

Office of the
Legislative Fiscal Analyst

FY 2002 Budget Recommendations

Joint Appropriations Subcommittee for
Health and Human Services

Utah Department of Health
Medical Assistance

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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 that allow the state some latitude in program implementation. The FY 01 estimated base program makes up almost 85 percent of all Medical Assistance expenditures.

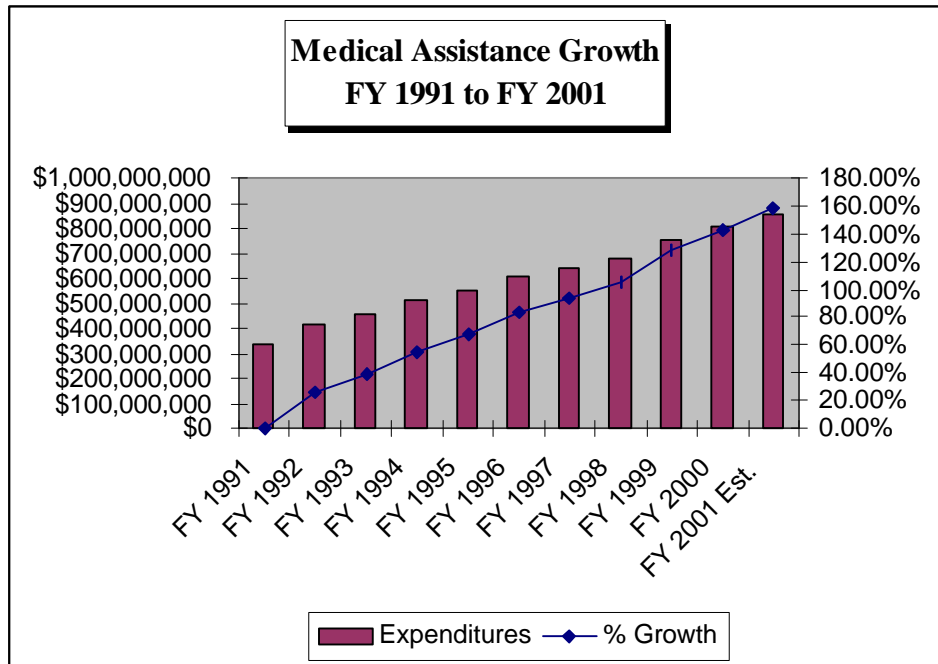
Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who qualify for the Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which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

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 2002 of \$839,429,100. The General Fund portion of the recommendation is \$162,303,600.

| | Analyst FY 2002 Base | Analyst FY 2002 Changes | Analyst FY 2002 Total |
|------------------------------------|----------------------------|-------------------------------|-----------------------------|
| Financing | | | |
| General Fund | 156,603,600 | 5,700,000 | 162,303,600 |
| Federal Funds | 578,037,700 | | 578,037,700 |
| Dedicated Credits Revenue | 40,926,500 | | 40,926,500 |
| GFR - Nursing Facility | 4,390,500 | | 4,390,500 |
| Transfers | 53,770,800 | | 53,770,800 |
| Total | \$833,729,100 | \$5,700,000 | \$839,429,100 |
| Programs | | | |
| Medicaid Base Program | 690,070,800 | 5,700,000 | 695,770,800 |
| Title XIX for Human Services | 136,211,000 | | 136,211,000 |
| Utah Medical Assistance Program | 7,447,300 | | 7,447,300 |
| Total | \$833,729,100 | \$5,700,000 | \$839,429,100 |
| FTE/Other | | | |
| Total FTE | 61 | | 61 |

The Analyst's total recommendation for FY 2002 represents an increase on 0.7 percent when compared to the estimated FY 2001 level of expenditures. The following chart shows the growth in expenditures for Medical Assistance from FY 1991 through FY 2001.



2.0 Issues: Department of Health-Medical Assistance

2.1 Medicaid – Replacement of One-Time Funding Source

For the past few years, a portion of the State’s funding for the Medicaid program has been appropriated from the General Fund Restricted – Medicaid Savings Account. This revenue source was established to help fund Medicaid services, with the source being savings accrued from moving Medicaid recipients to managed care services. The Medicaid Savings Account is getting low, as there is no ongoing revenue source into the account. The amount of (one-time) Medicaid Savings Account funding ongoing Medicaid services is \$5.7 million. This funding needs to be moved back to the General Fund, as the restricted account is getting low. The replacement of \$5.7 million keeps the program whole, while providing the program with ongoing state funding. This General Fund increase is part of the Analyst’s funded recommendation.

| | |
|--------------|-------------|
| General Fund | \$5,700,000 |
|--------------|-------------|

2.2 Medicaid - Critical Funding Issues

Each year, several items are traditionally funded by the Legislature, since the federal government mandates that they be funded. 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 General Fund amount for FY 2002 is \$6,644,500, which will offset most of the federal fund decrease of \$6,816,000. Other sources will be used to make up the balance.
- ▶ **Inflationary Increases** – Federal regulations require funding to increase to cover increased costs in certain specific categories of service. The total projected amount is \$37,103,700, of which, \$9,956,600 would be from the General Fund.
- ▶ **Utilization/Caseload Increases** – With an increasing number of recipients requesting more services, additional funding is required to cover the additional services provided. The projections in only those areas showing increases indicate the need for an additional \$17,915,600, of which \$4,942,600 would be General Funding support.

The total for these increases is \$55,019,300; the total General Fund required is \$21,543,700. These three items, which have traditionally been funded in the past, are not part of the Analyst’s funded recommendation, due to the limited amount of new revenue allocated by the Executive Appropriations Committee. The Analyst recommends that these items be considered for additional funding on the Subcommittee’s prioritization list.

2.3 Medicaid – Federal Mandate to Expand Coverage

Several years ago, the federal government mandated that state Medicaid programs cover all children up through age 18 who are in families at or below 100 percent of the federal poverty level. The states were given several years to implement this increase. The 1994 Legislature elected to approve funding for the 12 through 17 year-old ages groups, beginning in FY 1995. That left the 18-year-old children not covered. Fiscal Year 2002 is the last year to cover this last age group. The amount is \$2,532,200, of which \$704,900 would come from the General Fund. This is not part of the Analyst’s funded recommendations, but should be one of the items considered by the Subcommittee for prioritization for additional funding.

2.4 Medicaid - Disabled Individuals Return to Work

The federal Balanced Budget Act of 1997 provided states with the option of allowing disabled individuals to return to work, while retaining their Medicaid eligibility, and reducing the effect of Medicaid “spenddown”. Last year, the Legislature approved intent language to have the Division of Health Care Financing look into this option and provide recommendations on how to implement it in Utah. The report was presented to the Health and Human Services Interim committee and will be shared with the Appropriations Subcommittee. In order to implement this option, an appropriation of \$1.9 million would be needed, of which \$538,300 would be from the General Fund.

2.5 Medicaid - Rate Increases

Federal Medicaid regulations require inflationary adjustments for some service providers. However, many providers are not subject to these increases. As costs have increased, especially medical costs, the reimbursement rate for providers should periodically be considered for adjustments. The Department is requesting that the following three providers be considered for rate adjustments:

- ▶ Dentists \$250,000 total, \$69,600 General Fund
- ▶ Physicians \$1,771,000 total, \$493,000 General Fund
- ▶ Ambulance providers \$1,652,000 total, \$459,900 General Fund

2.6 Medicaid - Intent Language

The Legislature included the following intent language in the FY 2001 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.

Due to budgetary restrictions, the Medicaid Program tightened the eligibility restrictions in the Utah Medical Assistance Program (UMAP). This had the effect of reducing services to certain individuals who have previously been eligible to receive UMAP services. The Department notified the Chairs of the Executive Appropriations Committee as well as the Fiscal Analyst of the proposed reduction.

2.7 UMAP Inflation

The Utah Medical Assistance Program (UMAP) is faced with medical inflation, which is considerably higher than regular consumer inflation. The program has not received any increased funding since 1987. The requested amount, while not funded in the Analyst's recommendation, would help this problem. The amount is \$380,400, from the General Fund. The Analyst has shown this piece separate from the Medicaid Inflation as this is not a mandatory issue as it is in Medicaid.

2.8 UMAP Utilization/Caseload Growth

Similar to the Utilization/Caseload Growth issues in Medicaid, UMAP is experiencing requests for more services and coverage for more recipients. The Analyst has shown this piece separate from the Medicaid Utilization/Caseload growth as this is not a mandatory issue as it is in Medicaid. However, the pressure is significant and does warrant consideration from the Subcommittee for additional funding. The suggested amount is \$187,900.

2.9 UMAP - Rate Increases

Like the Medicaid service providers, UMAP providers experience increased costs. Two of the specific groups of providers have requested adjustments in the UMAP reimbursement rates, similar to the Medicaid increases. The Department is requesting that the following provider groups be considered for rate adjustments:

- ▶ Physicians \$142,300 General Fund
- ▶ Ambulance providers \$26,200 General Fund

Again, these increases are shown separate from the Medicaid budget as these pertain specifically to UMAP.

3.1 Medical Assistance-Medicaid Base Program

Recommendation The Analyst recommends an appropriation of \$695,770,800 for the Medicaid Base Program for FY 2002. The recommendation requires \$158,808,900 from the General Fund, which, with the other sources of revenue, is matchable by Federal funds in the amount of \$479,449,500. The Analyst's total recommendation is approximately \$20 million below the FY 2001 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 2002, the federal medical assistance percentage (FMAP) for programs qualifying under Title XIX is projected to be 70.36 percent, meaning that for each Medicaid dollar of expenditure, the State provides 29.64 cents, with the federal government picking up the remaining 70.36 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, 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.

Medicaid Restricted Account - Replacement The Medicaid Restricted Account is a source of funding that has been utilized in the past 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 Legislature used \$7.24 million from this account for the funding of the FY 2001 Medicaid program. This included \$5.7 million funding a portion of the ongoing Medicaid program and \$1.54 million for a one-time FY 2001 Medicaid expense. Part of the Analyst's recommendation includes replacing the ongoing \$5.7 million with General Funds.

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). This nursing facility account provides nearly \$4.4 million, which is matched with an additional \$10.4 of Federal Funds.

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

| | 2000 | 2001 | 2002 | Est/Analyst |
|----------------------------|----------------------|----------------------|----------------------|-----------------------|
| Financing | Actual | Estimated | Analyst | Difference |
| General Fund | 141,697,600 | 153,108,900 | 158,808,900 | 5,700,000 |
| Federal Funds | 459,000,673 | 497,589,253 | 479,449,500 | (18,139,753) |
| Dedicated Credits Revenue | 36,823,616 | 39,530,300 | 39,530,300 | |
| GFR - Hosp Provider Assess | 1,345,500 | | | |
| GFR - Medicaid Restricted | 4,900,200 | 7,241,200 | | (7,241,200) |
| GFR - Nursing Facility | 4,212,900 | 4,390,500 | 4,390,500 | |
| Transfers | 13,468,235 | 13,591,600 | 13,591,600 | |
| Beginning Nonlapsing | 134,529 | 339,347 | | (339,347) |
| Closing Nonlapsing | (339,347) | | | |
| Lapsing Balance | (212,364) | | | |
| Total | <u>\$661,031,542</u> | <u>\$715,791,100</u> | <u>\$695,770,800</u> | <u>(\$20,020,300)</u> |
| Expenditures | | | | |
| Other Charges/Pass Thru | 661,031,542 | 715,791,100 | 695,770,800 | (20,020,300) |
| Total | <u>\$661,031,542</u> | <u>\$715,791,100</u> | <u>\$695,770,800</u> | <u>(\$20,020,300)</u> |
| FTE/Other | | | | |

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 2002, the Analyst projects the General Fund requirement will be \$6,644,500. Other funding sources can be utilized to reach the total projected federal funds loss of \$6,816,000. This is simply a switch in the funding ratio and does not expand the level of services or increase the number of recipients covered. This funding 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 federal law. The total inflationary increase that the Analyst projects averages just over six percent and is estimated at \$37,103,700 with \$9,956,600 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 six percent or less. The increase for Pharmacy Services is projected at 12 percent and will cost almost \$13.6 million. This reflects the escalating prices of prescription drugs.

Caseload Growth and Utilization Increases

The Analyst projects an increase in the utilization and caseload of Medicaid services. This indicates that there is both an increasing number of Medicaid recipients and they total Medicaid population is using Medicaid services more often. The projected amount for FY 2002 is \$17,915,600, of which \$4,942,600 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 large percentage increases include Home Health, Lab and Radiology, Pharmacy, Rural Health, and Speech and Hearing. However, since many of those services have small bases, the actual dollar increase is not significant when compared with other areas. Pharmacy Services projections indicate an increase in utilization of nearly eight percent, at a cost of \$8.8 million.

18 Year Olds

The final mandate covers children in families below 100 percent of the federal poverty level who are 18 years old. Several years ago, the Legislature funded the age groups from 12 to 17. This is the final year to pick up the 18 year old cohort. This mandate is not included in the Analyst's funded recommendation, but is projected at \$2,532,200 (\$704,900 General Fund).

Disabled Individuals Return to Work

During the 2000 Legislative session, the Department was requested, through intent language, to investigate the federal "Ticket to Work" program (see pages 4-5 "Health Care Financing" tab). This waiver would provide the state with the option of allowing disabled individuals to return to work, while retaining their Medicaid eligibility, and reducing the effect of Medicaid "spenddown". In order to implement this option, an appropriation of \$1.9 million would be needed, of which \$538,300 would be from the General Fund.

Medicaid Rate Increases

Many providers of Medicaid services do not get automatic inflationary increases, despite the fact that their costs are increasing. Reimbursement rates have a significant effect on access, since some providers will not accept Medicaid recipients due to the level of reimbursement rates. By increasing those reimbursement rates, the issue of access to services is lessened. The Department is requesting that the following three providers be considered for rate adjustments:

- ▶ Dentists \$250,000 total, \$69,600 General Fund
- ▶ Physicians \$1,771,000 total, \$493,000 General Fund
- ▶ Ambulance providers \$1,652,000 total, \$459,900 General Fund

The Analyst recommends that the reimbursement rates for these providers be considered by the Subcommittee as items to be requested for additional funding.

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 tightened the eligibility restrictions in the Utah Medical Assistance Program (UMAP), due to budget restraints, which had the effect of reducing services to certain individuals who have previously been eligible to receive UMAP services. The Department notified the Chairs of the Executive Appropriations Committee as well as the Fiscal Analyst of the proposed reduction.

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 \$2.87 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 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.

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 2002, the FMAP is projected at 70.36 percent, which means that for each Medicaid dollar of expenditure, the State provides 29.64 cents, with the federal government picking up the remaining 70.36 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.

| 2000 FEDERAL MONTHLY POVERTY LEVELS | | | | |
|--|--------------------|--------------------------|--------------------|--------------------|
| <u>Family Size</u> | <u>100%</u> | <u>Annualized</u> | <u>133%</u> | <u>185%</u> |
| 1 | 696 | \$8,350 | \$928 | \$1,287 |
| 2 | 938 | 11,250 | 1,250 | 1,734 |
| 3 | 1,179 | 14,150 | 1,572 | 2,181 |
| 4 | 1,421 | 17,050 | 1,894 | 2,629 |
| 5 | 1,663 | 19,950 | 2,217 | 3,076 |
| 6 | 1,904 | 22,850 | 2,539 | 3,523 |
| 7 | 2,146 | 25,750 | 2,861 | 3,970 |
| 8 | 2,388 | 28,650 | 3,183 | 4,417 |
| 9 | 2,629 | 31,550 | 3,505 | 4,864 |
| 10 | 2,871 | 34,450 | 3,828 | 5,311 |

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.

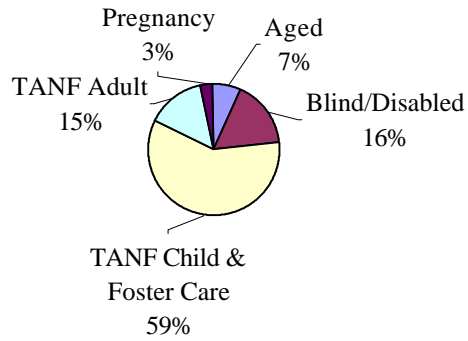
Much of the effort in the Medicaid program over the past several years has been toward moving eligibles who live in the populated Wasatch front counties from the traditional "fee-for-service" providers to managed care, or health maintenance organizations (HMOs). The purpose behind this effort is to provide more cost-effective health care. It is estimated that approximately 97 to 100 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.

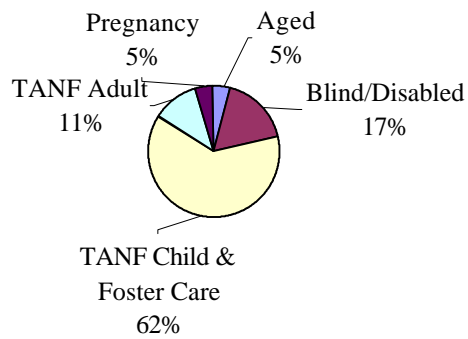
The distribution of FY 2000 Medicaid eligibles, recipients, and expenditures for each group are shown in the following charts.

Medicaid Eligibles

Medicaid Eligibles - Fee for Service

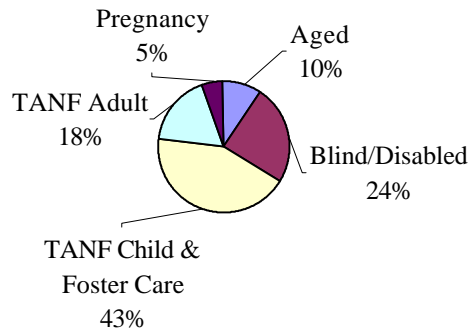


Medicaid Eligibles - HMOs

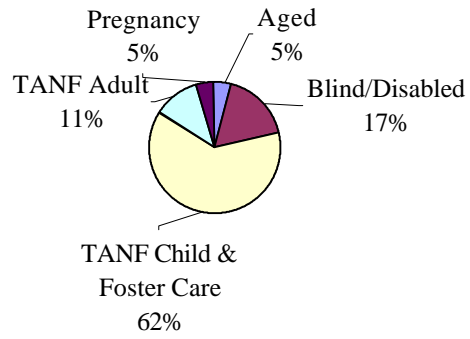


Medicaid Recipients

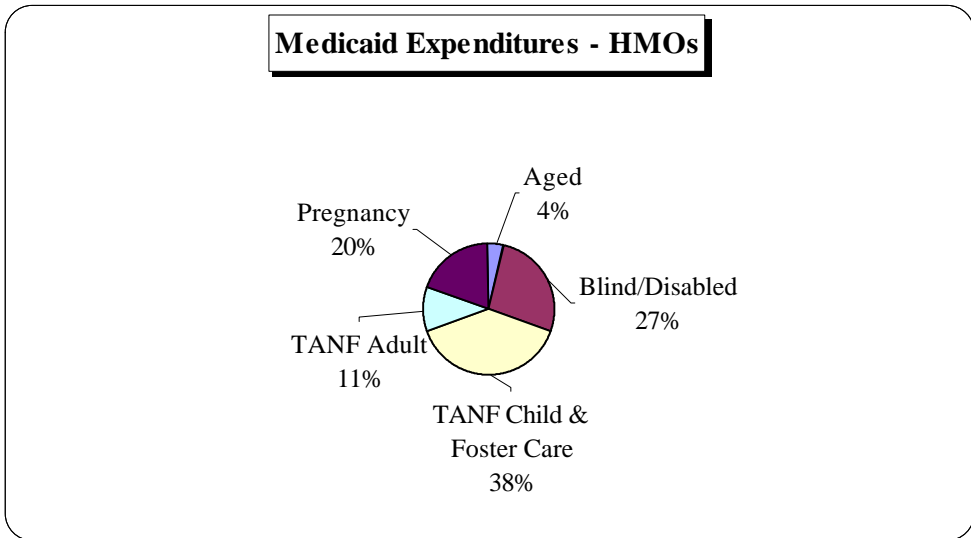
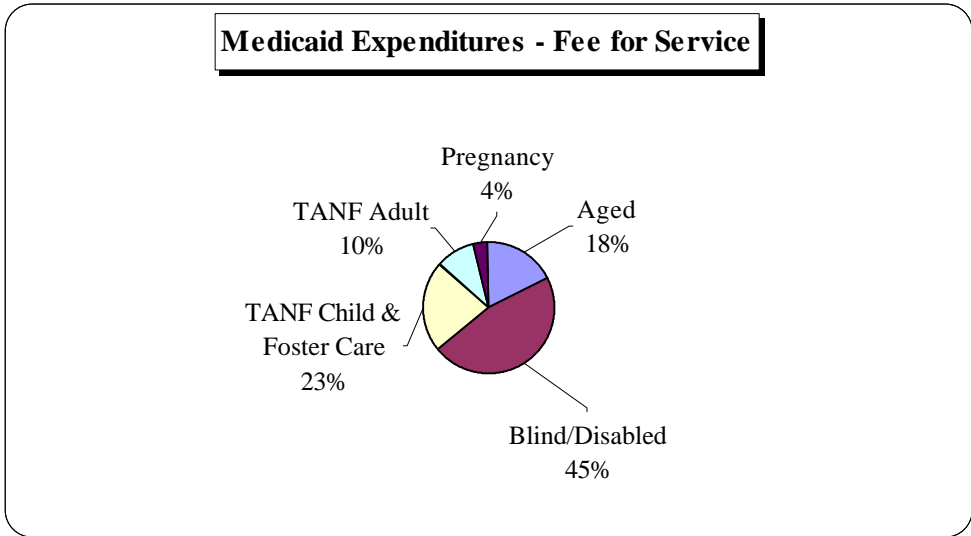
Medicaid Recipients - Fee for Service



Medicaid Recipients - HMOs



Medicaid Expenditures



FY 2001 Medicaid Funding

The 2000 Legislature increased funding for FY 2001 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 \$44.2 million, with \$12.3 million from the General Fund. In addition, the Legislature's funding covered an additional 20 children who are medically-fragile and technology-dependent.

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 2000, there was an average number of 10,843 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, outside of nursing facility services, 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 November 30, 2000, there were 7,663 nursing facility beds which were certified, with a census of 5,688 as shown in the following table.

| Nursing Facility Beds | | |
|------------------------------|--------------|--------|
| Private Pay | 1,475 | 25.93% |
| VA Contract | 46 | 0.81% |
| Part VA Contract | 11 | 0.19% |
| Medicaid | 3,408 | 59.92% |
| Medicare | 748 | 13.15% |
| Total | 5,688 | |
| Total Certified Beds | 7,633 | |
| Percent Occupancy | 74.52% | |

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 total number of blind and/or disabled individuals as of June 30, 2000 was 29,878. 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 just over 20 percent of recipients. In FY 2000, this group accounted for over 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 the Mentally Retarded (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 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 82 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 290. 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 88 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 2000 was approximately \$43,435, 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-related programs account for approximately 60 percent of all eligible persons in Medicaid, 53 percent of Medicaid recipients, and 26 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 eligibles during FY 2000 was 120,071.

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 (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 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 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. The 2001 Legislature will consider the final phase of this program – covering 18-year-old children. 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. 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 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 2000, the Pregnancy Program had a caseload of approximately 6,374. During FY 2000, the caseload averaged around 6,955.

3.2 Medical Assistance-Title XIX Funding for Human Services

Recommendation The Analyst recommends an appropriation of \$136,211,000 for the Title XIX funding for services provided by the Department of Human Services. This funding level is the same as the FY 2001 estimated levels. There is no General Fund in this appropriation.

| | 2000 | 2001 | 2002 | Est/Analyst |
|-------------------------|----------------------|----------------------|----------------------|--------------------|
| Financing | Actual | Estimated | Analyst | Difference |
| Federal Funds | 97,540,674 | 97,486,600 | 97,486,600 | |
| Transfers | 38,670,294 | 38,724,400 | 38,724,400 | |
| Total | <u>\$136,210,968</u> | <u>\$136,211,000</u> | <u>\$136,211,000</u> | <u>\$0</u> |
| Expenditures | | | | |
| Other Charges/Pass Thru | 136,210,968 | 136,211,000 | 136,211,000 | |
| Total | <u>\$136,210,968</u> | <u>\$136,211,000</u> | <u>\$136,211,000</u> | <u>\$0</u> |
| FTE/Other | | | | |

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, 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. 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 \$7,447,300 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.

| | 2000 | 2001 | 2002 | Est/Analyst |
|---------------------------|--------------------|--------------------|--------------------|--------------------|
| | Actual | Estimated | Analyst | Difference |
| Financing | | | | |
| General Fund | 3,297,100 | 3,414,500 | 3,494,700 | 80,200 |
| General Fund, One-time | 2,800 | | | |
| Federal Funds | 1,641,064 | 1,305,200 | 1,101,600 | (203,600) |
| Dedicated Credits Revenue | 2,705,139 | 1,344,900 | 1,396,200 | 51,300 |
| GFR - Medicaid Restricted | 500,000 | | | |
| Transfers | (243,579) | 1,396,600 | 1,454,800 | 58,200 |
| Lapsing Balance | 1 | | | |
| Total | \$7,902,525 | \$7,461,200 | \$7,447,300 | (\$13,900) |
| Expenditures | | | | |
| Personal Services | 2,255,184 | 2,388,269 | 2,351,000 | (37,269) |
| In-State Travel | 7,796 | 3,900 | 3,900 | |
| Out of State Travel | 1,833 | 800 | 800 | |
| Current Expense | 352,764 | 605,153 | 486,800 | (118,353) |
| DP Current Expense | 3,316 | 3,600 | 3,600 | |
| Capital Outlay | 7,638 | | | |
| Other Charges/Pass Thru | 5,273,994 | 4,459,478 | 4,601,200 | 141,722 |
| Total | \$7,902,525 | \$7,461,200 | \$7,447,300 | (\$13,900) |
| FTE/Other | | | | |
| Total FTE | 45 | 61 | 61 | |

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 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.

UMAP operates four medical and six 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 2000, the clinics registered over 43,400 patient encounters. The value of the medical and dental services totaled \$2,432,900. Of the \$2.4 million in services, approximately \$256,200 was donated by volunteer physicians/chiropractors and dentists. In addition, the medical clinics received over \$167,800 in donated goods.

UMAP has an enrollment of approximately 8,800 persons, of which 6,340 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.

UMAP Inflation

UMAP faces the problem of medical inflation, which is considerably higher than regular consumer inflation. The program has not received any increased funding since 1987. The requested amount, while not funded in the Analyst's recommendation, would help this problem. The amount is \$380,400, from the General Fund.

**UMAP Utilization/
Caseload Growth**

Similar to the Utilization/Caseload Growth issues in Medicaid, UMAP is experiencing more requests for services and coverage for more recipients. The suggested amount is \$187,900.

**UMAP – Rate
Increase**

Like the Medicaid service providers, UMAP providers are experiencing increased costs. Both private physicians and private ambulance carriers have requested adjustments in the UMAP reimbursement rates, similar to the Medicaid increases. The Department is requesting, that the following rate adjustments be considered:

- ▶ Physicians \$142,300 General Fund
- ▶ Ambulance providers \$26,200 General Fund

4.0 Additional Information: Medical Assistance

4.1 Funding History

| | 1998 | 1999 | 2000 | 2001 | 2002 |
|-------------------------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| Financing | Actual | Actual | Actual | Estimated | Analyst |
| General Fund | 133,317,800 | 136,852,600 | 144,994,700 | 156,523,400 | 162,303,600 |
| General Fund, One-time | | | 2,800 | | |
| Federal Funds | 479,124,916 | 527,797,470 | 558,182,411 | 596,381,053 | 578,037,700 |
| Dedicated Credits Revenue | 32,173,717 | 54,067,818 | 39,528,755 | 40,875,200 | 40,926,500 |
| GFR - Hosp Provider Assess | | 3,500,000 | 1,345,500 | | |
| GFR - Medicaid Hospital Provider | 6,335,900 | | | | |
| GFR - Medicaid Restricted | 1,750,000 | 3,439,000 | 5,400,200 | 7,241,200 | |
| GFR - Nursing Facility | 3,681,700 | 4,244,800 | 4,212,900 | 4,390,500 | 4,390,500 |
| Transfers | 33,894,858 | 26,486,206 | 51,894,950 | 53,712,600 | 53,770,800 |
| Beginning Nonlapsing | 49,850 | 134,529 | 134,529 | 339,347 | |
| Closing Nonlapsing | (134,529) | (134,529) | (339,347) | | |
| Lapsing Balance | (8,042,375) | (970,831) | (212,363) | | |
| Total | \$682,151,837 | \$755,417,063 | \$805,145,035 | \$859,463,300 | \$839,429,100 |
| Programs | | | | | |
| Medicaid Base Program | 572,021,470 | 627,421,087 | 661,031,542 | 715,791,100 | 695,770,800 |
| Title XIX for Human Services | 103,321,252 | 121,061,099 | 136,210,968 | 136,211,000 | 136,211,000 |
| Utah Medical Assistance Program | 6,809,115 | 6,934,877 | 7,902,525 | 7,461,200 | 7,447,300 |
| Total | \$682,151,837 | \$755,417,063 | \$805,145,035 | \$859,463,300 | \$839,429,100 |
| Expenditures | | | | | |
| Personal Services | 1,841,820 | 1,991,755 | 2,255,184 | 2,388,269 | 2,351,000 |
| In-State Travel | 2,357 | 4,270 | 7,796 | 3,900 | 3,900 |
| Out of State Travel | 853 | 768 | 1,833 | 800 | 800 |
| Current Expense | 418,575 | 391,928 | 352,764 | 605,153 | 486,800 |
| DP Current Expense | 6,105 | 380 | 3,316 | 3,600 | 3,600 |
| Capital Outlay | | | 7,638 | | |
| Other Charges/Pass Thru | 679,882,127 | 753,027,962 | 802,516,504 | 856,461,578 | 836,583,000 |
| Total | \$682,151,837 | \$755,417,063 | \$805,145,035 | \$859,463,300 | \$839,429,100 |
| FTE/Other | | | | | |
| Total FTE | 37 | 52 | 45 | 61 | 61 |

4.2 Federal Funds

| Program | | FY 2000 Actual | FY 2001 Estimated | FY 2002 Analyst |
|--------------------------------------|-----------------------------|---------------------------|------------------------------|----------------------------|
| Medicaid Base Program | Federal | \$458,263,906 | \$496,852,453 | \$478,712,700 |
| Title XIX Medicaid | Required State Match | 202,030,869 | 218,201,847 | 210,621,300 |
| | Total | 660,294,775 | 715,054,300 | 689,334,000 |
| Medicaid Base Program | Federal | 736,767 | 736,800 | 736,800 |
| Medicaid Administration | Required State Match | | | |
| | Total | 736,767 | 736,800 | 736,800 |
| Title XIX Funding for Human Services | Federal | 97,540,674 | 97,486,600 | 97,486,600 |
| Title XIX Medicaid | Required State Match | 38,670,294 | 38,724,400 | 38,724,400 |
| | Total | 136,210,968 | 136,211,000 | 136,211,000 |
| Utah Medical Assistance Program | Federal | 1,641,064 | 1,305,200 | 1,101,600 |
| Title XIX Medicaid | Required State Match | 6,261,462 | 6,156,000 | 6,277,400 |
| | Total | 7,902,526 | 7,461,200 | 7,379,000 |
| | Federal | 558,182,411 | 596,381,053 | 578,037,700 |
| | Required State Match | 246,962,625 | 263,082,247 | 255,623,100 |
| | Total | \$805,145,036 | \$859,463,300 | \$833,660,800 |

4.3 Definitions: Medical Assistance Categories of Service

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| 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. |

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| 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 waived 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. |

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| 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. |

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| 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: <ol style="list-style-type: none">1.Certified Registered Nurse Anesthetists (CRNA)2.Certified Registered Nurse Midwives (CNM)3.Certified Family Nurse Practitioners (CFNP) |

4.Certified Pediatric Nurse Practitioners (CPNP)

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| 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. |