	3,447,589	3,930,385	4,130,412	4,296,207	3,730,500
DP Capital Outlay	113,049	39,647	28,300	126,342	0
Capital Outlay	5,200	0	0	0	0
Other Charges/Pass Thru	26,701,657	36,716,167	33,332,603	23,684,751	33,890,700
<b>Total</b>	<b>\$67,722,683</b>	<b>\$78,860,943</b>	<b>\$72,941,682</b>	<b>\$64,274,904</b>	<b>\$71,563,100</b>
<b>Other Data</b>					
Total FTE	471.5	465.8	460.3	454.5	455.0
Vehicles	8	9	14	14	14

Table 7-2

**Special Funding**

As shown in Table 7-2, a portion of the funding for this division comes from the Nursing Care Facilities Account, as detailed in Table 7-3.

<b>Restricted Funds Summary - Health Care Financing</b>				
<b>Fund/Account Name</b>	<b>Statutory Authority</b>	<b>Revenue Source</b>	<b>Prescribed Uses</b>	<b>FY 2004 Balance</b>
Nursing Care Facilities Account	26-35a-106	Collections from an assessment imposed on nursing facilities determined by the total number of patient days of care to non-Medicare patients.	Funds appropriated may only be used to increase the rates paid to facilities providing care to Medicaid recipients and up to 3 percent for administrative costs.	\$0 (Account authorized to begin collections 1 July 2004)

**Table 7-3**

**DIRECTOR'S OFFICE****Function**

The Director's Office of the Division of Health Care Financing administers and coordinates Utah's Medicaid program to comply with Titles XIX and XXI of the Social Security Act, other laws of the State, and the appropriated budget. This is accomplished by planning, managing and evaluating activities which authorize payments to qualified providers of approved services who are reimbursed for appropriate and necessary medical assistance rendered to eligible beneficiaries.

**Funding Detail**

<b>Director's Office</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	335,400	51,900	1,065,363	305,600	1,204,500
General Fund, One-time	(57,700)	(937,000)	0	4,300	8,900
Federal Funds	2,297,109	2,297,559	2,175,530	4,031,792	2,319,300
Dedicated Credits Revenue	1,259,672	1,048,674	585,586	1,459,333	585,600
GFR - Nursing Facility	1,600,000	0	0	0	0
Transfers	98,366	110,059	0	1,395,807	0
Beginning Nonlapsing	0	1,600,000	0	0	0
Closing Nonlapsing	(1,600,000)	0	0	0	0
Lapsing Balance	(67,283)	1,250,282	(114,103)	(272,481)	0
<b>Total</b>	<b>\$3,865,564</b>	<b>\$5,421,474</b>	<b>\$3,712,376</b>	<b>\$6,924,351</b>	<b>\$4,118,300</b>
<b>Categories of Expenditure</b>					
Personal Services	3,080,332	2,929,489	2,963,524	3,302,754	3,164,800
In-State Travel	6,939	10,243	13,339	16,265	13,600
Out of State Travel	19,510	16,104	9,447	18,380	9,900
Current Expense	703,103	733,120	469,042	2,740,910	541,700
DP Current Expense	49,978	78,468	133,734	234,596	134,100
DP Capital Outlay	0	0	0	18,730	0
Other Charges/Pass Thru	5,702	1,654,050	123,290	592,716	254,200
<b>Total</b>	<b>\$3,865,564</b>	<b>\$5,421,474</b>	<b>\$3,712,376</b>	<b>\$6,924,351</b>	<b>\$4,118,300</b>
<b>Other Data</b>					
Total FTE	58.0	54.5	53.0	46.5	46.5

**Table 7-4****FINANCIAL SERVICES****Function**

The Bureau of Financial Services is responsible for the following functions within the division:

- Managing the administration and service budgets for both the Medicaid and PCN programs, and assisting with CHIP.
- Monitoring the drug rebate program within the State.
- Performing audits on Medicaid providers within the State to cost settle Medicaid reimbursements. This involves cost studies on

reimbursement rates to evaluate if fair rates are being set for provider services.

- Purchasing office equipment and computer hardware and software for the division.

**Funding Detail**

<b>Financial Services</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	1,811,000	905,900	2,079,126	1,158,700	1,474,700
General Fund, One-time	(6,100)	(25,000)	0	(97,100)	10,000
Federal Funds	8,785,492	9,482,580	8,673,407	5,922,095	5,577,200
Dedicated Credits Revenue	0	0	37,000	0	37,000
GFR - Nursing Facility	31,900	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	0	0	300,000
Transfers	69,846	1,993,243	5,013	0	5,000
Lapsing Balance	(1,392,510)	(2,390,910)	0	812,951	0
<b>Total</b>	<b>\$9,299,628</b>	<b>\$9,965,813</b>	<b>\$10,794,546</b>	<b>\$7,796,646</b>	<b>\$7,403,900</b>
<b>Categories of Expenditure</b>					
Personal Services	1,876,206	2,522,772	2,559,982	2,938,806	2,727,000
In-State Travel	10,667	6,745	6,722	8,230	6,700
Out of State Travel	3,879	4,123	6,830	3,526	6,900
Current Expense	4,149,024	3,906,260	4,497,253	1,565,027	1,353,900
DP Current Expense	3,141,603	3,486,266	3,684,659	3,162,645	3,277,000
DP Capital Outlay	113,049	39,647	28,300	107,612	0
Capital Outlay	5,200	0	0	0	0
Other Charges/Pass Thru	0	0	10,800	10,800	32,400
<b>Total</b>	<b>\$9,299,628</b>	<b>\$9,965,813</b>	<b>\$10,794,546</b>	<b>\$7,796,646</b>	<b>\$7,403,900</b>
<b>Other Data</b>					
Total FTE	31.0	26.5	32.8	40.5	40.5
Vehicles	1	1	1	1	1

**Table 7-5**

MANAGED HEALTH CARE

Function

The Bureau of Managed Health Care is responsible for implementing and operating the managed care initiative that includes contracts with managed care plans to serve the medical and mental health needs of Medicaid clients. The bureau is also responsible for the development, implementation, and operation of specialized Medicaid services for special populations in relation to managed care, a home and community-based waiver program, and the Child Health Evaluation and Care (CHEC) program that is Utah’s version of the federally-mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program covering prevention, outreach, and expanded services for enrolled children.

The current status of clients in fee-for-service and HMOs is detailed in the following table.

Distribution of Medicaid Clients			
	FY 2003	FY 2004	FY 2005 est.
Fee for Service Clients	210,791	229,401	245,000
Managed Care Clients (Monthly Average)	95,801	105,625	115,000
<b>Total</b>	<b>306,592</b>	<b>335,026</b>	<b>360,000</b>

Note: Almost all managed care clients are also enrolled in fee-for-service for pharmacy claims.

Table 7-6

Funding Detail

Managed Health Care					
	2001	2002	2003	2004	2005
Sources of Finance	Actual	Actual	Actual	Actual	Appropriated
General Fund	1,031,200	1,041,700	860,200	802,800	810,200
General Fund, One-time	(400)	(8,200)	0	2,900	8,200
Federal Funds	1,398,321	1,455,680	1,404,137	1,404,047	1,532,900
Dedicated Credits Revenue	106,232	134,945	113,501	11,517	113,500
Transfers	39,506	61,450	0	96,801	0
Lapsing Balance	33,045	(235,079)	0	110,644	0
<b>Total</b>	<b>\$2,607,904</b>	<b>\$2,450,496</b>	<b>\$2,377,838</b>	<b>\$2,428,709</b>	<b>\$2,464,800</b>
Categories of Expenditure					
Personal Services	1,953,080	1,967,864	1,942,989	1,569,450	2,094,100
In-State Travel	22,630	17,937	17,015	16,006	17,100
Out of State Travel	6,842	9,846	6,240	9,037	6,700
Current Expense	540,754	403,321	331,634	728,804	321,600
DP Current Expense	21,279	24,186	25,287	76,812	25,300
Other Charges/Pass Thru	63,319	27,342	54,673	28,600	0
<b>Total</b>	<b>\$2,607,904</b>	<b>\$2,450,496</b>	<b>\$2,377,838</b>	<b>\$2,428,709</b>	<b>\$2,464,800</b>
Other Data					
Total FTE	41.5	37.5	34.5	36.0	36.0

Table 7-7

---

**MEDICAL CLAIMS****Function**

The Bureau of Medical Claims has the following five components:

- Customer Service - The bureau staffs the Medicaid Information Line, providing on-line service to providers and clients regarding Medicaid eligibility, provider payment, and general information regarding all aspects of services provided by the Department of Health. A call management system ensures that calls get routed to the correct area without having to go through numerous transfers.
- Utah Health Information Network (UHIN) Involvement - The UHIN is a statewide cooperative of Medicaid, providers, and other third party medical claims payers. Its goal is to standardize health care information so that all claims data can be submitted in an electronic transaction to any payee. This activity was mandated by the 1992 Legislature.
- Claims Processing - The bureau processes all claims received by Health Care Financing, ensuring that the claims are properly entered into the MMIS system, and are adjudicated properly. They serve as troubleshooters working with providers in the event there are questions regarding payment or non-payment of claims, and coordinates recoupment processes with other State and Federal agencies.
- MMIS - Bureau staff identifies and approves updates and corrections to the MMIS to ensure the system is properly handling information on services provided by Health Care Financing. The staff also requests additional programming to implement policy changes and new federal/state regulations affecting claims processing. Staff are responsible for maintenance, upgrades, and data input of the MMIS subsystems, i.e. provider file, reference file, and security file.
- Special Projects - The bureau manages special projects under contract with Community and Family Health Services (Pre-natal program) and the Division of Family Services (Custody Medical Care Program). It also manages the Buy-Out program that ensures compliance with the third party liability requirements of the OBRA '90 legislation.

## Funding Detail

Medical Claims					
Sources of Finance	2001 Actual	2002 Actual	2003 Actual	2004 Actual	2005 Appropriated
General Fund	705,700	735,000	853,453	866,200	822,000
General Fund, One-time	(300)	(21,300)	0	1,500	6,400
Federal Funds	1,797,591	2,013,461	1,933,453	2,429,530	2,298,000
Dedicated Credits Revenue	(439)	0	25,752	(34)	25,800
Transfers	25,141	37,648	0	(28,285)	0
Lapsing Balance	99,390	183,358	0	239,630	0
<b>Total</b>	<b>\$2,627,083</b>	<b>\$2,948,167</b>	<b>\$2,812,658</b>	<b>\$3,508,541</b>	<b>\$3,152,200</b>
<b>Categories of Expenditure</b>					
Personal Services	1,614,562	1,710,530	1,754,444	1,966,721	2,103,900
In-State Travel	2,682	2,378	2,440	3,263	2,400
Out of State Travel	7,605	4,181	0	1,729	0
Current Expense	958,870	1,095,039	945,543	1,264,263	935,900
DP Current Expense	43,364	136,039	110,231	272,565	110,000
<b>Total</b>	<b>\$2,627,083</b>	<b>\$2,948,167</b>	<b>\$2,812,658</b>	<b>\$3,508,541</b>	<b>\$3,152,200</b>
<b>Other Data</b>					
Total FTE	52.0	48.0	46.0	49.5	49.5

Table 7-8

## ELIGIBILITY SERVICES

## Function

The Bureau of Eligibility Services is responsible for eligibility policy and operations related to Medicaid eligibility, including nursing home eligibility determinations and out-stationed eligibility workers who are in hospitals and public health clinics. The bureau is also responsible for eligibility determination for the CHIP and Primary Care Network. The bureau coordinates and oversees the eligibility contract with the Department of Workforce Services and also coordinates Medicaid recovery activities with the Office of Recovery Services. Besides administration and office support staff, the bureau has 229.5 eligibility staff stationed throughout the State, with a total caseload (as of June 2004) of 62,533, including CHIP.

The following table shows the duplicated caseload that each eligibility worker handles during the course of a year.

Eligibility Services - Historical Caseloads and FTE						
	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Medicaid Caseload	35,266	37,192	40,467	40,504	43,100	45,966
CHIP Caseload	4,676	7,943	11,071	10,217	10,818	14,115
PCN						5,000
<b>Total Caseload</b>	<b>39,942</b>	<b>45,135</b>	<b>51,538</b>	<b>50,721</b>	<b>53,918</b>	<b>65,081</b>
Medicaid FTE	150.00	154.75	156.50	152.00	155.50	154.00
CHIP/Supervisory FTE	44.00	51.00	57.00	50.00	50.00	50.00
<b>Total FTE</b>	<b>194.00</b>	<b>205.75</b>	<b>213.50</b>	<b>202.00</b>	<b>205.50</b>	<b>204.00</b>
<b>Medicaid Caseload per FTE</b>	<b>235</b>	<b>240</b>	<b>259</b>	<b>266</b>	<b>277</b>	<b>298</b>

Table 7-9

## Funding Detail

Eligibility Services					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	4,022,100	5,844,500	3,828,064	5,337,500	3,957,800
General Fund, One-time	(1,200)	(34,500)	0	482,700	66,200
Federal Funds	6,230,741	6,668,991	7,348,325	8,088,751	7,352,500
Dedicated Credits Revenue	344,008	424,408	3,880,674	1,339,265	4,150,800
Transfers	1,430,441	14,269	0	1,794,331	0
Closing Nonlapsing	0	0	0	(247,275)	0
Lapsing Balance	2,285,110	886,906	0	(749,928)	0
<b>Total</b>	<b>\$14,311,200</b>	<b>\$13,804,574</b>	<b>\$15,057,063</b>	<b>\$16,045,344</b>	<b>\$15,527,300</b>
<b>Categories of Expenditure</b>					
Personal Services	11,550,865	12,126,642	12,961,831	13,589,084	13,441,500
In-State Travel	43,999	39,676	31,131	31,205	31,600
Out of State Travel	3,905	2,489	254	1,303	500
Current Expense	2,609,434	1,456,733	1,472,121	1,390,344	1,454,500
DP Current Expense	101,437	175,309	165,323	498,800	172,800
Other Charges/Pass Thru	1,560	3,725	426,403	534,608	426,400
<b>Total</b>	<b>\$14,311,200</b>	<b>\$13,804,574</b>	<b>\$15,057,063</b>	<b>\$16,045,344</b>	<b>\$15,527,300</b>
<b>Other Data</b>					
Total FTE	243.0	255.3	265.5	256.5	257.0
Vehicles	7	8	13	13	13

Table 7-10

**COVERAGE AND REIMBURSEMENT**

**Function**

The Bureau of Coverage and Reimbursement Policy has the following seven basic functions:

- Research, analyze, formulate, and make recommendations for policy modifications and to develop new policy;
- Analyze all pending and current federal and state legislation dealing with health care;
- Formulate and process all State Plan changes and all rule-makings dealing with the Medicaid program;
- Manage Utilization Review through medical professional evaluation of requests for medically necessary services that vary from policy, or which need additional professional review;
- Evaluate Medicaid expenditures through post payment review to ensure that payments were in compliance with Medicaid policy, and to identify possible situations of fraud or abuse;
- Fulfill federal requirements for determination of payment error rate required under the federal Improper Payments Information Act of 2002;
- Determine appropriate reimbursement rates and methodology reflecting state and federal mandates and budget allocations.

**Funding Detail**

<b>Coverage and Reimbursement</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	668,100	778,500	755,484	704,100	693,600
General Fund, One-time	(300)	(4,500)	0	2,500	4,300
Federal Funds	1,933,420	2,006,471	1,870,842	1,868,085	1,957,400
Dedicated Credits Revenue	0	(18)	18	0	0
Transfers	477,815	444,712	413,462	358,901	413,500
Lapsing Balance	150,963	92,358	0	96,518	0
<b>Total</b>	<b>\$3,229,998</b>	<b>\$3,317,523</b>	<b>\$3,039,806</b>	<b>\$3,030,104</b>	<b>\$3,068,800</b>
<b>Categories of Expenditure</b>					
Personal Services	2,102,025	2,309,198	2,073,022	1,995,631	2,016,800
In-State Travel	2,243	3,941	1,971	2,509	1,800
Out of State Travel	3,701	7,582	1,748	9,077	1,700
Current Expense	1,053,815	988,290	951,887	972,098	1,037,200
DP Current Expense	68,214	8,512	11,178	50,789	11,300
<b>Total</b>	<b>\$3,229,998</b>	<b>\$3,317,523</b>	<b>\$3,039,806</b>	<b>\$3,030,104</b>	<b>\$3,068,800</b>
<b>Other Data</b>					
Total FTE	30.5	31.0	28.5	25.5	25.5

**Table 7-11**

**CONTRACTS**

**Function**

Agencies both within and outside of the Department of Health contract with this program, by sending some of their General Fund appropriations to the Division of Health Care Financing, which then uses those funds to draw down the matching federal Medicaid funds, then forwards all of the funds back to the original agencies. This helps those agencies leverage their state funds by the Federal match. Contracts are for non-medical services performed for the Division by the Departments of Human Services and Workforce Services, such as recovery services, training, and administration. When eligibility for Medicaid services involves more services than just medical (e.g. food stamps), then eligibility is determined by employees of the Department of Workforce Services.

In addition, this program deals with medical and dental consultants and CPA audits and reviews, which serve the Medicaid program.

**Funding Detail**

	<b>Contracts</b>				
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	794,100	146,300	12,510	277,900	494,300
General Fund, One-time	(10,700)	(160,000)	0	0	0
Federal Funds	16,733,281	21,682,494	18,464,672	13,000,111	18,685,300
Dedicated Credits Revenue	2,420,396	5,679,560	5,858,285	0	5,858,300
Transfers	12,167,003	12,447,401	10,811,928	11,500,532	10,789,900
Lapsing Balance	(1,131,922)	309,172	0	(237,334)	0
<b>Total</b>	<b>\$30,972,158</b>	<b>\$40,104,927</b>	<b>\$35,147,395</b>	<b>\$24,541,209</b>	<b>\$35,827,800</b>
<b>Categories of Expenditure</b>					
Personal Services	0	0	19,519	0	0
Current Expense	4,366,082	5,098,877	2,410,439	2,023,182	2,650,100
Other Charges/Pass Thru	26,606,076	35,006,050	32,717,437	22,518,027	33,177,700
<b>Total</b>	<b>\$30,972,158</b>	<b>\$40,104,927</b>	<b>\$35,147,395</b>	<b>\$24,541,209</b>	<b>\$35,827,800</b>
<b>Other Data</b>					

**Table 7-12**

---

**CHAPTER 8 MEDICAL ASSISTANCE**

---

**Function**

Medical Assistance is a joint federal/state entitlement service that provides health care to selected low-income populations. The program is commonly referred to as Medicaid.

There are three programs within the Medicaid line item, which include the Medicaid Base Program, Title XIX Funding for the Department of Human Services, and DOH Health Clinics.

The Medicaid Base Program is the program most commonly identified with Medical Assistance. It provides a number of health services to specific eligible populations. While Federal law and regulations currently mandate some specific services within the program, the State has some flexibility and has been granted waivers that allow some latitude in program implementation, as well as to offer some optional services. The FY 05 estimated base program makes up over 86 percent of all Medical Assistance expenditures. This program also includes the new Primary Care Network (PCN). The State funding for this was formerly in the Utah Medical Assistance Program (UMAP), but with the approval of the PCN waiver, went into the Base Program and is now matched with Federal funds.

Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who are qualified to receive Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which is transferred to the Medicaid program to be matched with Federal Funds.

The Utah Medical Assistance Program (UMAP) was the State program designed to provide a very limited number of services to a population that previously did not qualify for any other medical assistance programs. With the PCN now in place, this funding is now incorporated in the Medicaid Base program. However, there are still some costs for specialty physician services which are paid for entirely with State dollars and fees. These are included in the DOH Medical/Dental Clinics.

**Statutory Authority**

The Medical Assistance Program is governed by several chapters of the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-18 establishes the Medical Assistance Program, commonly referred to as Medicaid and its administrative arm, the Division of Health Care Financing.
- UCA 26-19 authorizes the department to recover Medicaid benefits paid by the division from third parties, including estates and trusts.
- UCA 26-20 prohibits false Medicaid claims and establishes the Medicaid Fraud Unit.

- UCA 26-35a creates the Nursing Care Facilities Account and levies an assessment on the owners of nursing care facilities to generate seed money which draws down additional federal funds for the operation of those facilities.

**Intent Language**

Included in the FY 2005 appropriations act were several items of intent language for the Medical Assistance Program.

The Legislature stated three methods needed to improve the oral health status of low-income Utahns. The Legislature also wants the Department of Health to continue using the Resource Utilization Group System (RUGS) method in reimbursing nursing care facilities, but to also consider replacing the current property component with a fair market value model, including capital improvements, and to report on the implementation during the 2005 General Session. Intent language also covers the one-time funding of \$1 million (General Fund) for limited Medicaid dental services to clients who are aged, blind, or disabled. An additional \$1 million (General Fund) was approved with accompanying intent language to increase reimbursement rates paid to hospitals.

**Accountability**

The Medical Assistance Program has outlined the performance measures detailed in the following table:

Performance Data Summary - Medical Assistance					
Goal	Measure	Measure Type	FY 2004		FY 2005
			Target	Observed	Target
Utah Medicaid managed care plans, PCCM (IHC) and fee-for-service will meet or exceed the national average on 70% of the Consumer Assessment of Health Plans Survey (CAHPS) measures.	Information will be collected for Medicaid enrollees in medical managed care plans as well as our primary care case management plan and fee-for-service. Information will be collected by survey through the Department's CAHPS process. The results will be compared to nationally published CAHPS results for the applicable population.	Output	65.0%	78.0%	70.0%
			(Molina)	(Molina)	(Molina)
			65.0%	89.0%	70.0%
			(Healthy U)	(Healthy U)	(Healthy U)
			65.0%	78.0%	70.0%
			(IHC)	(IHC)	(IHC)
			65.0%	55.0%	70.0%
			(FFS)	(FFS)	(FFS)
Increase the use of generic medications. The use was about 49% generic and 51% name brand.	The Point-of-Sale computer program used by all pharmacies was programmed to allow generic products to be paid with no constraints while name brand products with generic equivalents were only available with physician documentation of medical necessity prohibiting the generic product.	Output	Twenty Five percent reduction in use by applications of "best practices guides" for atypical antipsychotic medications.	Observed a 60% change.	Maintain the 60% reduction achieved in FY 2004
Reduce the number of prescriptions used by Medicaid clients.	Number of Medicaid clients using more than seven prescriptions per month.	Output	Reduce prescriptions with the goal of 7 or less perscriptions per Medicaid client.	Made reduction with concomitant cost saving of \$3 million.	Maintiain the number of monthly prescriptions to not exceed 7 scrips per Medicaid client.

**Table 8-1**

**Funding Detail**

This division's primary source of revenue is federal funds due to the matching monies available for the cost of services within the Medicaid program. Other significant funding sources include the state General Fund, dedicated credits, transfers, and one restricted fund.

<b>Medical Assistance</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	156,591,800	189,699,900	199,583,500	229,967,400	251,458,000
General Fund, One-time	26,000	(6,398,500)	0	(37,347,300)	1,008,000
Federal Funds	589,884,966	664,418,167	765,098,122	915,450,204	1,005,874,500
Dedicated Credits Revenue	41,659,646	73,725,486	50,904,918	68,921,848	74,742,500
GFR - Medicaid Restricted	8,641,200	4,211,600	1,573,000	0	0
GFR - Nursing Facility	4,390,500	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	0	5,347,300	9,800,000
Transfers	72,115,345	67,975,893	90,072,692	92,503,627	100,878,800
Beginning Nonlapsing	339,347	1,607,505	(1,366,509)	476,404	476,400
Closing Nonlapsing	(1,607,505)	(468,038)	(476,404)	(620,901)	0
Lapsing Balance	0	(1,234)	(5,226,655)	(270,088)	0
<b>Total</b>	<b>\$872,041,299</b>	<b>\$994,770,779</b>	<b>\$1,100,162,664</b>	<b>\$1,274,428,494</b>	<b>\$1,444,238,200</b>
<b>Programs</b>					
Medicaid Base Program	714,290,223	823,832,003	923,387,419	1,095,156,768	1,250,056,000
Title XIX for Human Services	150,726,583	162,127,128	172,348,339	175,139,165	190,014,100
Utah Medical Assistance Program	7,024,493	8,811,648	0	0	0
DOH Health Clinics	0	0	4,426,906	4,132,561	4,168,100
<b>Total</b>	<b>\$872,041,299</b>	<b>\$994,770,779</b>	<b>\$1,100,162,664</b>	<b>\$1,274,428,494</b>	<b>\$1,444,238,200</b>
<b>Categories of Expenditure</b>					
Personal Services	2,489,308	2,752,305	2,986,022	3,463,246	3,319,200
In-State Travel	7,763	25,090	40,259	32,753	40,300
Out of State Travel	422	2,403	2,464	1,099	185,000
Current Expense	434,054	543,297	716,668	713,448	545,800
DP Current Expense	5,895	3,843	15,393	41,980	15,700
DP Capital Outlay	0	0	0	49,050	0
Other Charges/Pass Thru	869,103,857	991,443,841	1,096,401,858	1,270,126,918	1,440,132,200
<b>Total</b>	<b>\$872,041,299</b>	<b>\$994,770,779</b>	<b>\$1,100,162,664</b>	<b>\$1,274,428,494</b>	<b>\$1,444,238,200</b>
<b>Other Data</b>					
Total FTE	61.0	63.5	60.3	62.0	62.5

Table 8-2

**Special Funding**

As shown in Table 8-2, a portion of the funding for this division comes from the Nursing Care Facilities Account, as detailed in the following table.

Restricted Funds Summary - Medical Assistance				
Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2004 Balance
Nursing Care Facilities Account	26-35a-106	Collections from an assessment imposed on nursing facilities determined by the total number of patient days of care to non-Medicare patients.	Funds appropriated may only be used to increase the rates paid to facilities providing care to Medicaid recipients and up to 3 percent for administrative costs.	\$0 (Account authorized to begin collections 1 July 2004)

Table 8-3

**MEDICAID BASE PROGRAM**

**Function**

Medical Assistance is a joint federal/state entitlement service consisting of three programs that provide health care to selected low-income populations: (1) a health insurance program for low-income parents (mostly mothers) and children (nationally, about 28 percent of all births are covered by Medicaid); (2) a long-term care program for the elderly (nearly 70 percent of all nursing home residents are Medicaid beneficiaries); and (3) a funding source for services to people with disabilities (Medicaid pays for approximately one-third of the nation's bill for this population). Nationwide, Medicaid covers over 40 million people, or about 13 percent of all Americans and nearly half of those living in poverty.

Overall, Medicaid is an "optional" program, one that a state can elect to offer. However, if a state offers the program, it must abide by strict federal regulations. It also becomes an entitlement program for qualified individuals; that is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. The federal government establishes and monitors certain requirements concerning funding, and establishes standards for quality and scope of medical services. Requirements include services that must be provided and specific populations that must be served. States may expand their program to cover additional "optional" services and/or "optional" populations. In addition, states have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery.

There are currently 53 services included in the Medicaid Program. Of these, inpatient hospital, outpatient hospital, intermediate care facilities for the mentally retarded, long-term care, physician, dental, pharmacy, and health maintenance organizations make up approximately 66 percent of program expenditures. The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for specific populations or in specific settings. A brief description of each service is found in Appendix 3.

Mandatory services in the Medicaid Program are those that the federal government requires to be offered if a state has a Medicaid program. These include: inpatient and outpatient hospital, physician, skilled and intermediate care nursing facilities, medical transportation, home health, nurse midwife, pregnancy-related services, lab and radiology, kidney dialysis, Early Periodic Screening Diagnosis and Treatment, and community and rural health centers. The State is also required to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the poverty level.

The Early Periodic Screening Diagnosis and Treatment Program is a mandatory program which requires the State to screen all Medicaid children at scheduled intervals. The mandate includes providing all medically necessary services that can be covered under the program, such as organ transplants or any other service needed, regardless of cost.

Optional Services require approval from the federal Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration or HCFA). These services are eligible for the state's FMAP matching funds. These include pharmacy, dental, medical supplies, ambulatory surgery, chiropractic, podiatry, physical therapy, vision care, substance abuse treatment, speech and hearing services. The only optional long-term care service is Intermediate Care Facilities for the Mentally Retarded. As noted above, some of these services may be mandatory for certain populations or in certain settings. It should also be noted that while the service, as a whole may be optional, once the state elects to offer that service, it must make it available to all qualified eligibles.

Eligibility for many of the new Medicaid Programs, which Congress has added in recent years, is based on a person's income relative to the federal poverty level. The following table shows the annual federal poverty levels for 2004 by family size. The table also shows 133 percent of poverty because coverage for pregnant women is mandatory for persons with incomes up to 133 percent of poverty. Currently the State has the option of raising eligibility for programs for pregnant women and children to 185 percent of poverty.

<b>2004 FEDERAL POVERTY LEVELS</b>			
<b><u>Family Size</u></b>	<b><u>100%</u></b>	<b><u>133%</u></b>	<b><u>185%</u></b>
1	\$776	\$1,032	\$1,436
2	\$1,041	\$1,385	\$1,926
3	\$1,306	\$1,737	\$2,416
4	\$1,571	\$2,089	\$2,906
5	\$1,836	\$2,442	\$3,397
6	\$2,101	\$2,794	\$3,887
7	\$2,366	\$3,147	\$4,377
8	\$2,631	\$3,499	\$4,867
9	\$2,896	\$3,852	\$5,358
10	\$3,161	\$4,204	\$5,848

Table 8-4

The State has designated five major population groupings that may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as Aged); (2) Blind and/or Disabled individuals; (3) Children who receive Temporary Assistance for Needy Families (TANF) benefits, or are in the Foster Care program; (4) TANF Adults, with dependent children; and (5) Pregnant women. Each of these groups is discussed in more detail later in this section.

Much of the effort in the Medicaid program over the past several years was toward moving eligibles who live in the populated Wasatch Front counties from the traditional "fee-for-service" providers to managed care, or health maintenance organizations (HMOs). The purpose behind this effort was to provide more cost-effective health care. This was the case early in the movement toward HMOs. However, in recent years the savings gap has shrunk. During the 2002 Legislative session, the two largest HMO providers, IHC and United, told the subcommittee that they would need an increase of eight percent in their rates in order to continue providing HMO services. The Legislature did approve an eight percent increase, but both of those providers later notified the State that they would be terminating their HMO Medicaid services. This prompted the move back to fee for service for Medicaid services.

The distribution of FY 2004 Medicaid eligibles, recipients, and expenditures for each group are shown in the chart on the following page.

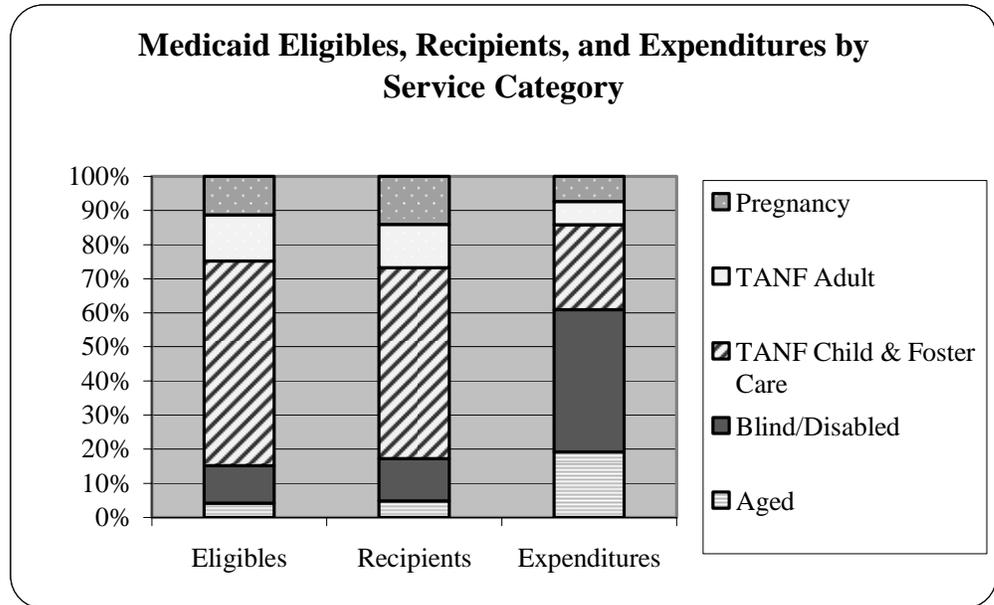


Figure 8-1

*FY 2005 Medicaid Funding*

The 2004 Legislature increased funding for FY 2005 for the Medical Assistance budget to cover increases due to general utilization and caseload growth as well as inflationary factors for pharmacy and some specific provider groups. In addition, the Legislature approved a one-time \$1 million appropriation to cover specific dental procedures for clients who are aged, blind or disabled. The Legislature also provided \$1 million to augment funding to hospitals providing services for Medicaid recipients.

*Kaiser Report on States' Efforts to Control Medicaid Costs*

The Kaiser Commission on Medicaid and the Uninsured, surveyed Medicaid officials in all 50 states. The following are excerpts from that report to demonstrate that Utah is not alone in its struggle to handle the Medicaid budget in extremely difficult economic times.<sup>1</sup>

Medicaid was the driving force of the increase for the Department of Health, as the balance of the Department also experienced budget reductions. Across the country, states are facing similar situations with their Medicaid budgets exerting tremendous pressures on their budgets. This is attributable to increased enrollment due to post-welfare reform, eligibility expansions, and economic conditions. By the program's design, Medicaid costs can be expected to increase when the economy weakens and causes more people to enroll in the program. Because Medicaid is means-tested, more people qualify for Medicaid when incomes fall. This is generally at the same time as when state tax revenues fall. These factors create an inevitable tension for the state: the need for the program is frequently the greatest when the sources of state funds to devote to the program are the lowest. The survey identified 49 states that had plans to reduce Medicaid funding growth. Most states are using increased controls on pharmacy costs and payments to providers. States

<sup>1</sup> "States Budgets Under Stress: How are States Planning to Reduce the Growth in Medicaid Costs?" The Kaiser Commission on Medicaid and the Uninsured, July 30, 2002

are also increasing cost-sharing, eliminating optional benefits, and reducing eligibility. These changes include:

**Increasing controls on prescription drugs**, including seeking larger discounts and rebates on purchases, increasing usage of prior authorization, preferred drug lists, generic drugs, and limiting the number of prescriptions filled in a given month. *Utah has implemented requiring generic drugs, reviewing the prescriptions for individuals having more than seven scripts per month, and authorized the return of unused prescription drugs in nursing facilities.* Note: nine states require generic drugs and six limit the number of monthly prescriptions.

**Cutting or freezing provider payments** to doctors, hospitals, nursing facilities, and managed care providers. *Utah had not reduced reimbursement rates, but began reducing pharmacy product costs by paying average wholesale price (AWP) minus 15 percent instead of 12 percent (January 1, 2003) and reducing hospital outlier payments (January 3, 2003), and will implement additional reductions beginning July 1, 2003.* Note: There are 37 states that are either cutting or freezing hospital or other provider payments or are increasing their AWP discount, or other provider payments.

**Eliminating benefits for Medicaid beneficiaries** in 25 states, including dental benefits for adults, home health, podiatry, chiropractic services, eyeglasses, psychological counseling, and translator services. *Utah has eliminated adult dental, case management, and vision care.*

**Initiating or increasing cost-sharing for Medicaid beneficiaries** in 15 states. *Utah has increased copayments for hospital services, physician services, and prescriptions.*

**Reducing the number of eligibles** through lowering income thresholds, reducing transitional coverage, and changing the period of allowable medical expenses for the medically needy. *Utah has not resorted to this measure.* 27 states have reported that they will reduce or restrict Medicaid eligibility.

The following information details the categorical eligibility groups in the Medicaid program:

*Aged*

Individuals aged 65 and over qualify for Medicaid if they qualify for the Federal Supplemental Security Income Program, which provides an income of approximately 77.6 percent of poverty. They also qualify for food stamps. During FY 2004, an average of 11,271 people received services under the aged category of eligibility. Many of the elderly also qualify for Medicare coverage. The Medicaid Program pays for the premiums and deductibles for those eligible under both programs. Medicare pays the actual medical cost for most of these people. The largest expenditure for the elderly, outside of nursing facility services, has for pharmacy items, which have not been covered under Medicare. With Medicare soon to pay for prescription drugs, this expenditure is expected to decrease. However, it will not be a windfall for the State, as the federal government will be recovering the funding from the Medicaid program. Medicaid is also required to pay Medicare premiums,

co-insurance, and deductibles for anyone qualifying for Medicare who has income up to 100 percent of poverty, but Medicare premiums only for those between 100 and 135 percent of poverty.

Medicaid also covers non-SSI aged people whose income does not exceed 100 percent of poverty. Aged people with income over 100 percent of poverty can spenddown to the Medically Needy Income Limit to receive Medicaid.

In July 1986, there were 5,794 nursing facility beds in the State. The census was 5,034 for an occupancy rate of 87 percent. Medicaid paid for 71 percent of all occupants. As of September 30, 2004, there were 7,025 nursing facility beds which were certified, with a census of 5,097 as shown in the following table.

Nursing Facility Beds		
Private Pay	1,132	22.21%
V A Contract	36	0.71%
Part V A Contract	1	0.02%
Medicaid	3,070	60.23%
Medicare	858	16.83%
<b>Total</b>	<b>5,097</b>	
 Total Certified Beds	 7,025	
 Percent Occupancy	 72.56%	

Table 8-5

A Medicaid waiver has been obtained by the Division of Aging which will allow Medicaid to pay for some services in home and community-based settings. This is diverting some elderly people from nursing facility care.

*Blind and Disabled*

Persons receiving assistance due to blindness have always been part of the Medicaid Program.

Persons with disabilities are also eligible for services under the Medicaid Program. The monthly average number of blind and/or disabled individuals receiving Medicaid services during FY 2004 was 28,254. The criteria for disability require that a person be unable to participate in gainful activity for at least a year, or have a medical condition that will result in death. Among the disabilities covered are mental retardation, mental health, spinal injury, and AIDS. Income is limited to 73.5 percent of the federal poverty level for blind individuals and 100 percent for disabled individuals. An asset test similar to that for AFDC is required. Eligible individuals also qualify for food stamps.

The Blind and Disabled make up approximately 11 percent of the Medicaid eligible population, while accounting for approximately 12 percent of recipients. In FY 2004, this group accounted for nearly 41 percent of total

Medicaid expenditures. Institutional care for disabled individuals is included in this category.

Intermediate Care  
Facilities for the  
Mentally Retarded  
(ICF/MR)

A special group of nursing facilities is Intermediate Care Facilities for people with Mental Retardation (ICF/MR). These facilities specialize in the care of people with disabilities. The individuals served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/MR are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs. Nursing services are available for those requiring nursing and medical services.

There are specific federal regulations requiring active treatment programs and other treatment options. Current state law limits the size of new ICF/MR facilities to 16 beds or less. There are currently 14 privately-owned facilities with populations ranging from 12 to 82 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 260. Only four of the facilities meet the 16-or-fewer bed standard. ICFs/MR are an optional service in the Medicaid Program, but are part of the basis allowing the Home and Community Based waiver. Occupancy in the private ICFs/MR is near 100 percent and near 88 percent at the USDC. The average cost per client in an ICF/MR for FY 2004 was approximately \$48,900 which is a full-service program (including residential, day program, transportation, recreation, and medical services).

*Temporary Assistance  
to Needy Families  
(TANF) and Foster  
Care*

Aid to Families with Dependent Children (AFDC) was a joint federal-state program which provided financial assistance to families with children deprived of the support of at least one parent. On August 22, 1996, President Clinton signed the welfare reform bill, which ended the Aid to Families with Dependent Children (AFDC) entitlement program and replaced it with block grants to the states and the Temporary Assistance to Needy Families (TANF) program. In general, however, people who meet AFDC eligibility criteria that were in effect on July 16, 1996 will be eligible for Medicaid. Also, those people who qualify for a TANF grant are eligible for Medicaid.

There are two groups of people who qualify for Medicaid under the TANF program. These include: (1) those in the basic program where a child is deprived of the support of one parent, and (2) those in two-parent families that qualify under the unemployed parent program. The TANF-related programs account for approximately 60 percent of all eligible persons in Medicaid, 56 percent of Medicaid recipients, and less than 25 percent of total expenditures.

Over 90 percent of eligible families are deprived because of divorce, desertion, or unwed mothers. TANF families may also qualify for food stamps. Depending on family size, the AFDC grant and food stamps provide between 62 and 74 percent of the federal poverty level. There is an asset limit of \$2,000 for families in the TANF program. The asset limit does not include a residence or a car with an equity value of less than \$8,000. The average monthly number of TANF recipients during FY 2004 was 128,400. This is

the category that has shown the most significant growth over the past couple of years.

Family Employment  
Program (FEP)

In addition to the basic Family Employment Program (FEP), there is also a program for unemployed two-parent families. This program provides cash assistance for seven months in any 13-month period. One parent in families in this program is required to work 32 hours a week (in an emergency work program) and spend at least 8 hours a week seeking regular employment. With the exception of the time limitation and work requirement, the criteria and benefits for the Family Employment Program - Two Parent (FEP-TP) are the same as those for the regular FEP. Federal law requires that the family be eligible for Medicaid for the full 12 months of the year. Besides those eligible through FEP cash assistance, there are several programs which provide transitional Medicaid coverage for periods of 4 months (for child support-related eligibles) or 24 months (for people who no longer receive cash assistance due to child support payments or earnings). Approximately 31 percent of the people who spend down to qualify for Medicaid come under the FEP category of eligibility. This portion of the FEP continues to grow. This likely is the result of self-sufficiency efforts in the FEP which have increased the number of people receiving transitional benefits.

Children in Foster Care are eligible for Medicaid coverage if they meet Medicaid program requirements. The State is responsible for their medical care. Most children placed in foster care have histories of abuse or neglect. This often means there are unresolved medical and mental health problems that must be dealt with.

In addition to the previously mentioned TANF children, there are four groups of children covered under the Medicaid Program. These are (1) medically needy children, (2) children under age 6 with family income up to 133 percent of poverty, (3) children and youth between age 6 and 18 with income up to 100 percent of poverty, (4) children in subsidized adoptions.

The Medically Needy Children program is for children who do not qualify for assistance under normal Family Medicaid because they are not deprived of the support of a parent. The asset test is the same as for TANF; the family is allowed to spend down to become eligible. This is an optional group, meaning it is not required by the federal government, and so coverage could be terminated. Many children who have been eligible for this group in the past have become eligible in the mandatory programs for children.

The program for children under age six with family income up to 133 percent of poverty is a mandatory program. The program for children born after September 30, 1983 with family income up to 100 percent of the poverty level is designed to provide coverage for children in poverty. There is an asset test required for children in this category of \$3,000 for a family of two; one home is exempted, and a car with an equity value of \$1,500 is allowed.

Each year, a number of children come into the custody of the State and are placed for adoption. Some of these children have serious medical problems which makes them hard to place. In some of these cases, the State subsidizes

the adoption. Some families receive a small stipend to assist in the cost of care for these children, and the State covers the child's medical care under Medicaid until the child is 18 years old.

*TANF Adults*

The group referred to as TANF Adults includes those adults with dependent children who are either categorically or medically needy. Due to waivers initiated as a result of Utah's welfare reform initiative, any adult who qualifies for a financial payment through the FEP, qualifies for Medicaid as a TANF Adult. Some of the individuals may be required to "spenddown" to obtain their Medicaid card, which means that they must reduce their spendable income with payments to Medicaid or with medical bills which they have incurred. Some of the waivers expired at the end of 2000, others will continue.

*Pregnancy*

The prenatal/pregnancy program helps pregnant women receive prenatal care. The program covers the mother from the time of application to 60 days after the birth. A woman only needs to meet the eligibility requirements in any one month to be eligible for the balance of the pregnancy. Children born to women on this program can be covered on Medicaid (after the first 60 days) for the rest of the first year under the postnatal program.

Approximately one-third of all babies born in the state are paid for by Medicaid. This has been the case for the past several years.

Of the mothers in the program, approximately 23 percent are eligible under the FEP program, and 72 percent were eligible through the Pregnancy Program. Other mothers are eligible through other programs such as emergency medical care, blind or disabled, medically needy children, and foster children.

During FY 2004, the pregnancy caseload was 32,264. The individuals who were eligible for Medicaid because of pregnancy represented 11 percent of the Medicaid population in FY 2004. The percentage of recipients was 14 percent; the expenditures represented 7 percent of the total program.

## Funding Detail

<b>Medicaid Base Program</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	153,177,300	186,120,100	198,954,125	229,967,400	250,446,000
General Fund, One-time	0	(6,357,400)	0	(37,347,300)	1,000,800
Federal Funds	484,501,241	549,793,336	641,836,497	789,947,472	869,824,400
Dedicated Credits Revenue	40,837,712	73,139,600	47,873,911	67,742,682	71,612,400
GFR - Medicaid Restricted	7,241,200	4,211,600	1,573,000	0	0
GFR - Nursing Facility	4,390,500	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	0	5,347,300	9,800,000
Transfers	24,116,270	17,095,807	40,219,454	40,155,281	46,896,000
Beginning Nonlapsing	339,347	339,347	(1,366,509)	476,404	476,400
Closing Nonlapsing	(339,347)	(468,038)	(476,404)	(620,901)	0
Lapsing Balance	26,000	(42,349)	(5,226,655)	(511,570)	0
<b>Total</b>	<b>\$714,290,223</b>	<b>\$823,832,003</b>	<b>\$923,387,419</b>	<b>\$1,095,156,768</b>	<b>\$1,250,056,000</b>
<b>Categories of Expenditure</b>					
Personal Services	0	0	169,619	379,968	248,100
In-State Travel	0	0	0	10	0
Out of State Travel	0	0	0	0	182,400
Current Expense	0	0	182,386	157,821	0
DP Current Expense	0	0	7,117	7,348	7,400
Other Charges/Pass Thru	714,290,223	823,832,003	923,028,297	1,094,611,621	1,249,618,100
<b>Total</b>	<b>\$714,290,223</b>	<b>\$823,832,003</b>	<b>\$923,387,419</b>	<b>\$1,095,156,768</b>	<b>\$1,250,056,000</b>
<b>Other Data</b>					
Total FTE	0.0	0.0	4.0	0.0	4.5

Table 8-6

**TITLE XIX FUNDING FOR HUMAN SERVICES**

**Function**

It has been the historical policy of the Legislature for the Department of Human Services to maximize federal funds. One of the ways this has been done is through accessing Medicaid for Human Services programs when possible.

Certain services and clients of the Department of Human Services qualify for funding under the Medicaid Program. Some of the programs that receive Medicaid funding are: the Utah State Hospital, the Utah State Developmental Center, Home and Community based waivers in the Divisions of Aging, Services for People with Disabilities, Youth Corrections, and Family Services.

The General Fund for these services is appropriated to the various divisions of the Department of Human Services who then "seed" or purchase federal funds through the Division of Health Care Financing. The agencies seeding Medicaid are able to purchase more or less than the amounts appropriated depending on available General Fund, qualifying programs and clients, and the priorities of the program.

**Funding Detail**

<b>Title XIX for Human Services</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
Federal Funds	104,788,686	113,877,157	122,513,951	125,502,732	136,050,100
Transfers	45,937,897	48,249,971	49,834,388	49,636,433	53,964,000
<b>Total</b>	<b>\$150,726,583</b>	<b>\$162,127,128</b>	<b>\$172,348,339</b>	<b>\$175,139,165</b>	<b>\$190,014,100</b>
<b>Categories of Expenditure</b>					
Other Charges/Pass Thru	150,726,583	162,127,128	172,348,339	175,139,165	190,014,100
<b>Total</b>	<b>\$150,726,583</b>	<b>\$162,127,128</b>	<b>\$172,348,339</b>	<b>\$175,139,165</b>	<b>\$190,014,100</b>

**Table 8-7**

**MEDICAL/DENTAL CLINICS**

**Function**                      The Clinics are designed to provide access to medical and dental services to Medicaid, PCN, and CHIP clients.

**Funding Detail**

<b>DOH Medical/Dental Clinics</b>					
<b>Sources of Finance</b>	<b>2001 Actual</b>	<b>2002 Actual</b>	<b>2003 Actual</b>	<b>2004 Actual</b>	<b>2005 Appropriated</b>
General Fund	0	0	629,375	0	1,012,000
General Fund, One-time	0	0	0	0	7,200
Federal Funds	0	0	747,674	0	0
Dedicated Credits Revenue	0	0	3,031,007	1,179,166	3,130,100
Transfers	0	0	18,850	2,711,913	18,800
Lapsing Balance	0	0	0	241,482	0
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$4,426,906</b>	<b>\$4,132,561</b>	<b>\$4,168,100</b>
<b>Categories of Expenditure</b>					
Personal Services	0	0	2,816,403	3,083,278	3,071,100
In-State Travel	0	0	40,259	32,743	40,300
Out of State Travel	0	0	2,464	1,099	2,600
Current Expense	0	0	534,282	555,627	545,800
DP Current Expense	0	0	8,276	34,632	8,300
DP Capital Outlay	0	0	0	49,050	0
Other Charges/Pass Thru	0	0	1,025,222	376,132	500,000
<b>Total</b>	<b>\$0</b>	<b>\$0</b>	<b>\$4,426,906</b>	<b>\$4,132,561</b>	<b>\$4,168,100</b>
<b>Other Data</b>					
Total FTE	0.0	0.0	56.3	62.0	58.0

**Table 8-8**

**CHAPTER 9 CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)**

**Function** The 1998 Legislature passed House Bill 137, which established the Children's Health Insurance Program (CHIP) for the state. This program provides health insurance coverage to uninsured children up to age 19 living in families whose income is less than 200 percent of the Federal Poverty Levels. The program receives approximately 80 percent of its funding from Federal Funds, but requires a state match, which, beginning in FY 2001, comes from proceeds from the Master Settlement Agreement between the State and tobacco companies. The 2003 Legislature increased the funding from the Tobacco Settlement Account from \$5.5 million to \$7 million to allow for the expansion of the program to cover more children and to restore dental services.

**Statutory Authority** The Children’s Health Insurance Program is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-40 details the eligibility qualifications, minimum program benefits, and the funding mechanism for the program.

**Accountability** The CHIP has outlined the following performance measures:

<b>Performance Data Summary - Children's Health Insurance Program</b>					
<b>Goal</b>	<b>Measure</b>	<b>Measure Type</b>	<b>FY 2004</b>		<b>FY 2005</b>
			<b>Target</b>	<b>Observed</b>	<b>Target</b>
Average enrollment of 28,000	Average Enrollment Count	Input	28,000	28,596	28,000

**Table 9-1**

**Funding Detail** The Department utilizes funding from the Tobacco Settlement account to match with federal funds. In addition, premiums are collected from some recipients, which are listed as dedicated credits.

Children's Health Ins Prog					
	2001	2002	2003	2004	2005
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
Federal Funds	20,159,054	24,026,973	21,936,718	26,044,062	28,917,300
Dedicated Credits Revenue	0	517,046	451,970	629,690	650,000
GFR - Tobacco Settlement	5,500,000	5,495,800	5,496,800	7,003,200	7,006,200
Transfers	(1,416,587)	105,006	1,663,348	575,361	135,400
Lapsing Balance	(615,711)	(39)	0	(578,294)	0
<b>Total</b>	<b>\$23,626,756</b>	<b>\$30,144,786</b>	<b>\$29,548,836</b>	<b>\$33,674,019</b>	<b>\$36,708,900</b>
<b>Programs</b>					
Children's Health Insurance Program	23,626,756	30,144,786	29,548,836	33,674,019	36,708,900
<b>Total</b>	<b>\$23,626,756</b>	<b>\$30,144,786</b>	<b>\$29,548,836</b>	<b>\$33,674,019</b>	<b>\$36,708,900</b>
<b>Categories of Expenditure</b>					
Personal Services	242,836	566,310	538,317	406,658	491,700
In-State Travel	3,000	2,914	5,560	907	1,000
Out of State Travel	3,039	11,034	8,963	179	100
Current Expense	346,593	666,583	750,325	341,692	414,300
DP Current Expense	16,383	19,650	9,875	40,414	4,700
DP Capital Outlay	0	29,700	0	0	0
Other Charges/Pass Thru	23,014,905	28,848,595	28,235,796	32,884,169	35,797,100
<b>Total</b>	<b>\$23,626,756</b>	<b>\$30,144,786</b>	<b>\$29,548,836</b>	<b>\$33,674,019</b>	<b>\$36,708,900</b>
<b>Other Data</b>					
Total FTE	3.5	7.2	12.3	8.8	8.5

Table 9-2

**Special Funding**

As shown in Table 9-2, the state portion the funding for CHIP comes from the Tobacco Settlement Restricted Account, as detailed in the following table.

Restricted Funds Summary - Children's Health Insurance Program				
Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2004 Balance
Tobacco Settlement Restricted Account	63-97-201	70% of all funds received by the state relative to the settlement agreement with the tobacco manufacturers. (The allocation drops to 55% on July 1, 2006 - see UCA 63-97-201(d))	Alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs . . . with a preference in funding given to tobacco-related programs.	\$5,246,730 (balance listed is total amount in account for all designated purposes)

Table 9-3

The Federal government created the State Children's Health Insurance Initiative (Title XXI) as a part of the Balanced Budget Act of 1997. The purpose of this act is to provide health insurance to children who (1) are age 18 or under, (2) live in families with incomes below 200 percent of the Federal Poverty Level, (3) are not eligible for Medicaid, and (4) are uninsured.

During the 1998 Legislative session, the Legislature passed House Bill 137 which established the Children's Health Insurance Program for Utah.

The major portion of the funding for CHIP comes from Federal Funds. The authorized level of Federal Funds is tied to the State's Medicaid rate, but at an enriched level. Because the State of Utah has a relatively high Medicaid rate, the CHIP services match rate is also fairly high (approximately 80 percent), with the State putting up the balance of 20 percent. An assessment levied on hospitals in the State was established during the 1998 Legislature to provide the necessary revenue stream for the State's match requirement. This revenue source helped to fund the CHIP in FY 1999. Beginning in FY 2000, the revenue source was switched to the Tobacco Settlement Restricted Account and capped at \$5.5 million. Last year, the Legislature authorized the State funding level to be increased by \$1.5 million to \$7 million, increasing the federal funds by \$6 million.

Enrollment in CHIP began the first part of August 1998. Through October 2004, there were 27,395 children enrolled - about 67 percent of whom are in families with incomes below 150 percent of poverty (Plan A), with the other 33 percent from families with incomes between 150 and 200 percent (Plan B). Approximately 38 percent of the enrolled children come from rural areas and 62 percent from urban areas.

Since the inception of CHIP, 78,691 children have been enrolled. The difference between this figure and the current enrollment of 27,395 indicates that a significant number are enrolled only temporarily – until other medical insurance coverage is obtained for the family. Approximately 1/2 of the children leaving CHIP do so after enrolling in an employer-sponsored insurance plan, 18 percent were enrolled in Medicaid, 3 percent moved or could not be located, 16 percent later exceeded income limitations, with the balance leaving for other reasons.

Over the past few years, CHIP has had a few open enrollment periods, where funded slots were vacant through attrition. These open enrollments have allowed new children to become enrolled in the program.

The FY 2004 cost for the program is approximately \$102 per member per month for both health and dental coverage. The FY 2005 cost is expected to be \$105 per member per month.

#### *CHIP Benefit Package*

The benefit package for the CHIP is based on the benefit package for public employees, but emphasizes prevention. Well-child exams and immunizations are covered at 100 percent. In FY 2002, dental services were eliminated, except for preventative dental procedures, due to an increase in enrollment. With the increased funding from the 2003 Legislature, dental services were restored.

Some services require co-payments, which vary, depending on the family's income level.



**CHAPTER 10 LOCAL HEALTH DEPARTMENTS**

**Function** Local Health Departments (LHDs) cover all areas of the state and provide local public health services. The State utilizes the local health departments to administer many of the services required by state law. A significant portion of the funding for the local health departments comes from a General Fund block grant in the amount of \$2 million. While this line item is for the General Fund block grant funding only, the Utah Department of Health contracts with the LHDs for other services, totaling another \$2 million. The funding for these contracts is appropriated to and included in the various line items of the Department.

**Statutory Authority** The Local Health Departments are governed by Title 26a, Local Health Authorities, of the Utah Code. In addition, several statutes in the Utah Health Code detail responsibilities and enforcement by local health departments.

- UCA 26a establishes local health departments, local boards of health, powers and duties of the departments, and various authorized funding mechanisms.
- UCA 26-15 outlines the Department’s efforts, in conjunction with those of local health departments, in relation to general sanitation, including those dealing with the Indoor Clean Air Act.
- UCA 26-15a outlines the Department’s efforts, in conjunction with those of local health departments, in relation to food safety.
- UCA 26-38 is the Utah Indoor Clean Air Act, which restricts smoking in indoor public places, and establishes enforcement authority and penalties for noncompliance.
- UCA 26-42 establishes civil penalties for individuals and/or licensees that sell tobacco products to underage minors.

**Funding Detail** The funding associated with this line item is a General Fund block grant.

<b>Local Health Department Funding</b>					
	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
<b>Sources of Finance</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Actual</b>	<b>Appropriated</b>
General Fund	0	2,132,700	2,085,700	2,012,600	2,026,900
General Fund, One-time	0	(47,000)	0	0	14,300
<b>Total</b>	<b>\$0</b>	<b>\$2,085,700</b>	<b>\$2,085,700</b>	<b>\$2,012,600</b>	<b>\$2,041,200</b>
<b>Categories of Expenditure</b>					
Other Charges/Pass Thru	0	2,085,700	2,085,700	2,012,600	2,041,200
<b>Total</b>	<b>\$0</b>	<b>\$2,085,700</b>	<b>\$2,085,700</b>	<b>\$2,012,600</b>	<b>\$2,041,200</b>

**Table 10-1**

A major item of funding is the General Fund block grant for the 12 LHDs. The block grant is distributed to the LHDs according to a formula. The pass-through funding is appropriated to the Department as a separate line item, in order to maintain a clean record of the funding and to distinguish between the Department’s administrative budget and the local health departments’ state-funded services.

The following table illustrates the history of the block grant since FY 1997.

<b>Local Health Departments General Fund Block Grant History</b>								
	<u>FY 1997</u>	<u>FY 1998</u>	<u>FY 1999</u>	<u>FY 2000</u>	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>
Base Appropriation	1,944,956	2,013,800	1,937,000	1,983,500	2,027,300	1,984,600	2,085,700	2,012,600
COLA	68,844	48,200	46,500	43,800		48,100		
Budget Reduction		(125,000)			(101,365)	(47,000)	(73,100)	
Budget Restoration						100,000		
Grant Redistribution					58,665			
<b>Total</b>	<u>\$2,013,800</u>	<u>\$1,937,000</u>	<u>\$1,983,500</u>	<u>\$2,027,300</u>	<u>\$1,984,600</u>	<u>\$2,085,700</u>	<u>\$2,012,600</u>	<u>\$2,012,600</u>

**Table 10-2**

In addition to the General Fund block grant, the Department provides state and federal funds to local health departments for several different categorical programs.

## GLOSSARY

## APPENDIX 1: BUDGETING TERMS

Finance categories used by the state

<i>General Fund</i>	This is one of the state's most important sources of income. The primary revenue source is the sales tax, although there are other taxes and fees which are deposited into this fund. General Funds may be spent at the discretion of the Legislature, as the Constitution allows. Personal income taxes and corporate franchise taxes are not deposited into the General Fund, but into the Uniform School Fund.
<i>School Funds</i>	This is another of the state's most important sources of income. Revenues come primarily from personal income taxes and corporate franchise taxes. Funds are constitutionally restricted to public and higher education. In the Capital Facilities subcommittee, these funds are used for debt service and capital improvements (alteration, repair and improvements).
<i>Transportation Funds</i>	Transportation funds are derived primarily from the gas tax and are constitutionally restricted to road and highway related issues. In the Capital Facilities subcommittee, these funds are used for debt service on highway bonds, especially for Centennial Highway Fund projects.
<i>Federal Funds</i>	Federal agencies often make funds available to the state for programs that are consistent with the needs and goals of the state and its citizens and are not prohibited by law. Generally, federal funds are accompanied by certain requirements. A common requirement is some form of state match in order to receive the federal dollars. The Legislature must review and approve most large federal grants before state agencies may receive and expend them.
<i>Dedicated Credits</i>	Dedicated Credits are funds that are paid to an agency for specific services and are dedicated to financing that service. For example, fees collected by an internal service fund agency from another state agency are dedicated credits. By law, these funds must be spent before other appropriated state funds are spent. An agency must estimate the level of its service for the following fiscal year, and thus its level of dedicated credits.
<i>Restricted Funds</i>	Restricted funds are statutorily restricted to designated purposes. The restricted funds usually receive money from specific sources, with the understanding that those funds will then be used for related purposes.
<i>Lapsing/Nonlapsing</i>	Several other small funds are used by certain agencies. These will be discussed in further detail as the budgets are presented. Lapsing funds, however, should be addressed. Funds lapse, or revert back to the state, if the full appropriation is not spent by the end of the fiscal year. Since it is against the law to spend more than the Legislature has appropriated, all programs will either spend all the money or have some left over. The funds left over lapse to the state, unless specifically exempted. Those exceptions include funds that are setup as nonlapsing in their enabling legislation, or appropriations designated nonlapsing by annual intent language per UCA 63-38-8.1. In these

cases, left over funds do not lapse back to the state, but remain with the agency in a special nonlapsing balance, for use in the next fiscal year. In the budgets, the Beginning Nonlapsing balance is the balance on July 1, while the balance on the next June 30 is termed the Closing Nonlapsing balance. The Closing Nonlapsing balance from one fiscal year becomes the Beginning Nonlapsing balance of the following fiscal year. The reasoning behind nonlapsing funds is that a specific task may take an indeterminate amount of time, or span more than one fiscal year. By allowing departments to keep their unexpended funds, the state not only eliminates the rush to spend money at the end of a fiscal year, but also encourages managers to save money.

Expenditure categories used by the state

<i>Personal Services</i>	Includes employee compensation and benefits such as health insurance, retirement, and employer taxes.
<i>Current Expenses</i>	Includes general expenses such as utilities, subscriptions, communications, postage, professional and technical services, maintenance, laundry, office supplies, small tools, etc. that cost less than \$5,000 or are consumed in less than one year.
<i>Data Processing Current Expense</i>	Includes items such as small computer hardware and software, port charges, programming, training, supplies, etc.
<i>Capital Outlays</i>	Includes items that cost over \$5,000 and have a useful life greater than one year.
<i>Pass Through</i>	Includes funds passed on to other non-state entities for use by those entities, such as grants to local governments.

Other budgeting terms and concepts that Legislators may encounter

<i>Performance Measures</i>	<p>In recent years, performance based budgeting has received more attention as citizens and decision-makers demand evidence of improved results from the use of tax dollars.</p> <p>Care must be exercised in crafting performance measures to avoid misdirected results. Moving to performance based budgeting is a long term commitment. The Analyst has drafted some ideas for performance measures in the write-up, however, it is recognized that the measures are a work in progress and that long-term tracking of measures would require a statewide commitment in both the executive and legislative branches.</p>
<i>Intent Language</i>	Intent language may be added to an appropriation bill to explain or put conditions on the use of the funds in the line item. Intent language may restrict usage, require reporting, or impose other conditions within the item of appropriation. However, intent language cannot contradict or change statutory language.
<i>Supplemental Appropriation</i>	The current legislative session is determining appropriations for the following fiscal year. However, it may be determined that unexpected circumstances have arisen which require additional funding for the current year. The

appropriations subcommittee can recommend to the Executive Appropriations Committee that a supplemental appropriation be made for the current fiscal year.

***FTE***

An abbreviation for Full Time Equivalent, this is a method of standardizing personnel counts. A full time equivalent is equal to one employee working 40 hours per week. Four employees each working ten hours per week would also count as 1 FTE.

***Line Item***

This is a term that applies to an appropriation bill. A line number in the appropriations bill identifies each appropriated sum. Generally, each line item may contain several programs. Once the appropriation becomes law, the money may be moved from program to program within the line item, but cannot be moved to another line item of appropriation.

---

**APPENDIX 2: GLOSSARY OF HEALTH TERMS AND ACRONYMS**

<b>Access</b>	Often defined as the potential and actual entry of a population into the healthcare system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.
<b>Actual Charge</b>	One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge.
<b>Acute Care</b>	Medical treatment rendered to individuals whose illnesses or health problems are of short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.
<b>Acute Disease</b>	A disease which is characterized by a single episode of a relatively short duration from which the patient returns to his normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.
<b>AFDC</b>	Aid To Families with Dependent Children. Replaced by federal welfare reform with Temporary Assistance to Needy Families (TANF).
<b>Allowable Costs</b>	Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs which are not reasonable expenditures, which are unnecessary, for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure which was disapproved by a health planning agency.
<b>Alternatives to Long-Term Institutional Care</b>	The whole range of health, nutritional, housing, and social services designed to keep persons out of institutions, such as skilled nursing facilities, which Institutional Care provide care on a long-term basis. The goal is to provide the range of services necessary to all to allow the person to continue to function in the home and community environment. Alternatives to long-term care usually focus on the aged, disabled, and retarded, and include: day care centers, foster homes, or homemaker services.
<b>Ambulatory Care</b>	All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory setting and outpatient.

---

---

<b>Ambulatory Setting</b>	A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).
<b>Aucillary Services</b>	Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.
<b>Appropriate Health Care</b>	Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.
<b>Area Health Education Center (AHEC)</b>	An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use, and efficiency of health care personnel in specific medically underserved areas. The objectives of an AHEC are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions in scarcity areas.
<b>Capitation</b>	A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the Federal Government for each student enrolled.
<b>Carve Out</b>	Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.
<b>Case Management</b>	The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.
<b>Case-Mix</b>	A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' difference needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

---

<b>Catastrophic Health Insurance</b>	Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.
<b>Catchment Area</b>	A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.
<b>Centers for Disease Control and Prevention (CDC)</b>	The Centers for Disease Control and Prevention, based in Atlanta, Georgia, is the Federal agency charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. CDC is the U.S. Public Health Service agency that led efforts to prevent such diseases as malaria, polio, smallpox, toxic shock syndrome, Legionnaire's disease and, more recently, acquired immunodeficiency syndrome (AIDS) and tuberculosis. CDC's responsibilities as the nation's prevention agency have expanded over the years and will continue to evolve as the agency addresses contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.
<b>CHEC</b>	Child Health, Evaluation and Care program (see EPSDT)
<b>ChIP</b>	Child Injury Prevention program
<b>CHIP</b>	Children's Health Insurance Program
<b>Chronic Care</b>	Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.
<b>Chronic Disease</b>	A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alternation, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.
<b>Clinic</b>	A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.
<b>COB</b>	Coordination of Benefits

---

<b>Coinsurance</b>	A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.
<b>Community-Based Care</b>	The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.
<b>Community Health Center (CHC)</b>	An ambulatory health care program (defined under section 330 of the Public Health Center Health Service Act) usually serving a catchment area which has scarce or (CHC) nonexistent health services or a population with special health needs; sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.
<b>Community Mental Health Center (CMHC)</b>	An entity which provides comprehensive mental health services (principally Mental Health ambulatory), primarily to individuals residing or employed in a defined Center (CMHC) catchment area.
<b>Community Rating</b>	A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for difference groups or subgroups of subscribers on the basis of their specific claims experience.
<b>Continuing Medical Education (CME)</b>	Formal education obtained by a health professional after completing his or her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.
<b>Cost Containment</b>	A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of health services could be reduced by using a different combination of resources.
<b>Cost-Shifting</b>	The situation that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.

---

---

---

<b>Covered Services</b>	Health care services covered by an insurance plan.
<b>CTRPN</b>	Counseling, Testing, Referral and Partner Notification (HIV/AIDS)
<b>Customary Charge</b>	One of the factors that determines a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.
<b>DCP</b>	Diabetes Control Program
<b>Developmental Disability (DD)</b>	A severe, chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care treatments of services which are of lifelong or extended duration and are individually planned and coordinated.
<b>Diagnosis Related Groups (DRGs)</b>	Group of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.
<b>Disability</b>	Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.
<b>Disease</b>	May be defined as failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.
<b>DHCF</b>	Division of Health Care Financing (Medical Assistance Administration)

---

---

<b>Drug Abuse</b>	Persistent or sporadic drug use inconsistent with or unrelated to acceptable medical or cultural practice. the definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), dependence, or illegal use.
<b>Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)</b>	A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.
<b>ECF</b>	Extended Care Facility
<b>Emergency Medical Services (EMS)</b>	Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.
<b>Employee Retirement Income Security Act (ERISA)</b>	A Federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.
<b>Epidemic</b>	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.
<b>Epidemiology</b>	The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.
<b>ER</b>	Emergency Room
<b>Exclusive Provider Arrangement (EPA)</b>	An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).
<b>Experience Rating</b>	A method of adjusting health plan premiums based on the historical Rating utilization data and distinguishing characteristics of a specific subscriber group.
<b>Favorable Selection</b>	A tendency for utilization of health services in a population group to be lower than expected or estimated.

---

---

<b>FDA</b>	Food and Drug Administration
<b>Fee for Service</b>	Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. country's physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.
<b>Fee Schedule</b>	An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.
<b>Handicapped</b>	As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.
<b>Health</b>	The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.
<b>Health Care Financing Administration (HCFA)</b>	The Government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.
<b>Health Education</b>	Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.
<b>Health Facilities</b>	Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building which includes a physician's office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.

---

---

<b>Health Insurance</b>	Financial protection against the medical care costs arising from disease or Insurance accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.
<b>Health Maintenance Organization (HMO)</b>	An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.
<b>Health Manpower Shortage Area (HMSA)</b>	An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.
<b>Health Personnel</b>	Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.
<b>Health Promotion</b>	Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.
<b>Health Service Area</b>	Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.
<b>Health Status</b>	The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

<b>Home Health Care</b>	Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care are the following: nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.
<b>Hospice</b>	A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.
<b>Hospital</b>	An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or nonteaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat,), and by type of ownership or control (Federal, State, or local government; for profit and nonprofit). The hospital system is dominated by the short-term, general, and nonprofit community hospital, often called a voluntary hospital.
<b>ICU</b>	Intensive Care Unit
<b>ICF/MR</b>	Intermediate Care Facility for the Mentally Retarded
<b>Indemnity</b>	Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services.
<b>Indigent Care</b>	Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.
<b>Inpatient</b>	A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his or her room and board) for the purpose of receiving diagnostic treatment or other health services.
<b>Institutional Health Services</b>	Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

---

<b>Intermediate Care Facility (ICF)</b>	An institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded or people with related conditions are also included in the definition. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.
<b>Intervention or Intervention Strategy</b>	A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.
<b>License/Licensure</b>	A permission granted to an individual or organization by a competent authority, usually public, to engage lawfully in practice, occupation, or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education, or proof of competence.
<b>Long-Term Care</b>	A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g. the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.
<b>LPN</b>	License Practical Nurse
<b>Managed Care</b>	Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.
<b>MCAC</b>	Medical Care Advisory Committee
<b>MCH</b>	Maternal and Child Health
<b>Medical Assistance/Medicaid (Title XIX)</b>	A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, State determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

---

<b>Medicaid Notch</b>	The reduction in real income that occurs which increased earnings removes a person from not only public cash-assistance programs, and from Medicaid.
<b>Medically Indigent</b>	People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.
<b>Medically Underserved Population</b>	A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).
<b>Medicare (Title XVIII)</b>	A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums for beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).
<b>Mental Health</b>	The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and sometimes improperly used as a synonym for mental illness.
<b>Mental Health Services</b>	Comprehensive mental health services, as defined under some State laws and Federal statutes, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.
<b>Mental Illness</b>	All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types and severities.
<b>MMIS</b>	Medicaid Management Information System
<b>Morbidity</b>	The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

---

---

---

<b>Mortality</b>	Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).
<b>Need</b>	In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.
<b>Neighborhood Health Center</b>	An ambulatory health care program usually serving a catchment area which has scarce or nonexistence health services or population with special health needs and is often known as a community health center. Neighborhood health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health care and related social services to a defined population.
<b>Nurse</b>	An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses.
<b>Nurse Practitioner</b>	A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.
<b>Nursing Facility</b>	Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.
<b>OBRA</b>	Omnibus Budget Reconciliation Act
<b>Occupancy Rate</b>	A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

---

<b>Occupational Health Services</b>	Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S., the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).
<b>Open Enrollment</b>	A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during specific period each year.
<b>Outpatient</b>	A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.
<b>Passive Intervention</b>	Health promotion and disease prevention initiatives which do not require the direct involvement of the individual (e.g., fluoridation programs) are termed "passive". Most often these types of initiatives are Government sponsored.
<b>Peer Review</b>	Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.
<b>Personal Responsibility and Work Opportunity Reconciliation Act of 1996</b>	Conference Agreement for HR 3734: Public Law 104-193. Federal and welfare reform passed by the United State Congress on July 31, 1996 (U.S. House) and August 1, 1996 (U.S. Senate) and signed into law by Pres. Clinton on August 22, 1996. "Ends welfare as we know it."
<b>Physician Assistant (PA)</b>	Also known as a physician extender, a PA is a specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.
<b>Point of Service</b>	A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of medical services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or noncontracting providers.
<b>Poverty Area</b>	An urban or rural geographic area with a high proportion of low income families. Normally, average income is used to define a poverty area, but other indicators, such as housing conditions, illegitimate birth rates, and incidence of juvenile delinquency, are sometimes added to define geographic areas with poverty conditions.

---

---

<b>Preferred Provider Arrangement (PPA)</b>	Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.
<b>Preferred Provider Organization (PPO)</b>	Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at (discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.
<b>Prevailing Charge</b>	One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.
<b>Prevalence</b>	The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year.
<b>Preventive Medicine</b>	Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.
<b>Primary Care</b>	Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.
<b>Primary Prevention</b>	The prevention of an illness or disease before any symptoms manifest themselves.
<b>Provider</b>	Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

---

---

---

<b>Public Good</b>	A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.
<b>Public Health</b>	The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.
<b>QMB</b>	Qualified Medicare Beneficiary
<b>Quality of Care</b>	Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).
<b>Rate</b>	A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons.
<b>Rehabilitation</b>	The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.
<b>Reimbursement</b>	The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.
<b>Reinsurance</b>	The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

---

---

<b>Screening</b>	The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.
<b>Secondary Care</b>	Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.
<b>Secondary Prevention</b>	Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful and the goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment, and follow up programs.
<b>Service Period</b>	Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.
<b>Severity of Illness</b>	A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pretreatment risk.
<b>Skilled Nursing Facility (SNF)</b>	A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.
<b>SLAG</b>	State Legalization Impact Assistance Grant
<b>SLIMB</b>	Special Low-Income Medicare Beneficiary
<b>Sole Community Hospital (SCH)</b>	A hospital which (1) is more than 50 miles from any similar hospital, (2) is Hospital (SCH) 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.

---

<b>Spend Down</b>	The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.
<b>STD</b>	Sexually transmitted diseases
<b>Survey</b>	An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population.
<b>Symptomatic</b>	Someone who has symptoms of a disease or illness is symptomatic. Someone who has smoked all his/her life and has a heavy cough is said to be symptomatic. A heavy lifelong smoker who has not yet developed symptoms is said to be pre-symptomatic.
<b>Technology Assessment</b>	A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.
<b>Temporary Assistance for Needy Families (TANF)</b>	The federal block grants to states for assistance payments. Replaces the entitlement program known as Aid to Families with Dependent Children (AFDC).
<b>Tertiary Care</b>	Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.
<b>Tertiary Prevention</b>	Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.
<b>Third-Party Payer</b>	Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).
<b>Title XVIII (Medicare)</b>	The title of the Social Security Act which contains the principal legislative authority for the Medicare program and therefore a common name for the program.

---

---

<b>Title XIX (Medicaid)</b>	The title of the Social Security Act which contains the principal legislative authority for the Medicaid program and therefore a common name for the program.
<b>UMAP</b>	Utah Medical Assistance Program (discontinued)
<b>Uncompensated Care</b>	Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.
<b>Underinsured</b>	People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.
<b>Uninsured</b>	People who lack public or private health insurance.
<b>Usual, Customary and Reasonable (UCR) Fees</b>	The use of fee screens to determine the lowest value of physician and Reasonable reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.
<b>Utilization</b>	Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.
<b>Vital Statistics</b>	Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.
<b>WIC</b>	Women, Infant, and Children supplemental food program
<b>Wellness</b>	A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

**APPENDIX 3: DEFINITIONS OF MEDICAID CATEGORIES OF SERVICE**

<b>Aging Waiver</b>	The aging waiver allows state Medicaid agencies to cover services not otherwise available under Medicaid to individuals 65 and over, who would be in an institution without these services. This allows these older adults to retain some level of independence and a greater quality of life by enabling them to remain in their own homes.
<b>Ambulatory Surgical</b>	Surgery on an ambulatory basis is provided.
<b>Case Management Fees</b>	Payments made to local health departments for case management services.
<b>Child Health Evaluation and Care (CHEC/EPSDT)</b>	Screening, diagnostic, health care, treatment, and other measures to correct and/or ameliorate any defects and chronic conditions discovered in recipients under age 21. This is Utah's version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program.
<b>Chiropractic Services</b>	Services which involve manipulation of the spine that a chiropractor is legally authorized to perform under state law.
<b>Contracted Mental Health Services</b>	Mental health services provided to children in foster care and under the authority of Division of Family Services/Division of Youth Corrections Services (DFS/DYC) are eligible for reimbursement effective 7/1/93. These services must be provided by a provider under contract with DFS/DYC. DFS and DYC will provide the state match for these services.
<b>Dental Services</b>	Diagnostic, preventative, or corrective procedures provided by a dentist in the practice of his/her profession.
<b>Early Intervention</b>	Diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers (up to age four) with disabilities. The program is administered by Family Health Services which contracts with providers consisting of multi-disciplinary teams of health care professionals who work with the family to evaluate and coordinate services to ensure that the needs of the child are met.
<b>Group Pre/Postnatal Education</b>	Classroom learning experience for the pregnant woman with the objective of improving knowledge of pregnancy, labor and childbirth, informed self care, and preventing development of conditions which might complicate pregnancy. Infant, feeding, or parenting classes may also be included.
<b>Health Maintenance Organizations (HMOs)</b>	Basic medical and dental covered services provided by health maintenance organizations.

---

<b>Home and Community-Base Waiver for Developmentally Delayed/Mentally Retarded (DD/MR)</b>	Services provided within the community to a limited number of individuals who meet criteria established for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services. The State may provide waived services, including residential treatment, day training, respite care, family support, and case management.
<b>Home Health Services/Hospice</b>	A program of intermittent and part-time nursing care provided in the patient's place of residence as an alternative to premature or inappropriate institutionalization.
<b>Inpatient Hospital</b>	A required service that provides medically necessary and appropriate diagnostic and therapeutic services for the care and treatment of injured, disabled, or sick people who must remain in the hospital for more than 24 hours.
<b>Inpatient Hospital Mental-Mental Youth and Aged</b>	Mentally ill, youth and aged clients in an inpatient hospital setting, requiring constant care.
<b>Intermediate Care Facilities</b>	Intermediate care facilities offer care to chronically ill patients.
<b>Intermediate Care Facilities for the Mentally Retarded (ICF/MR)</b>	Intermediate care facilities cater to clients with mental retardation who require less care than an inpatient hospital patient.
<b>ICF/MR Day Treatment</b>	Day treatment is provided to intermediate care and mentally retarded individuals.
<b>Kidney Dialysis</b>	Kidney Dialysis is a program for people who have irreversible and permanent end-stage renal disease and require a regular course of dialysis.
<b>Lab and Radiology</b>	Laboratory and radiological services are provided for the client.
<b>Medical Supplies</b>	Medical supplies necessary for treatment are provided to individuals who require them.
<b>Medical Transportation</b>	Transportation is provided to and from medical appointments and treatment when needed.
<b>Mental Health Services</b>	These include the continuum of mental health services provided by the 11 community mental health centers, including the three prepaid mental health clinics. The county mental health authorities provide the state match for these services.

---

<b>Nutritional Assessment/Counseling</b>	Service provided by a dietician for pregnant women with complex nutritional, medical, or social risk factors identified in early prenatal visits and referred for intensive nutritional education, counseling, and monitoring for compliance and improvement.
<b>Occupational Therapy</b>	Occupational therapy is provided to needy individuals to assist them in returning to the work force.
<b>Optical Supplies</b>	Services which include lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist to the extent permitted under state law.
<b>Outpatient Hospital</b>	A required service that provides medically necessary diagnostic and therapeutic services ordered by a physician or other practitioner of the healing arts. These services must be appropriate for the adequate diagnosis and treatment of the patient's illness.
<b>Pediatric/Family Nurse Practitioner</b>	Registered nurses with specialty training and certification, licensed within the State to provide general and preventive services within a specific specialty as authorized by licensure within the State. See specialized nursing above. (Coverage of these practitioners is mandated.)
<b>PERINATAL CARE COORDINATION</b>	Targeted case management for pregnant women. Services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services. The purpose is to coordinate care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational, and other services for the pregnant woman throughout pregnancy and up to the end on the month in which the 60 days following pregnancy ends.
<b>Personal Care Services</b>	The personal care services program enables recipients to maintain a maximal functional level in their place of residence through providing minimal assistance with the activities of daily living.
<b>Pharmacy</b>	Drugs prescribed by their respective physicians are provided to individuals which are required for treatment.
<b>Physical Therapy</b>	Services prescribed by a physician and provided by a physical therapist.
<b>Physical Services</b>	"Physician services", whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician, (1) within the scope of practice of medicine or osteopathy as defined by state law and (2) by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
<b>Podiatry Services</b>	Services provided by a podiatrist who is licensed under state law to render medical or remedial care for the foot and associated structures.

---

<b>Pre/Postnatal Home Visits</b>	Home visits are part of the management plan for a pregnant woman. The visits are for the purpose of assessing the home environment and implications for management of care, to provide emotional support, determine educational needs, provide direct care and encourage regular visits for prenatal care.
<b>Pre/Postnatal Psychosocial Counseling</b>	Evaluation to identify families with high psychological and social risks and follow up to develop a plan of care to provide or coordinate appropriate intervention, counseling, or referral necessary to meet the identified needs of families.
<b>Private Duty Nursing</b>	Nursing service provided in a client's home for up to 24 hours per day as an alternative to prolonged hospitalization or institutionalization of technology dependent individuals. This option, when compared to other alternatives, must provide quality and cost effectiveness over the long term, and requires participation of family members in the care during hours when nurses are not present.
<b>Psychologist Services</b>	Licensed psychologists may provide evaluation and testing to individuals with a diagnosis of delayed development (DD) or mental retardation (MR), early periodic screening diagnosis and treatment (EPSDT)-eligible Medicaid recipients and to victims of sexual abuse. They may provide individual, group, and family therapy to those eligibles. The Department of Human Services provides the state match for services provided to the Division of Family Services (DFS) and the Division of Services to People with Disabilities (DSPD) clientele. Psychological evaluation and testing for Medicaid clients who exhibit mental retardation, developmental disabilities or are victims of sexual abuse and are eligible for EPSDT.
<b>Rural Health Services</b>	Health services are provided to individuals who live in rural areas.
<b>Skilled Nursing Facilities</b>	Skilled Nursing Facilities offer skilled nursing care to chronically ill patients.
<b>Skills Development</b>	Medically necessary services to improve and enhance the health and functional abilities of the children ages 2 to 22 and prevent further deterioration. Services include individual or group therapeutic intervention to ameliorate motor impairment, sensory loss, communication deficits, or psycho-social impairments and skills training to the family to enable them to enhance the health and development of the child. Services are identified in the child's I.E.P. and provided by or under the supervision of specified licensed practitioners.
<b>Specialized Nursing Service</b>	The following specific practitioners are covered as Medicaid providers. Services of nurses practicing within a specialty area to the extent of licensure within the state. Four groups currently have provider status: <ol style="list-style-type: none"><li>1.Certified Registered Nurse Anesthetists (CRNA)</li><li>2.Certified Registered Nurse Midwives (CNM)</li></ol>

---

3.Certified Family Nurse Practitioners (CFNP)

4.Certified Pediatric Nurse Practitioners (CPNP)

**Specialized Wheel  
Chairs**

Special wheel chairs are provided to needy individuals.

**Speech and Hearing**

Diagnostic, screening, preventive, or corrective services provided by a speech pathologist or audiologist for which a patient has been referred by a physician.

**Substance Abuse**

Treatment is given to clients for alcohol and drug abuse and misuse.

**Targeted Case  
Management**

Targeted case management services designed to assist an individual in a targeted group to gain access to needed medical, social, educational, and other services. In Utah, there are several targeted groups which assist individuals in the groups in planning, coordinating, and accessing needed services.

**Targeted Case  
Management for  
AIDS**

A set of planning, coordination, and monitoring activities that assist recipients in their target group to access services.

**Vision Care Services**

Diagnostic, screening, preventive, or corrective services provided by a physician skilled in disease of the eye or an optometrist to the extent permitted under state law.

## INDEX

- Bioterrorism Grants, 2-1, 2-8  
Center for Health Data, 2-1, 2-10  
Chemical and Environmental Services, 5-5  
Child Care Licensing, 3-1, 3-11  
Children with Special Health Care Needs, 6-4, 6-24  
Children's Health Insurance Program, 6-13, 6-16, 9-1  
Communicable Disease Control, 5-10  
Community and Family Health Services, 5-8, 6-1, 6-2, 6-4, 7-9  
Contracts, 6-18, 7-13  
Coverage and Reimbursement, 7-12  
Director's Office, 3-6, 5-4, 6-4, 7-6  
Eligibility Services, 7-10  
Emergency Medical Services, 3-1, 3-7, 3-8  
Epidemiology, 2-9, 5-1, 5-2, 5-4, 5-5, 5-15, 5-17, 5-18, 6-21, i  
Epidemiology and Laboratory Services, 5-1, 5-2, 5-4, 6-21  
Executive Director's Office, 2-1, 2-2, 2-4  
Financial Services, 7-6  
Forensic Toxicology, 5-5, 5-6  
Health Care Financing, 7-1, 7-3, 7-6, 7-9, 7-13, 8-1, 8-6, 8-15, h  
Health Facility Licensure, Certification, and Resident Assessment, 3-13  
Health Promotion, 5-17, 6-1, 6-4, 6-5, 6-11  
Health Systems Improvement, 3-1, 3-3, 3-6, 3-13, 3-14  
Health, Utah Department of, 1-1, 1-2, 2-1, 2-4, 2-8, 6-6, 6-11, 6-27, 7-1, 7-9, 7-13, 8-2, 8-8, 10-1, j, k  
Laboratory Improvement, 5-7  
Local Health Departments, 1-1, 10-1  
Managed Health Care, 7-8  
Maternal and Child Health, 6-4, 6-17, m  
Medicaid Base Program, 8-1, 8-5  
Medical Assistance, 1-1, 7-1, 8-1, 8-2, 8-3, 8-5, 8-8, h, u  
Medical Claims, 7-9  
Medical Examiner, 2-1, 2-7, 2-8, 5-6, 5-9  
Medical/Dental Clinics, 8-1, 8-16  
Microbiology, 5-8  
Primary Care Grants, 3-2, 3-14, 3-15  
Program Operations, 2-6  
Title XIX Funding for Human Services, 8-15  
Workforce Financial Assistance Program, 3-1, 4-1