MEDICAID MANDATORY SERVICES

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANDSEN

BUDGET BRIEF

SUMMARY

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 services, 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 special reimbursement to community and rural health centers. For more detailed information please visit the online Compendium of Budget Information for the 2011 General Session at http://le.utah.gov/lfa/reports/cobi2011/LI_LHB.htm.

ISSUES AND RECOMMENDATIONS

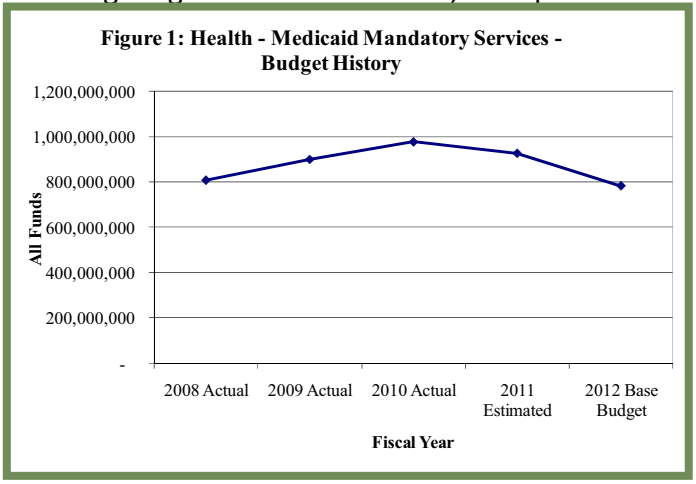
This budget funds nine programs within the line item, including:

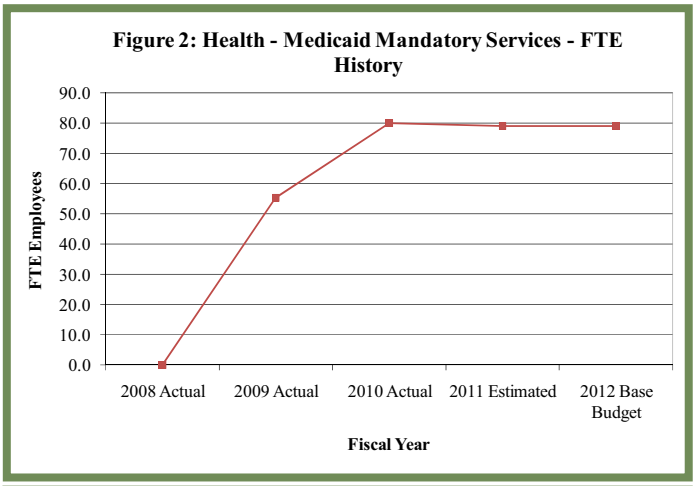
Crossover Services	$ 12,285,300
Inpatient Hospital	$206,943,600
Managed Health Care	$190,037,600
Medical Supplies	$ 10,791,400
Nursing Home	$143,547,900
Other Mandatory Services	$ 45,884,000
Outpatient Hospital	$ 88,523,300
Physician Services	$ 83,292,300
State-run Primary Care Case Management	$ 460,100

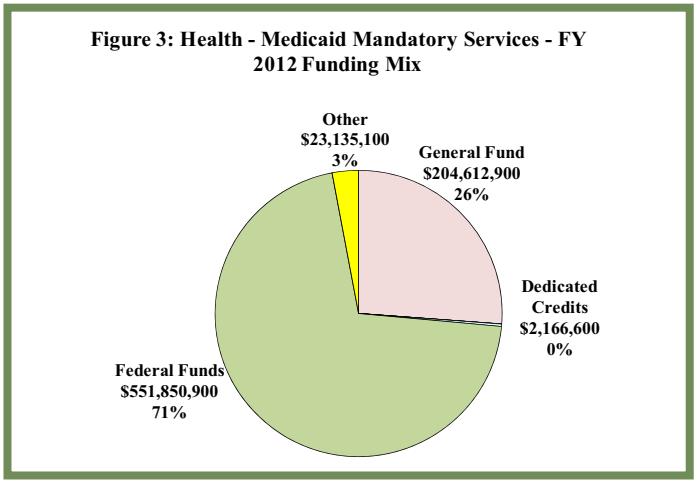
The Analyst recommends a base budget for the Medicaid Mandatory Services line item for FY 2012 in the amount of $762,824,100. The recommendation reflects adjustments to the General Fund, Federal Funds, Restricted Funds, Transfers, Dedicated Credits and Other Revenue for FY 2012. The funding level supports 79 FTE and 1 vehicle.

Restricted Funds Summary

- The Medicaid Restricted Account, established in UCA 26-18-402, as of July 1, 2010 has an unencumbered balance of $44,600. Revenues for this fund come from monies unexpended in the Medicaid program at the close of each fiscal year. Monies remain in the fund until appropriated by the legislature. Statute indicates that the monies may be used for expanding for medical insurance







coverage. For additional information please see the Issue Brief entitled "*Social Services Related Revenue Options.*"

- The Nursing Care Facilities Account, established in UCA 26-35a, ended FY 2010 with a balance of $0. Revenues come from an assessment on nursing homes based on their non-Medicare patient days. Revenues may only be used for increasing the rates paid to nursing care facilities and 3% for administrating the assessment.

Changes to the Healthy U Contract – What Does it Mean for Utah Medicaid?

Healthy U prior to February 2010 paid all services via their contracted providers. Effective February 2010, Healthy U gave about 14% or $13 million of their total reimbursements back to Medicaid to process via the fee-for-service reimbursement system. This change means that Healthy U hospital providers can now participate in the hospital assessment as passed by SB 273 in the 2010 General Session. For additional information, please see the Issue Brief entitled "SB 273 Follow Up."

Where Has the Growth in Medicaid Been from FY 1998 to FY 2010?

Medicaid has grown 164% from FY 1998 to FY 2010. The growth by category of service during this same time frame is shown in the table to the right. The table also indicates if the category listed has grown above or below (more or less than) the rate of the Medicaid program.

Category	Annual Growth	Total Growth	FY 2010 Exp.	Above/Below Average
INPATIENT HOSPITAL CARE	12.4%	348%	$350,796,700	Above
OTHER SEEDING	13.9%	300%	$38,000,100	Above
OTHER CARE	12.7%	299%	$577,904,300	Above
All MEDICAID	8.3%	164%	$1,783,879,200	
CAPITATED MENTAL HEALTH (FY 1999)	6.4%	106%	$23,750,700	Below
DEPARTMENT OF HUMAN SERVICES	6.4%	105%	$211,502,100	Below
MENTAL HEALTH	6.4%	96%	$137,036,500	Below
LONG TERM CARE (Health)	6.1%	91%	$198,713,800	Below
HEALTH MAINTENANCE ORGANIZATIONS	3.9%	56%	$240,115,800	Below
State Health And Dental Clinics (FY 2004)	N\A	N\A	$6,059,200	N\A

Outlier Calculations for Inpatient Hospital Reimbursement

If inpatient hospital bill charges are 300% above Medicaid reimbursement, then the claim may qualify for an additional outlier payment. The additional payment is based on a percentage of the billed charges above the normal reimbursement level. About 25% of claims have an outlier calculation. The amount of inpatient hospital payments for outlier claims has gone from $85 million in FY 2008 to $80 million in FY 2010. This information is shown in the table above. Part of the reason for the decrease is from budget reductions which changed the outlier reimbursement.

	FY 2008	FY 2009	FY 2010
Inpatient Hospital	$224,749,100	$226,598,600	$283,333,400
Total Paid on Outlier Claims	$ 84,730,400	$ 88,826,700	$ 80,466,700

Assignment of clients to HMOs

Medicaid clients, living in Utah, Salt Lake, and Davis Counties, that do not make a plan selection are assigned among the three managed care plans by Medicaid staff. Staff considers the following in making a plan assignment: client history of provider usage and if a client has private insurance that prefers a particular provider network. The Department indicates that there is no option available to assign based on price and quality.

Request to Transfer of Funds Across Line Items

The Department of Health is requesting a transfer of $81,500 General Fund from this line item to the Executive Director's Office because of 2 FTEs who should be part of Program Integrity, but currently are paid out of the Medicaid Mandatory Services line item.

Building Block Requests Included in the Governor's Budget

The three items below affect both of Medicaid's service line items (Medicaid Mandatory Services & Medicaid Optional Services):

1. **Federal match rate -** $3,076,200 General Fund to replace a reduction in federal funds due to a 0.14% unfavorable change in the federal match rate effective October 1, 2011.
2. **Restoration of Ongoing Funding for Elimination of Asset Test for Pregnant Women** - $3,200,000 to restore a reduction in eligibility that is prohibited under the federal Patient Protection and Affordable Care Act of 2010.
3. **Utilization/Caseload Increase -** $28,534,200 one-time General Fund ($99,349,800 total funds) for caseload growth in FY 2011 and $37,874,700 ongoing (131,829,800 total funds) General Fund for FY 2012 caseload growth. The Department is estimating a combined utilization/caseload increase of 9.0% in FY 2011 and 7.4% for FY 2012. Because Medicaid nonlapsed $17,696,900 from FY 2010, which is being used to help cover FY 2011 caseload costs, the $37,874,700 ongoing in FY 2012 does not fund $29 million General Fund in new caseload growth requested by Health.
4. **Forced Provider Inflation** - $5,923,600 General Fund ($15,441,000 total funds) for Medicaid services that the agency indicates the State cannot control the increase in the cost of the service. For more information please the Issue Brief entitled *"Medicaid Force Provider Inflation."*

For information on how the federal stimulus money (ARRA) was used in the Governor's budget, please see the Issue Brief entitled "*ARRA Funds Approval*."

ACCOUNTABILITY DETAIL

Use of Recent Appropriations

- **Medicaid Physician Provider Rate Add-back (FY 2011):** $284,000 General Fund ($1,002,900 total funds) to restore some of the prior reductions in physician provider reimbursement rates. The agency used this money to restore physician rates to FY 2010 levels.
- **Medicaid Cost Containment (FY 2010):** A higher federal match rate provided Federal Funds of $2,400,000, offsetting a $2,400,000 General Fund reduction, obtained through changing to a prospective, capitated payment system for one contracted health plans. The Legislature also approved $7,727,000 (one-time) General Fund for start-up costs. The Department spent $4,900,000 of these start-up funds. The cost was less because of the more favorable federal match rate from ARRA/stimulus money that became available.

Dedicated Credits

Dedicated Credits for the revised FY 2010 increase 145% over the FY 2010 original appropriation. The Department of Health traditionally gets an exemption for exceeding 125% growth in Dedicated Credits, which is normally prohibited as per UCA 63J-2-102. This is because these dedicated credits are from federal revenues.

BUDGET DETAIL

The budget listed in the table below details the budget allocations in the base budget bill.

Health - Medicaid Mandatory Services

Sources of Finance	FY 2010 Actual	FY 2011 Appropriated	Changes	FY 2011 Revised	Changes	FY 2012* Base Budget
General Fund	192,290,400	213,765,500	0	213,765,500	(9,152,600)	204,612,900
General Fund, One-time	(30,190,700)	(36,608,000)	3,923,200	(32,684,800)	32,684,800	0
Federal Funds	694,259,500	659,374,700	23,983,600	683,358,300	(131,507,400)	551,850,900
American Recovery and Reinvestment A	80,123,900	31,585,500	0	31,585,500	(31,585,500)	0
Dedicated Credits Revenue	9,698,100	1,941,700	224,900	2,166,600	0	2,166,600
GFR - Medicaid Restricted	8,320,500	1,847,600	0	1,847,600	(1,847,600)	0
GFR - Nursing Care Facilities Account	16,236,000	17,304,800	0	17,304,800	(38,000)	17,266,800
GFR - Tobacco Settlement	0	3,923,200	(3,923,200)	0	49,300	49,300
Hospital Provider Assessment Special R	0	2,000,000	0	2,000,000	0	2,000,000
Transfers	0	0	683,400	683,400	(124,500)	558,900
Transfers - Human Services	4,000	0	0	0	0	0
Transfers - Intergovernmental	327,400	40,000	(40,000)	0	125,400	125,400
Transfers - Within Agency	2,950,800	3,395,500	(384,700)	3,010,800	116,500	3,127,300
Transfers - Workforce Services	535,500	0	7,400	7,400	0	7,400
Pass-through	204,600	0	0	0	0	0
Beginning Nonlapsing	6,745,600	0	3,126,400	3,126,400	(3,126,400)	0
Closing Nonlapsing	(3,707,600)	(699,500)	699,500	0	0	0
Lapsing Balance	(1,155,600)	0	0	0	0	0
Total	$976,642,400	$897,871,000	$28,300,500	$926,171,500	($144,406,000)	$781,765,500
Programs						
Crossover Services	0	18,950,800	(5,960,200)	12,990,600	(705,300)	12,285,300
Inpatient Hospital	283,333,400	177,046,800	106,870,300	283,917,100	(76,973,500)	206,943,600
Managed Health Care	234,223,400	187,119,900	25,179,000	212,298,900	(22,261,300)	190,037,600
Medical Supplies	0	11,674,800	(263,900)	11,410,900	(619,500)	10,791,400
Nursing Home	157,197,200	155,418,300	(5,944,800)	149,473,500	(5,925,600)	143,547,900
Other Mandatory Services	87,667,400	141,870,500	(85,326,300)	56,544,200	(10,660,200)	45,884,000
Outpatient Hospital	119,497,300	114,341,100	(3,328,100)	111,013,000	(22,489,700)	88,523,300
Physician Services	94,723,700	91,037,800	(3,039,500)	87,998,300	(4,706,000)	83,292,300
State-run Primary Care Case Managemer	0	411,000	114,000	525,000	(64,900)	460,100
Total	$976,642,400	$897,871,000	$28,300,500	$926,171,500	($144,406,000)	$781,765,500
Categories of Expenditure						
Personnel Services	5,068,100	5,071,200	147,200	5,218,400	(449,400)	4,769,000
In-state Travel	28,200	32,700	(4,400)	28,300	0	28,300
Out-of-state Travel	2,300	1,200	1,100	2,300	0	2,300
Current Expense	3,258,000	1,576,500	819,900	2,396,400	(60,300)	2,336,100
DP Current Expense	41,300	43,800	(2,600)	41,200	0	41,200
Other Charges/Pass Thru	968,244,500	891,145,600	27,339,300	918,484,900	(143,896,300)	774,588,600
Total	$976,642,400	$897,871,000	$28,300,500	$926,171,500	($144,406,000)	$781,765,500
Other Data						
Budgeted FTE	80	75	4	79	0	79
Actual FTE	31	0	0	0	0	0
Vehicles	1	1	0	1	0	1

LEGISLATIVE ACTION

- The Analyst recommends that the Health and Human Services Appropriations Subcommittee approve a base budget for FY 2011 for Medicaid Mandatory Services in the amount of $781,765,500 with funding as listed in the Budget Detail Table.