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Office of the
Legislative Fiscal Analyst

FY 2001 Budget Recommendations

Joint Appropriations Subcommittee for
Health and Human Services

Utah Department of Health
Medical Assistance

Contents:

1.0 Department of Health-Medical Assistance

Summary

Medical Assistance is a joint federal/state entitlement service that provides health care to selected low-income populations.

There are three programs within the Medicaid line item as follows:

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, there are some state options and waivers which allow the state some latitude in program implementation. The FY 2000 estimated base program makes up almost 85 percent of all Medical Assistance expenditures.

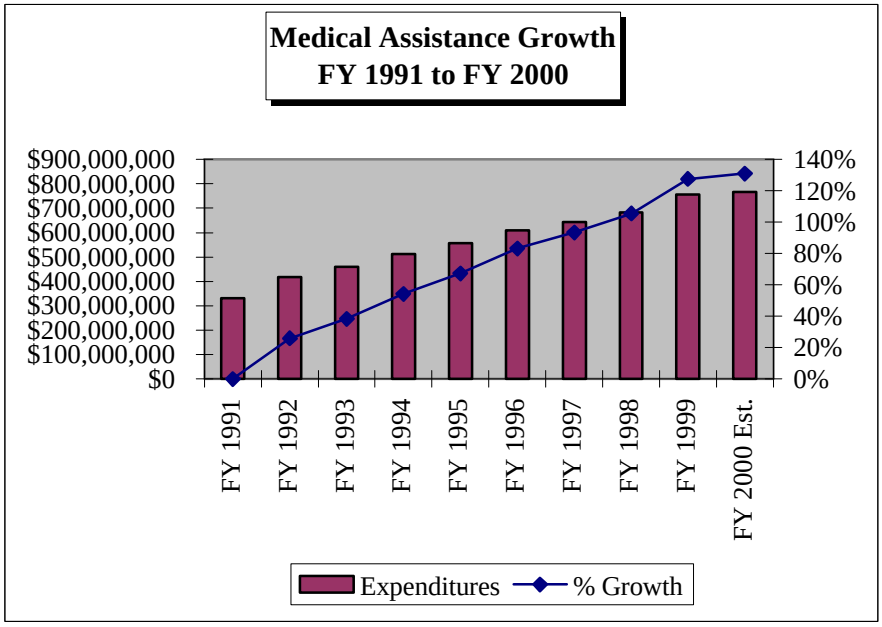
Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who qualify for the Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which is then transferred to the Medicaid program.

The Utah Medical Assistance Program (UMAP) is a State program designed to provide a very limited number of services to a population that does not qualify for any other medical assistance.

The Analyst recommends a total budget for Medical Assistance for FY 2001 of $775,949,200. The General Fund portion of the recommendation is $144,983,300.

Financing	Analyst FY 2001 Base	Analyst FY 2001 Changes	Analyst FY 2001 Total
General Fund	$144,983,300		$144,983,300
Federal Funds	524,824,200	$4,145,100	528,969,300
Dedicated Credits Revenue	66,964,700	102,500	67,067,200
GFR - Hospital Provider Assessment	193,800		193,800
GFR - Medicaid Restricted Account	4,900,200	1,541,000	6,441,200
GFR - Nursing Facility Account	4,216,600	0	4,216,600
Transfers	24,077,800		24,077,800
Total	$770,160,600	$5,788,600	$775,949,200
Programs			
Medicaid Base Program	$642,337,700		$642,337,700
Extra Week's Payments		$5,788,600	5,788,600
Title XIX for Human Services	$121,061,100		121,061,100
Utah Medical Assistance	$6,761,800		6,761,800
Total	$770,160,600	$5,788,600	$775,949,200
FTE	45.0		45.0

The Analyst's total recommendation for FY 2001 represents an increase of 1.2 percent when compared to the estimated FY 2000 expenditures. The following chart shows the growth in expenditures for Medical Assistance from FY 1991 through FY 2000.



2.0 Issues: Department of Health-Medical Assistance

2.1 Extra Week's Provider Payment Needed in FY 2001

Regular Medicaid provider payments are made each Saturday. In Fiscal Year 2001, there are 53 Saturdays, so one additional week's payment will be made. This is a one-time cost, which occurs once every five or six years. The Analyst recommends the funding level of $5,788,600, with the state match coming from the Medicaid Restricted Account, which is a source of one-time funds, which fits well with a one-time expenditure.

2.2 Intent Language

The Legislature included the following intent language in the FY 2000 Appropriations Acts for Medical Assistance:

> *It is the intent of the Legislature that the Department of Health will review with the Interim Executive Appropriations Committee any Medicaid Program reductions or additions.*

The Medicaid Program added a Diabetes Education program during FY 2000. It was reported to the Legislative Fiscal Analyst and the chairs of the Committee. The program is estimated to be budget neutral, as the costs should be offset by fewer hospital stays.

2.2 Critical Funding Issues

Due to the limited allocation of funding, the Analyst has been unable to recommend funding for three items in the Medical Assistance budget. These items are federal mandates and have traditionally been funded by the Legislature. These three items include:

- Federal Match rate change – With federal funds being reduced, an offsetting increase in the General Fund appropriation would be required to maintain the program at its current levels. The projected amount for FY 2001 is $658,800.
- Inflationary Increases – Federal regulations require funding to increase to cover increased costs in certain specific categories of service. The total projected amount is $18,693,600, of which, $6,799,600 would be from the General Fund.
- Utilization Increases – With the same overall number of recipients requesting more services, additional funding is required to cover the additional frequency of services provided. The projections in only those areas showing increases indicate the need for an additional $12,632,100, of which $4,696,300 would be General Funding support.
  The total for these increases is $31,325,700; the total General Fund required is $12,154,700. These increases are not part of the Analyst's recommendation for FY 2001.

3.1 Medical Assistance-Medicaid Base Program

Recommendation

The Analyst recommends an appropriation of $648,126,300 for the Medicaid Base Program for FY 2001. The recommendation requires $141,697,600 from the General Fund, which, with the other sources of revenue, is matchable by Federal funds in the amount of $440,799,000. The Analyst's total recommendation is approximately $9 million over the FY 2000 estimated level.

Since Medicaid is a joint State/federal program, the federal government provides a portion of the funding to administer and implement the program. In general, states chose to participate in Medicaid because of the substantial financial incentives from the federal government to assist in the costs of health services for people who otherwise would not be able to pay. The federal share is based on the state's per-capita income and is recomputed annually. Since Utah has a relatively low per-capita income, the federal portion is higher than most other states. For FY 2001, the federal medical assistance percentage (FMAP) for programs qualifying under Title XIX is 71.47 percent, meaning that for each Medicaid dollar of expenditure, the State provides 28.53 cents, with the federal government picking up the remaining 71.47 cents. The State utilizes various funding streams (dedicated credits and restricted funds) to make up its share. Over the past several years, as the State has experienced economic prosperity the past several years, its per-capita income has increased which has translated into a decrease in the federal match rate. The federal share of Medicaid expenditures was 74.58 percent in FY 1994, and has experienced small percentage drops annually since then. It is projected to be 71.47 percent for FY 2001.

Funds from an assessment on hospitals for the Children's Health Insurance Program (CHIP) beyond that which is needed to fund the CHIP may also be used to help fund the Medicaid program (26-40-112). Last year, the Analyst used $1.3 million in excess funds from the assessment not needed to fund the CHIP budget, but projects that in FY 2001, there will be less than $200,000 available from this assessment after the Children’s Health Insurance Program is funded.

The Medicaid Restricted Account is a sources of funding utilized to fund the Medicaid program. This account was established to capture any excess funds from the Medicaid program and keep them in a separate, nonlapsing account, for ". . . programs that expand medical assistance coverage and private health insurance plans to low income persons who have not traditionally been served by Medicaid, including the Utah Children's Health Insurance Program created in Chapter 40." (UCA 26-18-402). The Analyst's recommendation for FY 2001 include the use of one-time funds from the Medicaid Restricted Account in the amount of $6,441,200. This amount continues the amount from FY 2000, plus $1.54 million for the state match portion of the one additional week's provider payment. The balance in the Medicaid Restricted Account, at the end of FY 1999, was $18.6 million. The FY 2000 appropriation of $4.9 million from the account will bring the balance to approximately $13.7 million at the end of the current fiscal year.

Legislation was approved several years ago, which imposes an assessment on nursing facilities, then utilizes those funds as "State" funds in order to draw down, or match the federal funds at the nearly three-to-one match rate. (A similar assessment, imposed on hospitals, again to draw down additional federal dollars, was terminated two years ago.)

All of the funding for the Medicaid Base program is used to pay claims for services provided to recipients by health care providers. There are no expenditures in the Medicaid Base budget for personal services (FTEs), travel, current expenses, or capital equipment.

Financing	**FY 1999 Actual**	**FY 2000 Estimated**	**FY 2001 Analyst**	**Est/Analyst Difference**
General Fund	$133,593,700	$141,697,635	$141,697,600	($35)
Federal Funds	440,248,037	444,148,665	440,799,000	(3,349,665)
Dedicated Credits Revenue	18,877,754	20,635,100	32,698,000	12,062,900
GFR - Hospital Assessment	3,500,000	1,345,500	193,800	(1,151,700)
GFR - Medicaid Rest. Acct.	3,439,000	4,900,200	6,441,200	1,541,000
GFR - Nursing Fac. Acct.	4,244,800	4,212,900	4,216,600	3,700
Transfers	24,488,626	22,080,100	22,080,100	
Beginning Nonlapsing	134,529	134,500		(134,500)
Closing Nonlapsing	(134,529)			
Lapsing Balance	(970,830)			
Total	$627,421,087	$639,154,600	$648,126,300	$8,971,700
Expenditures				
Other Charges/Pass Thru	$627,421,087	$639,154,600	$648,126,300	$8,971,700
Total	$627,421,087	$639,154,600	$648,126,300	$8,971,700

Federal Match Rate Change

To maintain the program at a consistent level, the decreased level of federal funds need to be replaced. Each year, the Legislature has funded this loss of federal funds by increasing the General Fund allocation. For FY 2001, the Analyst projects the General Fund requirement will be $658,800. Other funding sources can be utilized to reach the total projected federal funds loss of $739,300. This is simply a switch in the funding ratio and does not expand the level of services or increase the number of recipients covered. However, this switch is not included in the Analyst's recommendation.

Inflationary Increases

The Analyst's recommendation also does not include inflationary increases for Hospital Services, HMOs, Nursing Home Facilities, Ambulatory Surgical Centers, and Pharmacy Services, as required by law. The total inflationary increase that the Analyst projects averages 4.94 percent and is estimated at $18,693,600 with $6,799,600 coming from the General Fund. It is interesting to note that with the exception of Pharmacy Services, all of the other increases are projected at 4.3 percent or less. The increase for Pharmacy Services is projected at 12 percent and will cost almost $11 million. This reflects the escalating prices of prescription drugs.

Caseload Growth and Utilization Increases

While there are no increases projected in caseload growth, the Analyst does project an increase in the utilization of services. This indicates that the same number of Medicaid recipients are using Medicaid services more often. The projected amount for FY 2001 is $12,632,100, of which $4,696,300 would come from the General Fund. Again, this projected increase is not part of the Analyst's recommendation.

Again, the Analyst's utilization projections consider each category of service and include only those that show actual increases. The main categories showing increases include Ambulatory Surgical Centers, Dental Services, Pharmacy Services, and HMOs. Pharmacy Services projections indicate an increase in utilization of 11 percent, at a cost of over $10 million.

Intent Language

The Legislature included the following intent language in the FY 2000 Appropriations Acts for Medical Assistance:

> *It is the intent of the Legislature that the Department of Health will review with the Interim Executive Appropriations Committee any Medicaid Program reductions or additions.*

Response

The Medicaid Program added a Diabetes Education program during FY 2000. It was reported to the Legislative Fiscal Analyst and the chairs of the Committee. The program is estimated to be budget neutral, as the costs should be offset by fewer hospital stays.

Summary of the Medicaid Program

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 36 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. States have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery.

Medicaid Services

There are currently 45 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 Section 4.3.

Mandatory Services

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. (Medicaid pays the premiums for individuals between 100 and 135 percent. Medicaid is also required to pay a benefit of $1.07 per month for Medicare beneficiaries with incomes between 135 and 175 percent of poverty. This change is due to a federal mandate and is 100 percent federally funded).

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

Optional Services require approval from the federal Health Care Financing Administration (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 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.

Utah is one of the 49 states which has a Medicaid Program. For budgeting purposes, the Medicaid line item consists of three programs: the Medicaid Base Program, Title XIX Seeding for the Department of Human Services, and the Utah Medical Assistance Program (UMAP). The first two programs are rely heavily on federal funds under Title XIX of the Social Security Act, while UMAP is funded with State funds only. For FY 2001, the FMAP is projected at 71.47 percent, which means that for each Medicaid dollar of expenditure, the State provides 28.53 cents, with the federal government picking up the remaining 71.47 cents. The State utilizes various funding streams (dedicated credits and restricted funds) to make up its share.

Federal Poverty Level

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 federal poverty levels for 1999 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.

1999 FEDERAL MONTHLY POVERTY LEVELS

Family Size	100%	Annualized	133%	185%
1	$687	$8,244	$914	$1,271
2	922	11,064	1,226	1,706
3	1,157	13,884	1,539	2,140
4	1,392	16,704	1,851	2,575
5	1,627	19,524	2,164	3,010
6	1,862	22,344	2,476	3,445
7	2,097	25,164	2,789	3,879
8	2,332	27,984	3,102	4,314
9	2,567	30,804	3,414	4,749
10	2,802	33,624	3,727	5,184
each add'l person	235	2,820	313	435

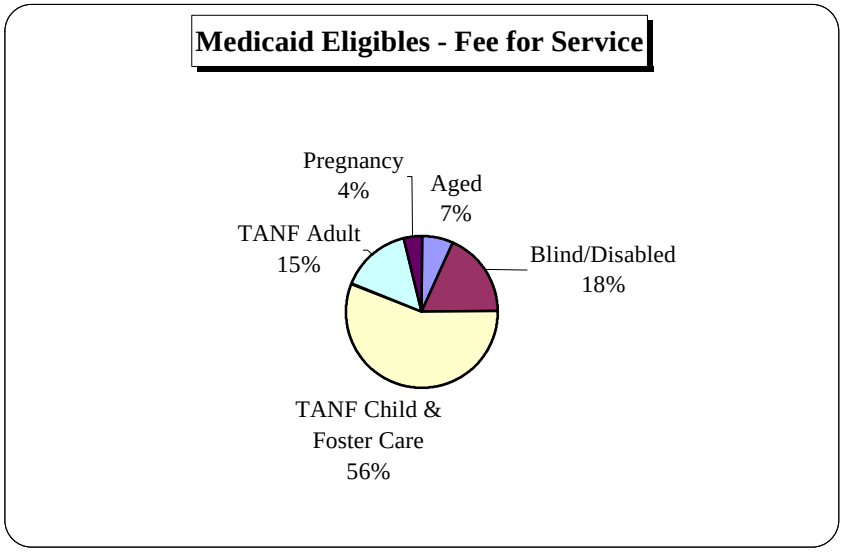
The state has designated five major population groupings who may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as Aged); (2) Blind and/or Disabled individuals; (3) Children who receive Temporary 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.

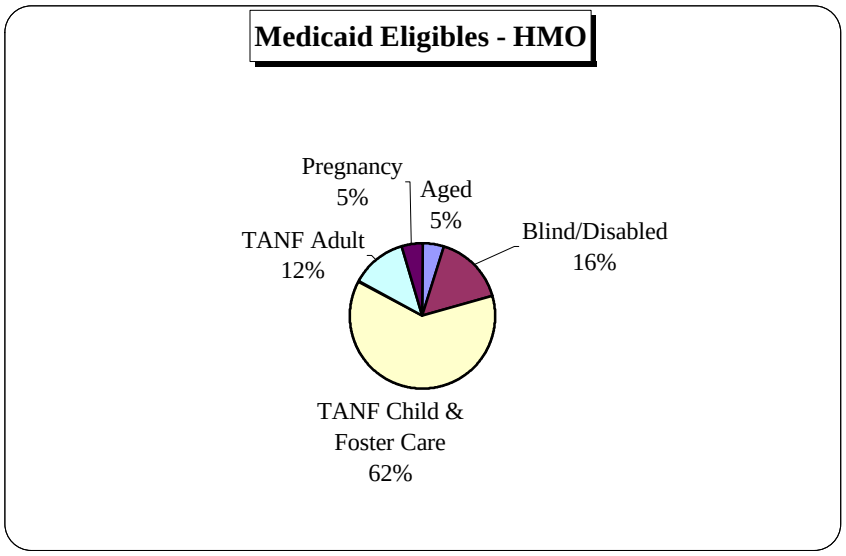
Much of the effort in the Medicaid program over the past several years has been toward moving eligibles who live in the populated Wasatch front counties from the traditional "fee-for-service" providers to managed care, or health maintenance organizations (HMOs). The purpose behind this effort is to provide more cost-effective health care. It is estimated that approximately 97 to100 percent of Medicaid clients living on the Wasatch Front are now enrolled in a HMO. Approximately 66 percent of the same Medicaid population was enrolled in a HMO during 1995.

As a result of this movement, data is collected differently than in the past, blurring historical trends. In some portions of this analysis, both fee-for service and HMO data will be shown.

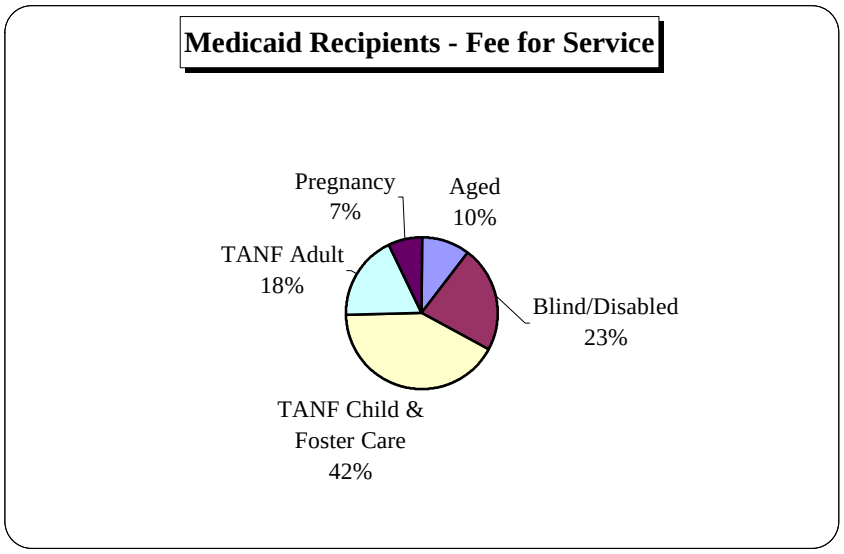
The distribution of eligible people, recipients, and expenditures for each group are shown in the following charts.

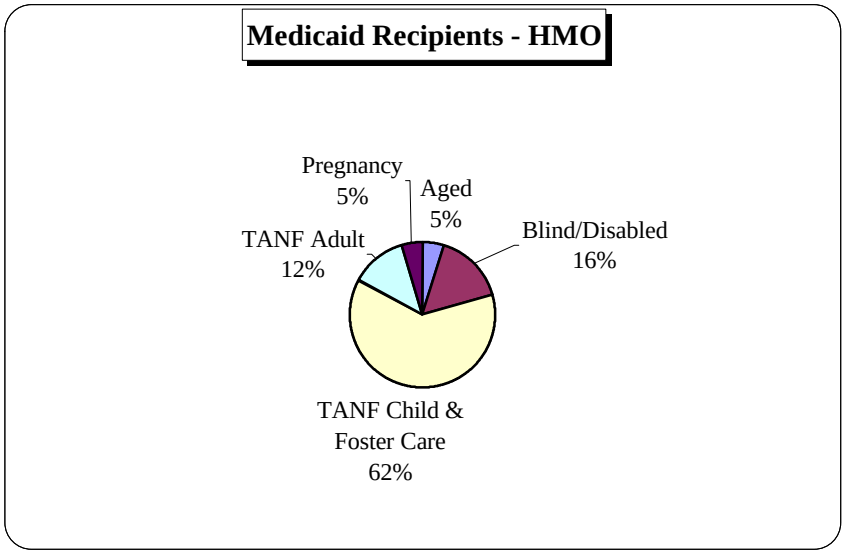
Medicaid Eligibles



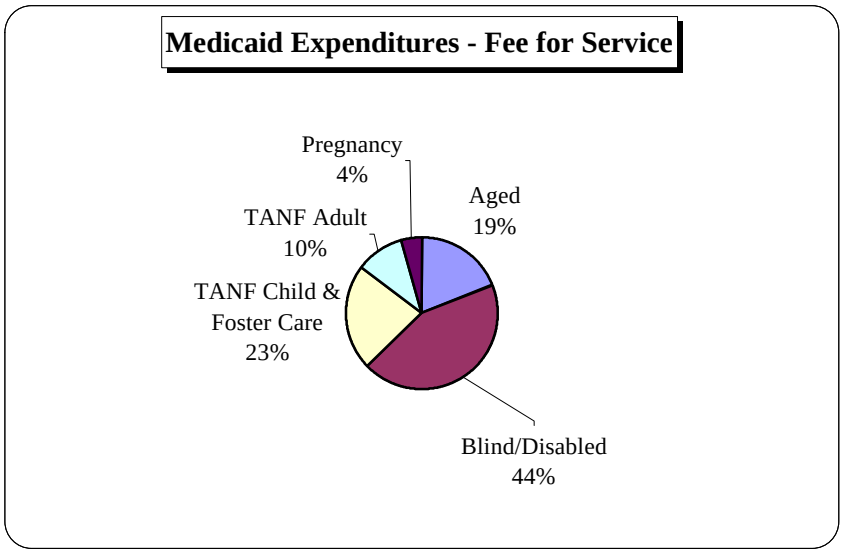


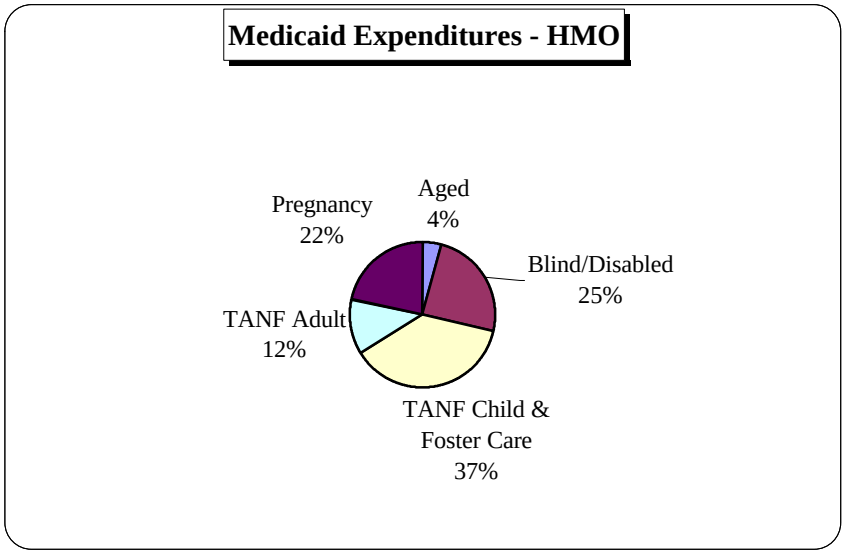
Medicaid Recipients





Medicaid Expenditures





The 1999 Legislature increased funding for FY 2000 for the Medical Assistance budget to cover the reduction in the Federal funds match rate and for inflation and utilization. The total increase for these items was $34.4 million, with $8.8 million from the General Fund. In addition, the Legislature funded $600,000 to cover an additional 32 children who are medically-fragile and technology-dependent.

A few years ago, the Federal government required states to add children under age 18 and under 100 percent of the Federal Poverty Level (FPL) at the rate of at least one age group per year. The 1994 Legislature elected to approve funding for the entire group of Medicaid eligible children up to the age of 18 all at once. Currently, all children under age 18 and under 100 percent of the Federal Poverty Level are considered eligible. (CHIP covers the same age group of children from 100 percent to 200 percent of poverty).

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 1999, there was an average number of 10,370 people receiving 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 is for pharmacy items, which are not covered under Medicare. 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.

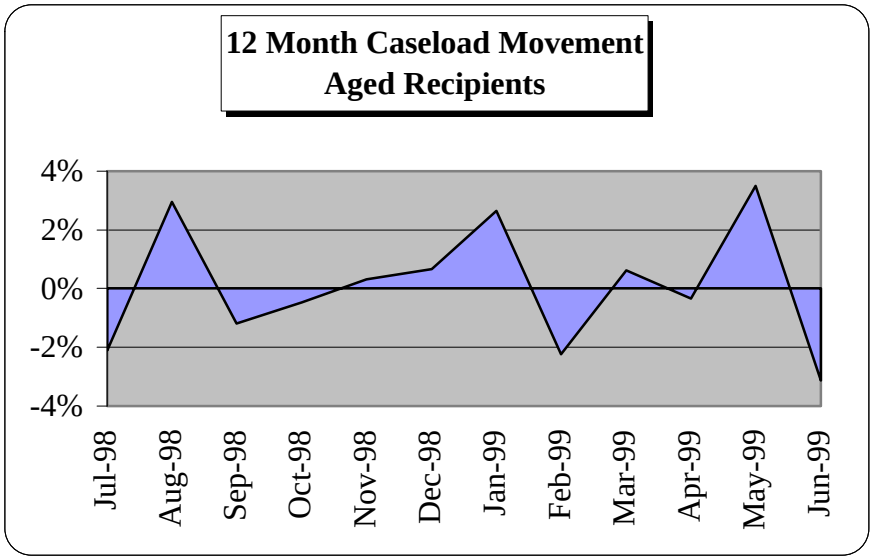
In July 1986, there were 5,794 nursing facility beds in the State. The census was 5,034 for an occupancy rate of 87 percent. Medicaid paid for 71 percent of all occupants. As of the end of FY 1999, there were 7,556 nursing facility beds which were certified, with a census of 5,719 as shown in the following table.

Nursing Facility Beds

Private Pay	1,572	27.49%
VA Contract	29	0.51%
Medicaid	3,466	60.61%
Medicare	652	11.40%
Total	**5,719**	
Total Certified Beds	7,556	
Percent Occupancy	75.69%	

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.

The following chart shows the growth rate for the aged and nursing home categories during FY 1999.

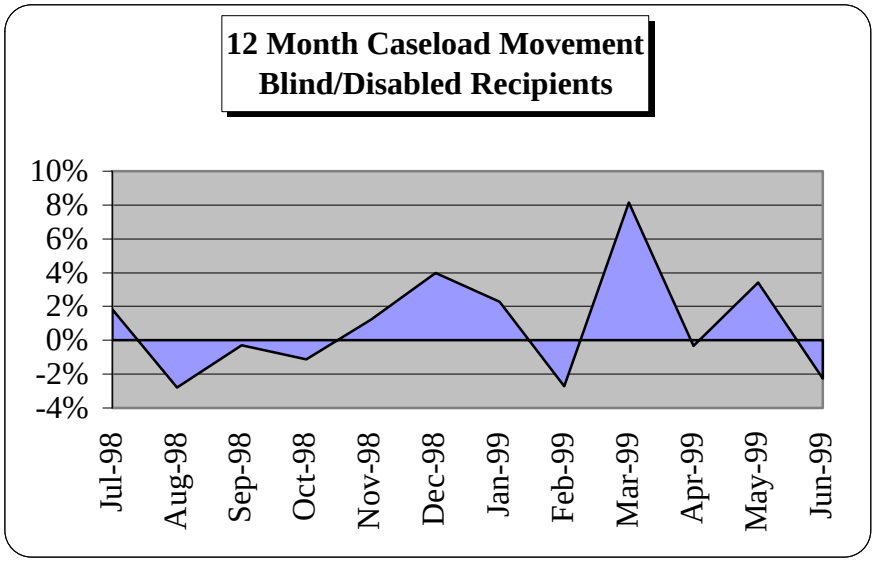


Blind and Disabled

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 total number of blind and/or disabled individuals as of June 30, 1999 was 28,853. Criteria for disability requires 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 17 percent of the Medicaid eligible population, while accounting for 19 percent of recipients. In FY 1999, this group accounted for almost 40 percent of total Medicaid expenditures. Institutional care for disabled individuals is included in this category . The following chart shows the 12-month growth rate for the combined Blind and Disabled categorical group.



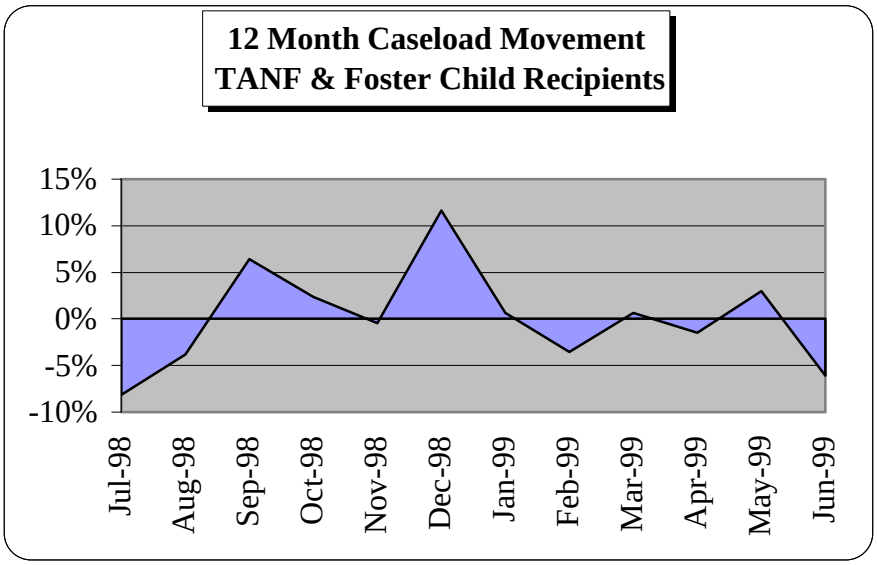
A special group of nursing facilities is Intermediate Care Facilities for the Mentally Retarded (ICF/MR). These facilities specialize in the care of people with disabilities. The populations served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different 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 which are met in a community environment. 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 13 privately-owned facilities with populations ranging from 12 to 83 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 390. Only three of the facilities meet the 16-or-fewer bed standard. ICFs/MR are an optional service in the Medicaid Program. Occupancy in the ICFs/MR is currently near 96 percent. The industry suggests that many of the vacant certified beds are not available due to the conversion of space to meet federal active treatment standards. The average cost per client in an ICF/MR for FY 1999 was approximately $42,340, which is a full-service program (including a residential, day program, transportation, 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 programs account for approximately 58 percent of all eligible persons in Medicaid, 52 percent of Medicaid recipients, and 26 percent of total expenditures. The following chart shows the 12-month caseload growth rate for the TANF population.



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 eligibles during FY 1999 was 117,372.

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 (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. The coverage is optional for Medicaid, but if not covered, the State would be responsible for the full cost of care. Most children placed in foster care have histories of abuse or neglect. This often means there are unresolved medical and mental health problems which 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 income test is the same as for the Blind and Disabled, and 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. The 1994 and 1995 Legislatures approved funding to cover the entire group of children, up to age 18. 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 or other 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. The waivers are set to expire at the end of 2000.

Pregnancy

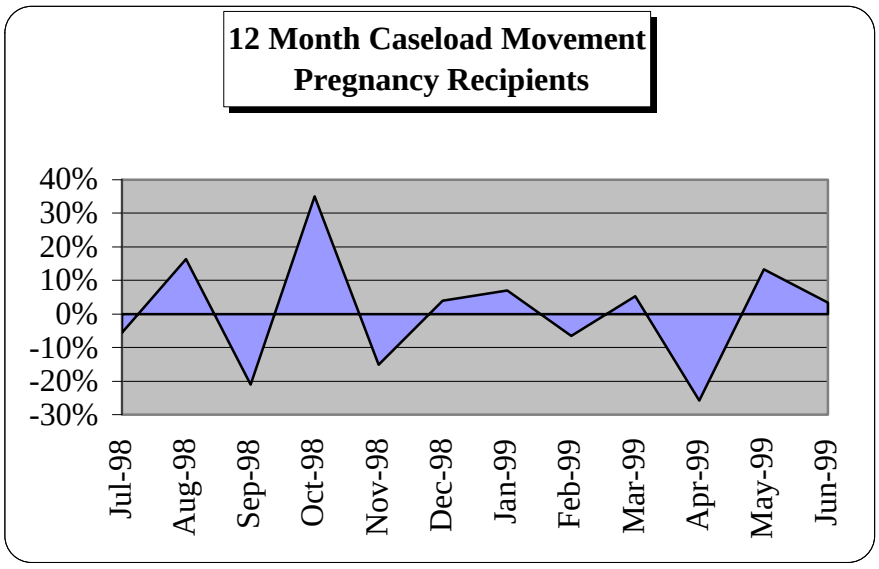
The prenatal/pregnancy program helps pregnant women receive prenatal care. The program covers the mother from the time of application to 60 days after the birth. A woman only needs to meet the eligibility requirements in any one month to be eligible for the entire pregnancy. Children born to women on 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.

At the beginning of 1999, the Pregnancy Program had a caseload of approximately 8,051. During 1999, the caseload averaged around 8,500.

The chart on the following page shows the fluctuations in the number of cases for the pregnancy program during FY 1999.


12 Month Caseload Movement
Pregnancy Recipients
40%
30%
20%
10%
0%
-10%
-20%
-30%
Jul-98
Aug-98
Sep-98
Oct-98
Nov-98
Dec-98
Jan-99
Feb-99
Mar-99
Apr-99
May-99
Jun-99

3.2 Medical Assistance-Title XIX Funding for Human Services

Recommendation

The Analyst recommends an appropriation of $121,061,100 for the Title XIX funding for services provided by the Department of Human Services. This funding level is the same as the FY 2000 estimated levels. There is no General Fund in this appropriation.

Financing	FY 1999 Actual	FY 2000 Estimated	FY 2001 Analyst	Est/Analyst Difference
Federal Funds	$85,871,035	$86,691,900	$86,691,900	
Dedicated Credits Revenue	35,190,064	34,369,200	34,369,200	
Total	$121,061,099	$121,061,100	$121,061,100	$0
Expenditures				
Other Charges/Pass Thru	$121,061,099	$121,061,100	$121,061,100	
Total	$121,061,099	$121,061,100	$121,061,100	$0

Summary

It has been the historical policy of the Legislature to have the Department of Human Services 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, 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. The Analyst has based his recommendation on the amount of funding requested by the divisions in the Department of Human Services.

3.3 Medical Assistance-Utah Medical Assistance Program (UMAP)

Recommendation

The Analyst recommends an appropriation for $6,761,800 for the Utah Medical Assistance Program (UMAP).

If a recipient is deemed Medicaid eligible after services have been provided, Medicaid will be billed and pay for the services. Because this happens frequently, Federal funds and Revenue transfers (from the Medicaid program) are included in the funding schedule.

Financing	FY 1999 Actual	FY 2000 Estimated	FY 2001 Analyst	Est/Analyst Difference
General Fund	$3,258,900	$3,297,065	$3,285,700	($11,365)
General Fund, One-time		2,800		(2,800)
Federal Funds	1,678,398	1,478,435	1,478,400	(35)
Transfers	1,997,580	1,997,700	1,997,700	
Lapsing Balance	(1)			
Total	$6,934,877	$6,776,000	$6,761,800	($14,200)
Expenditures				
Personal Services	$1,991,755	$2,065,400	$2,045,300	($20,100)
In-State Travel	4,270	4,700	4,700	
Out of State Travel	768	1,100	1,100	
Current Expense	391,928	478,400	486,200	7,800
DP Current Expense	380	400	400	
Other Charges/Pass Thru	4,545,776	4,226,000	4,224,100	(1,900)
Total	$6,934,877	$6,776,000	$6,761,800	($14,200)
FTE	51.5	45.0	45.0	

Summary

The Utah Medical Assistance Program (UMAP) is designed to serve individuals who cannot qualify for Medicaid or Medicare. Funding for UMAP is from the General Fund.

Eligible individuals are Utah residents, ages 19 through 64, who are not blind or disabled. They must have income which is no greater than $50 above the Basic Maintenance Standard (BMS) for the size of household. (The BMS for one person is $337 per month). Allowable assets are limited to $500 for a one-person household. The Bureau of Eligibility Services or the Department of Workforce Services determine eligibility for this population,. Eligibility can be established back to the first of the month 30 days prior to the month of application.

UMAP operates four medical and five dental clinics. UMAP clinics are staffed with UMAP medical and dental staff and volunteer physicians, dentists, and chiropractors. The medical clinics provide both primary and preventative medical care. During FY 1999, the clinics registered over 38,000 patient encounters. The value of the medical and dental services totaled $2,351,400. Of the $2.3 million in services, approximately $112,400 was donated by volunteer physicians/chiropractors and dentists. In addition, the medical clinics received over $174,100 in donated goods.

UMAP serves approximately 11,000 recipients, of which 6,000 receive covered services. Coverage is generally limited to medical conditions that are acute, life-threatening, or contagious to the general public. Among conditions that are excluded are psychiatric conditions, chronic, non-life threatening conditions, and conditions which arose during the commission of a crime or while incarcerated. Inpatient hospital services are not a covered benefit of the program (in-state hospitals donate care when the service is otherwise a UMAP covered benefit.) All services covered by UMAP must be pre-authorized before payment. UMAP is the payer of last resort.

4.0 Additional Information: Medical Assistance

4.1 Funding History

Financing	FY 1997 Actual	FY 1998 Actual	FY 1999 Actual	FY 2000 Estimated	FY 2001 Analyst
General Fund	$127,889,700	$133,317,800	$136,852,600	$144,994,700	$144,983,300
General Fund, One-time				2,800	
Federal Funds	463,094,517	479,124,916	527,797,470	532,319,000	528,969,300
Dedicated Credits Revenue	21,223,867	32,173,717	54,067,818	55,004,300	67,067,200
GFR - Hospital Provider Assessment			3,500,000	1,345,500	193,800
GFR - Medicaid Hospital Provider Accc	7,345,300	6,335,900			
GFR - Medicaid Restricted Account		1,750,000	3,439,000	4,900,200	6,441,200
GFR - Nursing Facility Account	3,579,200	3,681,700	4,244,800	4,212,900	4,216,600
Transfers	28,446,168	33,894,858	26,486,206	24,077,800	24,077,800
Beginning Nonlapsing	49,850	49,850	134,529	134,500	
Closing Nonlapsing	(49,850)	(134,529)	(134,529)		
Lapsing Balance	(8,947,431)	(8,042,375)	(970,831)		
Total	$642,631,321	$682,151,837	$755,417,063	$766,991,700	$775,949,200
% Change		6.1%	10.7%	1.5%	1.2%
Programs					
Medicaid Base Program	$539,523,484	$572,021,470	$627,421,087	$639,154,600	$648,126,300
Title XIX for Human Services	97,004,112	103,321,252	121,061,099	121,061,100	121,061,100
Utah Medical Assistance	6,103,725	6,809,115	6,934,877	6,776,000	6,761,800
Total	$642,631,321	$682,151,837	$755,417,063	$766,991,700	$775,949,200
Expenditures					
Personal Services	$1,583,881	$1,841,820	$1,991,755	$2,065,400	$2,045,300
In-State Travel	409	2,357	4,270	4,700	4,700
Out of State Travel		853	768	1,100	1,100
Current Expense	342,167	418,575	391,928	478,400	486,200
DP Current Expense	1,650	6,105	380	400	400
Other Charges/Pass Thru	640,703,214	679,882,127	753,027,962	764,441,700	773,411,500
Total	$642,631,321	$682,151,837	$755,417,063	$766,991,700	$775,949,200
FTE	35.0	37.3	51.5	45.0	45.0

4.2 Federal Funds

Program		FY 1999 Actual	FY 2000 Estimated	FY 2001 Analyst
Medicaid Base Program	Federal	$439,864,123	$443,758,665	$430,689,000
Title XIX Medicaid	Required State Match	133,593,701	141,697,635	141,697,601
	Total	573,457,824	585,456,300	572,386,601
Medicaid Base Program	Federal	1,715	1,700	1,700
Federal Refugee Special Assistance	Required State Match	0	0	0
	Total	1,715	1,700	1,700
Medicaid Base Program	Federal	382,199	388,300	388,300
Medicaid Administration	Required State Match	0	0	0
	Total	382,199	388,300	388,300
Title XIX Funding for Human Services	Federal	85,871,035	86,691,900	86,691,900
Title XIX Medicaid	Required State Match	35,190,064	34,369,200	34,369,200
	Total	121,061,099	121,061,100	121,061,100
Utah Medical Assistance Program	Federal	1,678,398	1,478,400	1,478,400
Title XIX Medicaid	Required State Match	3,258,899	3,299,865	3,294,299
	Total	4,937,297	4,778,265	4,772,699
Utah Medical Assistance Program	Federal		35	
Medicaid Administration	Required State Match			0
	Total	0	35	0
	Federal	**527,797,470**	**532,319,000**	**519,249,300**
	Required State Match	**172,042,664**	**179,366,700**	**179,361,100**
	Total	**$699,840,134**	**$711,685,700**	**$698,610,400**

4.3 Definitions: Medical Assistance Categories of Service

Aging Waiver	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.
Ambulatory Surgical	Surgery on an ambulatory basis is provided.
Case Management Fees	Payments made to local health departments for case management services.
Child Health Evaluation and Care (CHEC/EPSDT)	Screening, diagnostic, health care, treatment, and other measures to correct and/or ameliorate any defects and chronic conditions discovered in recipients under age 21. Utah's version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program.
Chiropractic Services	Services which involve manipulation of the spine that a chiropractor is legally authorized to perform under state law.
Contracted Mental Health Services	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.
Dental Services	Diagnostic, preventative, or corrective procedures provided by a dentist in the practice of his/her profession.
Early Intervention	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.
Group Pre/Postnatal Education	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.
Health Maintenance Organizations (HMOs)	Basic medical and dental covered services provided by health maintenance organizations.

Home and Community-Base Waiver for Developmentally Delayed/Mentally Retarded (DD/MR)	Provides services 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 waivered services, including residential treatment, day training, respite care, family support, and case management.
Home Health Services/Hospice	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.
Inpatient Hospital	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.
Inpatient Hospital Mental-Mental Youth and Aged	Mentally ill, youth and aged clients in an inpatient hospital setting, requiring constant care.
Intermediate Care Facilities	Intermediate care facilities offer care to chronically ill patients.
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	Intermediate care facilities catering to mentally ill clients requiring less care than an inpatient hospital patient.
ICF/MR Day Treatment	Day treatment is provided to intermediate care and mentally retarded individuals.
Kidney Dialysis	A program for people who have irreversible and permanent end-stage renal disease and require a regular course of dialysis.
Lab and Radiology	Laboratory and radiological services are provided for the client.
Medical Supplies	Medical supplies necessary for treatment are provided to individuals who require them.
Medical Transportation	Transportation is provided to and from medical appointments and treatment when needed.
Mental Health Services	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.

Nutritional Assessment/ Counseling	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.
Occupational Therapy	Occupational therapy is provided to needy individuals to assist them in returning to the work force.
Optical Supplies	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.
Outpatient Hospital	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.
Pediatric/Family Nurse Practitioner	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.)
Perinatal Care Coordination	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.
Personal Care Services	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.
Pharmacy	Drugs prescribed by their respective physicians are provided to individuals which are required for treatment.
Physical Therapy	Services prescribed by a physician and provided by a physical therapist.
Physical Services	"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.
Podiatry Services	Services provided by a podiatrist who is licensed under state law to render medical or remedial care for the foot and associated structures.

Pre/Postnatal Home Visits	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.
Pre/Postnatal Psychosocial Counseling	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.
Private Duty Nursing	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.
Psychologist Services	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.
Rural Health Services	Health services are provided to individuals who live in rural areas.
Skilled Nursing Facilities	Skilled Nursing Facilities offer skilled nursing care to chronically ill patients.
Skills Development	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.
Specialized Nursing Service	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: 1.Certified Registered Nurse Anesthetists (CRNA) 2.Certified Registered Nurse Midwives (CNM) 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.