



MEDICAID MANDATORY SERVICES

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE
STAFF: RUSSELL FRANSEN

BUDGET BRIEF

SUMMARY

The Analyst’s base budget recommendation is \$1,051,247,100 for Medicaid Mandatory Services in FY 2014. This recommendation is \$33,401,300 higher than the revised FY 2013 estimated budget. This includes decreases of \$31,678,700 General Fund in FY 2013 and \$14,793,700 ongoing General Fund beginning in FY 2014 as part of the updated consensus caseload cost estimates. This funding level supports 68 FTE and one vehicle. This brief highlights some issues in Medicaid Mandatory Services as well as some uses of the funding provided. The Subcommittee annually reviews each base budget to propose any changes and to vote to approve it. The Analyst recommends that the Subcommittee approve the \$1,051,247,100 base budget.

LEGISLATIVE ACTION

The Analyst recommends that the Social Services Appropriations Subcommittee take the following action:

1. Approve a base budget for FY 2014 for Medicaid Mandatory Services in the amount of \$1,051,247,100 with funding as listed in the Budget Detail Table.
2. For FY 2013 and FY 2014 approve a \$5.5 million increase for the Hospital Provider Assessment to reflect the current projections for revenue collections.

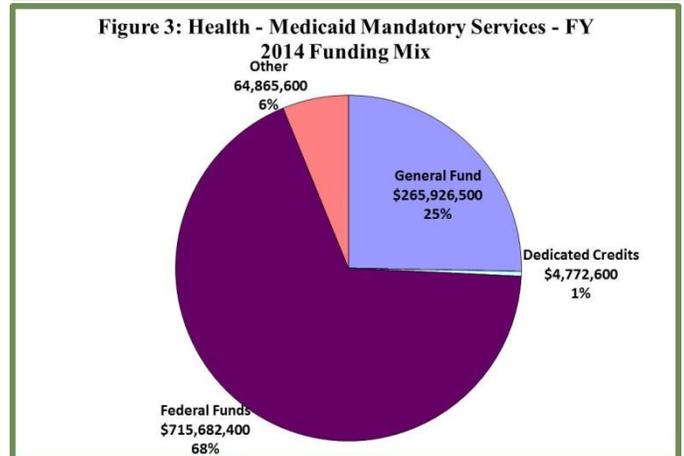
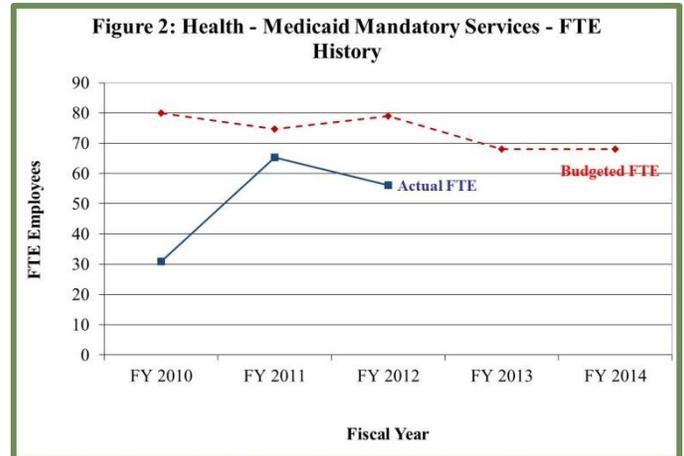
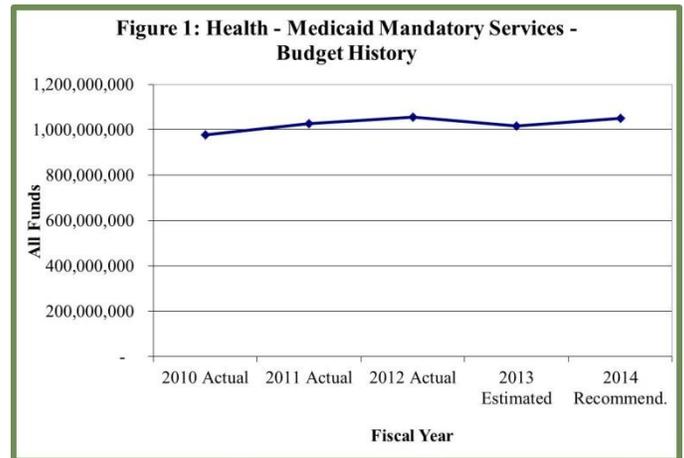
OVERVIEW

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 2013 General Session at http://le.utah.gov/lfa/reports/cobi2013/LI_LHB.htm.

ISSUES AND RECOMMENDATIONS

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

Inpatient Hospital	\$382,142,100
Managed Health Care	\$231,069,100



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Nursing Home	\$170,651,100	Medical Supplies	\$ 15,454,000
Outpatient Hospital	\$ 84,690,800	State-run Primary Care Case Management	\$ 515,000
Physician Services	\$ 95,821,400	Other Mandatory Services	\$ 56,493,000
Crossover Services	\$ 14,410,600		

The Analyst recommends a base budget for the Medicaid Mandatory Services line item for FY 2014 in the amount of \$1,051,247,100. The funding level supports 68 FTE and one vehicle.

Where Has the Growth in Medicaid Been from FY 1998 to FY 2011?

Medicaid has grown 177% from FY 1998 to FY 2011. 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 overall Medicaid program.

Category	Annual Growth	Total Growth	FY 2011 Exp.	Above/Below Average
Inpatient Hospital Care	14%	493%	\$ 464,008,900	Above
Other Seeding	14%	372%	\$ 44,829,300	Above
Other Care	12%	290%	\$ 565,337,000	Above
All Medicaid	8%	177%	\$ 1,868,872,700	
Long Term Care	6%	96%	\$ 204,508,700	Below
Department of Human Services	6%	95%	\$ 201,622,000	Below
Mental Health	5%	79%	\$ 124,645,800	Below
Health Maintenance Organizations	3%	54%	\$ 236,932,800	Below
Capitated Mental Health (FY 1999)	4%	53%	\$ 17,672,700	Below
State Health and Dental Clinics (FY 2004)	N/A	N/A	\$ 9,315,500	Below

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.

How does Utah Medicaid Compare to Other States?

The following Utah Medicaid rankings as compared to the 50 States and the District of Columbia all come www.statehealthfacts.org, part of the Henry J. Kaiser Family Foundation:

1. 13th for highest percent of long term care budget spent on home & personal health care (49% in FY 2009)
2. 18th highest percentage of Medicaid clients enrolled in managed care plans (83% as of July 1, 2010)
3. 20th in lowest spending per enrollee (\$5,173 in FY 2008)
4. 32nd for highest physician fees paid (82% of Medicare rates in 2008)

Medicaid 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; (2) a long-term care program for the elderly; and (3) services program to people with disabilities.

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 Federal Poverty Level. Additionally, the State pays for Medicare premiums for qualifying individuals with incomes up to 120 percent of the Federal Poverty Level.

Department Has Deep Concerns With Proposed Federal Rule Regarding Provider Rate Changes

The Department of Health has deep concerns over the CMS 2328-P proposed federal rule. The Department indicates that the federal rule proposes to add exceedingly burdensome requirements for provider rate changes. Specifically the rule proposes the following:

§447.203(b)(3) "...the State must submit with any State plan amendment that would reduce provider payment rates or restructure provider payments in circumstance when the

changes could result in access issues, an access review described under paragraph (b)(1) of this section completed within the prior 12 months. That access review must demonstrate sufficient access for any service for which the State agency proposes to reduce payment rates or restructure provider payments in circumstance when the changes could result in access issues.”

The Department feels that this would require an annual review of all rates in order to anticipate any possible changes that the Legislature might make during January to March for the fiscal year starting the following July. Additionally, the federal rule proposes to require that all covered services have a full rate review every five years. For more information regarding this proposed federal rule please visit <http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/html/2011-10681.htm>.

Analyst-recommended Changes

Hospital Provider Assessment Increase – for FY 2013 and FY 2014 approved a \$5.5 million increase for the Hospital Provider Assessment to reflect the current projections for revenue collections.

Transfer of Funds For Accountable Care Organizations – the Department of Health recommends moving \$13,301,400 General Fund (\$43,768,900 total funds) from the Medicaid Optional Services to the Medicaid Mandatory Services line item to reflect the increase in clients served by managed care effective January 2013.

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. **Affordable Care Act** – the consensus forecast for the costs from mandatory changes to the Medicaid program beginning January 2014 is \$19,400,000. For more information please see the brief entitled *Medicaid Consensus Forecasting* available at <http://le.utah.gov/interim/2012/pdf/00002730.pdf>. *Should additional resources become available to the subcommittee, the fiscal analyst would recommend funding this item.*
2. **Medicaid Caseload Reduction** – the consensus forecast is a reduction of \$21,200,000 ongoing General Fund (\$71,045,600 total funds) and \$40,900,000 one-time General Fund (\$136,151,800 total funds). For more information please see the brief entitled *Medicaid Consensus Forecasting* available at <http://le.utah.gov/interim/2012/pdf/00002730.pdf>. *The fiscal analyst recommends taking this reduction.*

ACCOUNTABILITY DETAIL

Use of Recent Appropriations

1. **Medicaid Managed Care One-time Add Back (FY 2012):** \$2,933,600 one-time (\$850,000 General Fund) to delay until July 1, 2012 reductions to the administrative reimbursement for contracted Health Maintenance Organizations.
2. **Accountable Care Organizations Run Out (FY 2013):** \$20,704,500 one-time (\$6,000,000 General Fund) will be used to pay fee for service claims that occurred prior to accountable care organization implementation but that will be paid after January 1, 2013.
3. **Accountable Care Ongoing Cost (FY 2013):** \$6,656,700 ongoing (\$2,000,000 General Fund) used to raise the administration rate paid to Accountable Care Organizations to 8.3% within Medicaid..
4. **Nursing Home Assessment (FY 2013):** \$1,993,800 increase in the General Fund Restricted - Nursing Care Facilities Restricted Account to increase reimbursement to nursing home provider rates by a net of \$4,587,300 or 9%. The appropriation is funded by an increase in the assessment paid by nursing facilities.

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5. **2% Increase in Medicaid Physician Rates (FY 2013):** \$2,514,000 ongoing (\$764,000 General Fund) used to restore some of the prior reductions in physician provider reimbursement rates.
6. **Medicaid Provider Inflation (FY 2013):** \$13,139,400 ongoing (\$4,891,000 General Fund) used for increases in the cost of Medicaid services that the State cannot control, such as pharmacy drug costs, Clawback payments, Medicare buy-in, and Medicare crossovers.
7. **FMAP Change (FY 2013):** \$13,100,000 ongoing used to replace a reduction in federal funds due to a 1.07% unfavorable change in the federal match rate effective October 1, 2012.

BUDGET DETAIL

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

Health - Medicaid Mandatory Services						
	FY 2012	FY 2013		FY 2013		FY 2014*
Sources of Finance	Actual	Appropriated	Changes	Revised	Changes	Recommended
General Fund	227,329,100	280,720,200	0	280,720,200	(14,793,700)	265,926,500
General Fund, One-time	27,115,600	6,000,000	(31,678,700)	(25,678,700)	25,678,700	0
Federal Funds	749,080,000	810,195,200	(132,295,800)	677,899,400	37,783,000	715,682,400
American Recovery and Reinvestment Act	1,900	0	0	0	0	0
Dedicated Credits Revenue	4,772,600	1,807,200	2,965,400	4,772,600	0	4,772,600
GFR - Nursing Care Facilities Account	17,914,000	19,878,100	0	19,878,100	0	19,878,100
Hospital Provider Assessment	41,500,000	41,500,000	0	41,500,000	0	41,500,000
Transfers - Intergovernmental	0	607,100	(607,100)	0	0	0
Transfers - Medicaid - DHS	0	154,100	(154,100)	0	0	0
Transfers - Medicaid - DWS	0	141,300	(141,300)	0	0	0
Transfers - Medicaid - Internal DOH	1,643,700	1,510,700	321,300	1,832,000	0	1,832,000
Transfers - Medicaid - UDC	0	600,000	0	600,000	0	600,000
Transfers - Within Agency	1,107,200	448,300	470,700	919,000	0	919,000
Pass-through	136,500	0	136,500	136,500	0	136,500
Beginning Nonlapsing	574,300	0	15,266,700	15,266,700	(15,266,700)	0
Closing Nonlapsing	(15,266,700)	0	0	0	0	0
Total	\$1,055,908,200	\$1,163,562,200	(\$145,716,400)	\$1,017,845,800	\$33,401,300	\$1,051,247,100
Programs						
Inpatient Hospital	382,142,000	321,198,100	60,944,000	382,142,100	0	382,142,100
Managed Health Care	231,069,000	243,660,000	(6,590,900)	237,069,100	(6,000,000)	231,069,100
Nursing Home	170,651,100	166,239,300	4,411,800	170,651,100	0	170,651,100
Outpatient Hospital	82,690,700	103,799,500	(19,108,700)	84,690,800	0	84,690,800
Physician Services	95,821,400	99,792,100	(3,970,700)	95,821,400	0	95,821,400
Crossover Services	14,410,700	14,661,000	(250,400)	14,410,600	0	14,410,600
Medical Supplies	15,454,000	14,044,000	1,410,000	15,454,000	0	15,454,000
State-run Primary Care Case Management	515,000	484,000	31,000	515,000	0	515,000
Other Mandatory Services	63,154,300	199,684,200	(182,592,500)	17,091,700	39,401,300	56,493,000
Total	\$1,055,908,200	\$1,163,562,200	(\$145,716,400)	\$1,017,845,800	\$33,401,300	\$1,051,247,100
Categories of Expenditure						
Personnel Services	4,273,600	4,757,700	(108,800)	4,648,900	0	4,648,900
In-state Travel	30,600	21,300	9,100	30,400	0	30,400
Out-of-state Travel	1,500	6,200	(4,700)	1,500	0	1,500
Current Expense	3,154,900	2,018,100	1,012,500	3,030,600	0	3,030,600
DP Current Expense	147,200	60,900	11,800	72,700	0	72,700
Capital Outlay	72,000	0	0	0	0	0
Other Charges/Pass Thru	1,048,228,400	1,156,698,000	(146,636,300)	1,010,061,700	33,401,300	1,043,463,000
Total	\$1,055,908,200	\$1,163,562,200	(\$145,716,400)	\$1,017,845,800	\$33,401,300	\$1,051,247,100
Other Data						
Budgeted FTE	79	72	(4)	68	0	68
Actual FTE	56	0	0	0	0	0
Vehicles	1	1	0	1	0	1

*Does not include amounts in excess of subcommittee's state fund allocation that may be recommended by the Fiscal Analyst.