

Office of the
Legislative Fiscal Analyst

FY 2003 Budget Recommendations

Joint Appropriations Subcommittee for
Health and Human Services

Utah Department of Health
Medical Assistance

Contents:

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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.

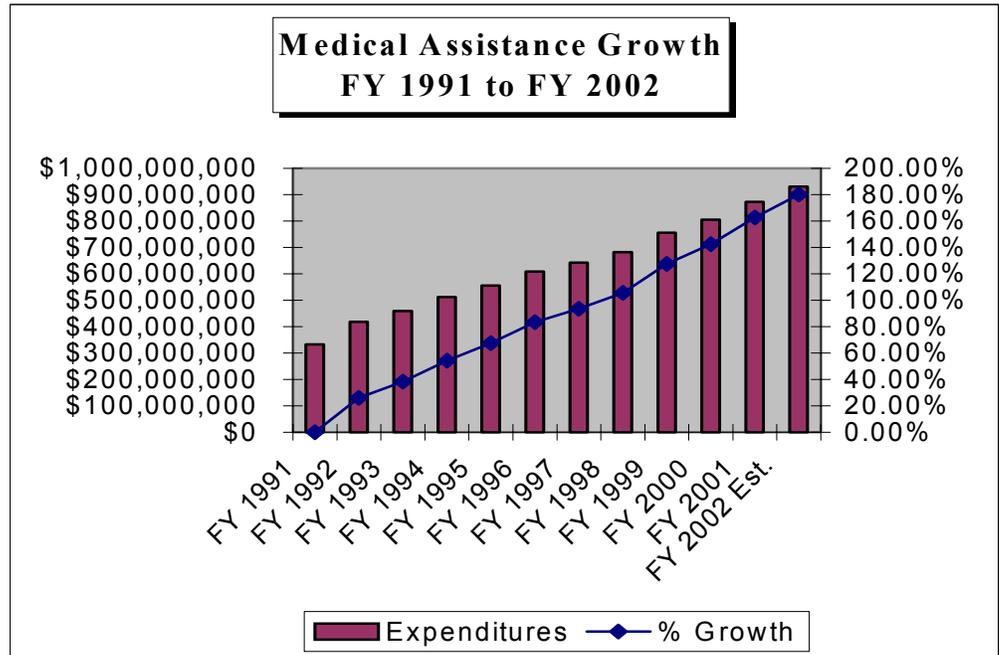
Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who qualify for the Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which 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 2003 of \$910,358,500. The General Fund portion of the recommendation is \$182,781,700.

	Analyst FY 2003 Base	Analyst FY 2003 Changes	Analyst FY 2003 Total
Financing			
General Fund	187,784,000	(5,002,300)	182,781,700
Federal Funds	628,514,400	(6,746,000)	621,768,400
Dedicated Credits Revenue	42,491,900		42,491,900
GFR - Medicaid Restricted	2,601,600	(2,601,600)	
Transfers	61,216,500	2,100,000	63,316,500
Total	\$922,608,400	(\$12,249,900)	\$910,358,500
Programs			
Medicaid Base Program	765,003,400	(12,256,100)	752,747,300
Title XIX for Human Services	150,726,600		150,726,600
Utah Medical Assistance Program	6,878,400	6,200	6,884,600
Total	\$922,608,400	(\$12,249,900)	\$910,358,500
FTE/Other			
Total FTE	63.99		63.99

The Analyst's total recommendation for FY 2003 represents a decrease of 2.1 percent when compared to the original FY 2002 estimated level of expenditures. When compared with the revised FY 2002 level, including the supplemental budget reductions, the decrease is 1.5 percent. The following chart shows the growth in expenditures for Medical Assistance from FY 1991 through FY 2002.



2.0 Issues: Medical Assistance

2.01 Original Governor's Holdbacks

Early in FY 2002, the Governor identified \$1,387,200 in ongoing General Fund reductions. However, the Executive Appropriations Committee approved restoring one-time funding for the Medicaid provider inflation cuts in the Governor's holdback, only \$1,088,000 in reductions actually carried forward to the FY 2003 budget year. Therefore, the Analyst has included the balance of \$299,200 as incremental reductions for this budget.

General Fund **(\$299,200)**

2.02 Across-the-Board Reductions

The Analyst has included 10 percent across the board decreases in the General Fund in the following expense categories: Conventions / Workshops, Data Processing, Entertainment / Receptions, Office supplies / Equipment, and Travel. For the Medical Assistance budget, these General Fund reductions total \$11,100.

General Fund **(\$11,100)**

2.03 Medical Assistance Reductions

Medicaid and the Division of Health Care Financing make up over 87 percent of the Department's General Fund budget. It would be impossible to take the Department's necessary reductions from the remaining 13 percent. The Analyst has identified several areas which could be changed to achieve savings in the Medicaid program. These changes include limiting the number of prescriptions dispensed on a monthly basis, decreasing the reimbursement rates for prescriptions, implementing a copay for some services, and eliminating chiropractic and other optional Medicaid services. The total for Medicaid reductions and adjustments is \$4,692,000.

General Fund **(\$4,692,000)**

2.04 Potential Revenue Enhancements

The Analyst has identified an additional \$2.1 million potential revenue offset to proposed reductions from accessing a newly-available increase in disproportionate share (DSH) payments by contracting with the University of Utah Hospital. Currently, the University of Utah Hospital provides a significant amount of “uncompensated” care. The Federal government allows a higher Medicaid reimbursement rate for those institutions that provide a “disproportionate share” of uncompensated care. The University of Utah Hospital would transfer \$3.5 million to the Department of Health, which would use \$2.1 million to offset the reductions, then with the remaining \$1.4 million, draw down \$3.4 million in Federal Funds, totaling \$4.8 million that would be paid back to the University Hospital in the form of higher reimbursement rates for Medicaid services. Utilizing this funding mechanism frees up that much in General Fund to go toward the overall shortfall and allows the associated programs to operate at levels which otherwise would be much lower. It also increases the reimbursement to the University of Utah Hospital.

Transfers **\$2,100,000**

2.05 Administrative Cost Intent Language

The 2001 Legislature approved the following intent language to be implemented by this division:

It is the intent of the Legislature that the budget analysis for the Department of Health be presented with a breakdown between costs of administration and services delivered and the number of citizens served and categorized by cost and type of service.

The Department reports that the Medicaid budget is 17 percent indirect services, and 83 percent direct services. The following table shows the allocation of costs between administrative, indirect services, and direct services.

MEDICAL ASSISTANCE				
ADMINISTRATIVE and SERVICE COSTS				
FY 2001 Authorized Costs				
	<u>Admin- istration</u>	<u>Indirect Services</u>	<u>Direct Services</u>	<u>Total</u>
Medical Assistance Base			714,290,223	714,290,223
	0.0%	0.0%	100.0%	
Title XIX Human Services	0	150,726,600	0	150,726,600
	0.0%	100.0%	0.0%	
UMAP	110,639	0	6,913,854	7,024,493
	1.6%	0.0%	98.4%	
Total	110,639	150,726,600	721,204,077	872,041,316
	0.0%	17.3%	82.7%	

Source: Department of Health

2.06 Medicaid Program Intent Language

The Legislature included the following intent language in the FY 2002 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 began reducing services early in the fiscal year. Because the directive came from the Governor's office and because of the significant amount of publicity, no further notification was made.

It is the intent of the Legislature that supplemental funds appropriated for the Utah Medical Assistance Program be considered nonlapsing.

The purpose of this intent was to allow supplemental FY 2001 funding to be utilized in FY 2002. This was done by the Department.

It is the intent of the Legislature that all pharmacy rebate monies received by the Medical Assistance Program be used to fund the Medical Assistance Program and the Utah Medical Assistance Program, and be considered nonlapsing.

The purpose of this intent was to provide documentation to the Division of Finance that the pharmacy rebates were to remain in the Medicaid program.

2.07 FY 2002 One-time General Fund Appropriation

During the 2001 General Session, the Legislature approved a one-time funding appropriation of \$117,500 for a newly-approved federal program to cover breast and cervical cancer screenings in the Medicaid program. This program has been going for six months and has assisted 40 women with screenings. With one-time FY 2002 funding, the program, if not funded again for FY 2003, will not continue past the end of the current fiscal year. The Analyst recommends that the Subcommittee consider this funding in its priority process.

2.08 FY 2002 One-time Medicaid Restricted Appropriation

For the past several years, a portion of the State's funding for the Medicaid program has been appropriated from the General Fund Restricted – Medicaid Restricted 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. Last year, the Legislature appropriated \$5.7 million of on-going General Fund to replace the funding from the Medicaid Restricted Account. Then, in the final days of the 2001 General Session, \$500,000 was appropriated to the Medicaid program for the Disabled Individuals Return to Work initiative which benefits approximately 152 individuals, and \$110,000 was appropriated to the UMAP program for inflationary and caseload increases. If the Legislature wishes to make these programs ongoing, the \$610,000 would need to be replaced with General Fund. The replacement keeps the programs whole, while providing them with ongoing state funding. This General Fund replacement is not part of the Analyst's funded recommendation.

2.09 Medicaid - Critical Funding Issues

Each year, several items are traditionally funded by the Legislature, since the federal government mandates that they be funded. They are not, however, included in the Analyst's recommendation for FY 2003. These three items include:

- ▶ **Federal Match rate change** – In the past, the federal match rate change has been reduced, requiring an offsetting increase in the General Fund to maintain the program at current levels. For FY 2003, however, the Center for Medicare and Medicaid Services (CMS, formerly Health Care Financing) recalculated the federal match rate and determined that the rate for Utah should actually increase. This means that the federal government will pay a slightly larger portion of the costs than during FY 2002. In the past, when the rate decreased, the State had to increase the General Fund just to keep the program at the same level. For FY 2003, with the rate increasing, the State can reduce its General Fund contribution, while still maintaining the program at its current level. The projected amount of General Fund savings is \$3,886,900. In the past, the General Fund increase has not been included in the Analyst's recommendation; for FY 2003 the decreased General Fund requirement is not as well.
- ▶ **Inflationary Increases** – Federal regulations require funding to increase to cover increased costs in certain specific categories of service. The total projected amount is \$47,577,700, of which, \$13,005,400 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 \$40,922,600, of which \$11,186,300 would be General Funding support.

The net total for these increases is \$88,500,300; the total General Fund required is \$20,304,800. 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. The Analyst recommends that these items be considered for additional funding on the Subcommittee's prioritization list.

3.1 Medical Assistance - Medicaid Base Program

Recommendation The Analyst recommends an appropriation of \$752,747,300 for the Medicaid Base Program for FY 2003. The recommendation requires \$179,405,900 from the General Fund, which, with the other sources of revenue, is matchable by Federal funds in the amount of \$516,584,700.

Since Medicaid is a joint State/federal program, the federal government provides a major 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 2003, the federal medical assistance percentage (FMAP) for programs qualifying under Title XIX is projected to be 70.93 percent, meaning that for each Medicaid dollar of expenditure, the State provides 29.07 cents, with the federal government picking up the remaining 70.93 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 an overall 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 until FY 2002. The FMAP for FY 2003 is actually slightly higher than the FY 2002 rate.

Other Medicaid Funding Sources

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 has used funds from this account in the past for the funding of the Medicaid program. For FY 2002, the Legislature appropriated \$500,000 from this account to fund the Disabled Return to Work program. The balance in the Medicaid Restricted Account as of June 30, 2001 was \$5.8 million, less \$615,600 appropriated for FY 2002. The Legislature recently approved utilizing an additional \$2.6 million from the account to cover FY 2002 budget shortfalls.

Legislation was approved several years ago, which imposed assessments on hospitals and nursing facilities, then utilized those funds as "State" funds in order to draw down, or match the federal funds at the nearly three-to-one match rate. The assessment on hospitals was repealed three years ago; the assessment on nursing facilities was repealed last year. In both cases, the General Fund replaced the assessments, so that the Medicaid program remained whole.

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.

	2001	2002	2003	Est/Analyst
	Actual	Estimated	Analyst	Difference
Financing				
General Fund	153,177,300	186,120,100	179,405,900	(6,714,200)
General Fund, One-time		(5,157,400)		5,157,400
Federal Funds	484,501,241	524,040,485	516,584,700	(7,455,785)
Dedicated Credits Revenue	40,837,712	41,611,000	41,611,000	
GFR - Medicaid Restricted	7,241,200	3,101,600		(3,101,600)
GFR - Nursing Facility	4,390,500			
Transfers	24,116,270	13,045,700	15,145,700	2,100,000
Beginning Nonlapsing	339,347	339,300		(39,300)
Closing Nonlapsing	(339,347)			
Lapsing Balance	26,000			
Total	<u>\$714,290,223</u>	<u>\$763,100,785</u>	<u>\$752,747,300</u>	<u>(\$10,353,485)</u>
Expenditures				
DP Current Expense		(7,700)	(7,700)	
Other Charges/Pass Thru	714,290,223	763,108,485	752,755,000	(10,353,485)
Total	<u>\$714,290,223</u>	<u>\$763,100,785</u>	<u>\$752,747,300</u>	<u>(\$10,353,485)</u>
FTE/Other				

Federal Match Rate Change

The federal government computes the Federal Match Rate annually. In the past, the match rate has decreased each year. When it has decreased, the Legislature then has increased the General Fund allocation in order to keep the Medicaid program at a constant level. Last year, for example, the Legislature approved an additional \$6.6 million to cover a \$6.8 million reduction of federal funds. For the first time in recent years, the match rate is going to increase slightly in FY 2003. This means that for the same program level, the federal government will contribute a slightly larger percentage. In the past, the Legislature has funded the loss with new General Fund. For FY 2003, there will be excess General Funds, so that amount can be reduced or applied to the other increases. For FY 2003, the Analyst projects the excess General Fund at \$3,886,900. This is simply a switch in the funding ratio and does not affect the level of services or the number of recipients covered. In years past, when Medicaid needed additional funds for the match rate change, the funding switch was not included in the Analyst’s recommendation. Now when the General Fund base is higher than it needs to be, it is also not included in the Analyst’s recommendation, which gives the Subcommittee some latitude in FY 2003 budget deliberations.

**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 Analyst projects an average inflationary increase of 4.5 percent, estimated at \$47,577,700 (\$13,005,400 from the General Fund). It is interesting to note that with the exception of Pharmacy Services, all of the other increases are projected at 4-6 percent. The increase for Pharmacy Services is projected at 12 percent and will cost \$13 million. This reflects the continuing escalation of prescription drugs prices.

**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 the total Medicaid population is using Medicaid services more often. The projected amount for FY 2003 is \$40,922,600, of which \$11,186,300 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 large percentage increases include Ambulatory Surgical, Pharmacy, and Rural Health. 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 7 percent, at a cost of \$7.6 million.

**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 rely heavily on federal funds under Title XIX of the Social Security Act, while UMAP is funded with State funds only. For FY 2003, the FMAP is projected at 70.57 percent, which means that for each Medicaid dollar of expenditure,

the State provides 29.43 cents, with the federal government picking up the remaining 70.57 cents. The State utilizes various funding streams (dedicated credits and transfers) 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.

2001 FEDERAL POVERTY LEVELS			
<u>F a m i l y S i z e</u>	<u>100 %</u>	<u>133 %</u>	<u>185 %</u>
1	\$ 8,590	\$ 11,453	\$ 15,892
2	\$ 11,610	\$ 15,480	\$ 21,479
3	\$ 14,630	\$ 19,507	\$ 27,066
4	\$ 17,650	\$ 23,533	\$ 32,653
5	\$ 20,670	\$ 27,560	\$ 38,240
6	\$ 23,690	\$ 31,587	\$ 43,827
7	\$ 26,710	\$ 35,613	\$ 49,414
8	\$ 29,730	\$ 39,640	\$ 55,001
9	\$ 32,750	\$ 43,667	\$ 60,588
10	\$ 35,770	\$ 47,693	\$ 66,175

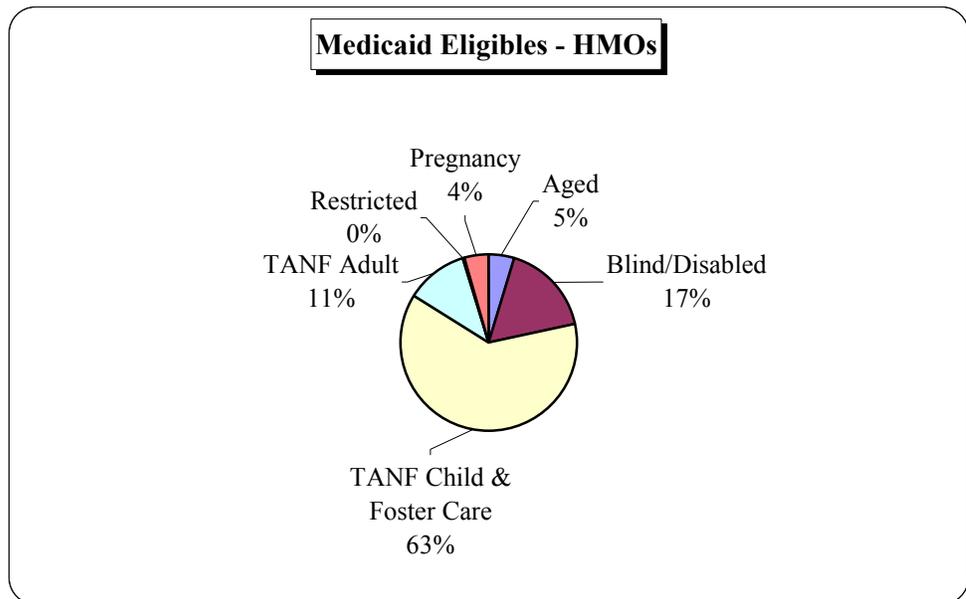
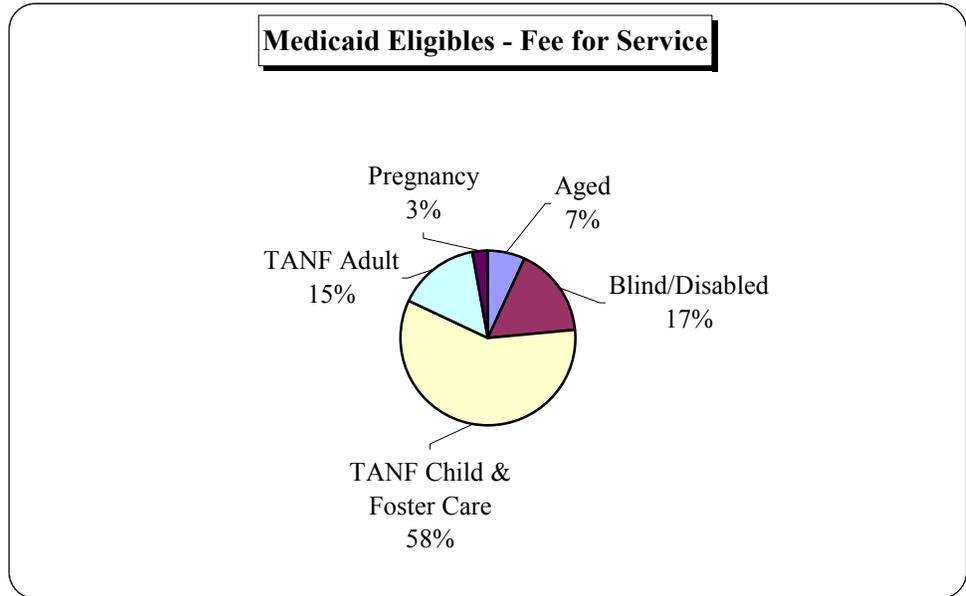
The state has designated five major population groupings that may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as Aged); (2) Blind and/or Disabled individuals; (3) Children who receive Temporary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

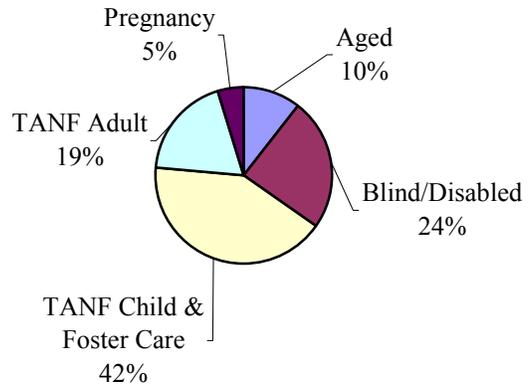
The distribution of FY 2001 Medicaid eligibles, recipients, and expenditures for each group are shown in the following charts.

Medicaid Eligibles

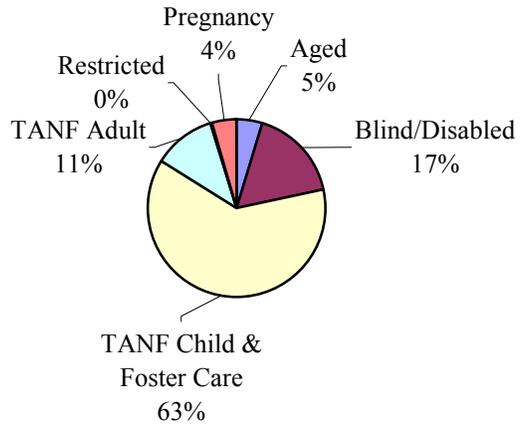


Medicaid Recipients

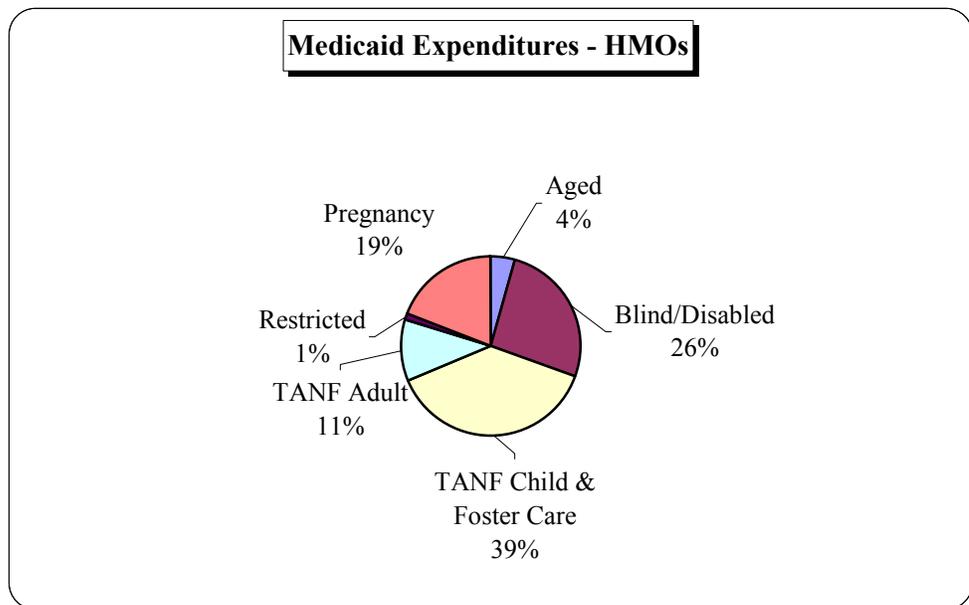
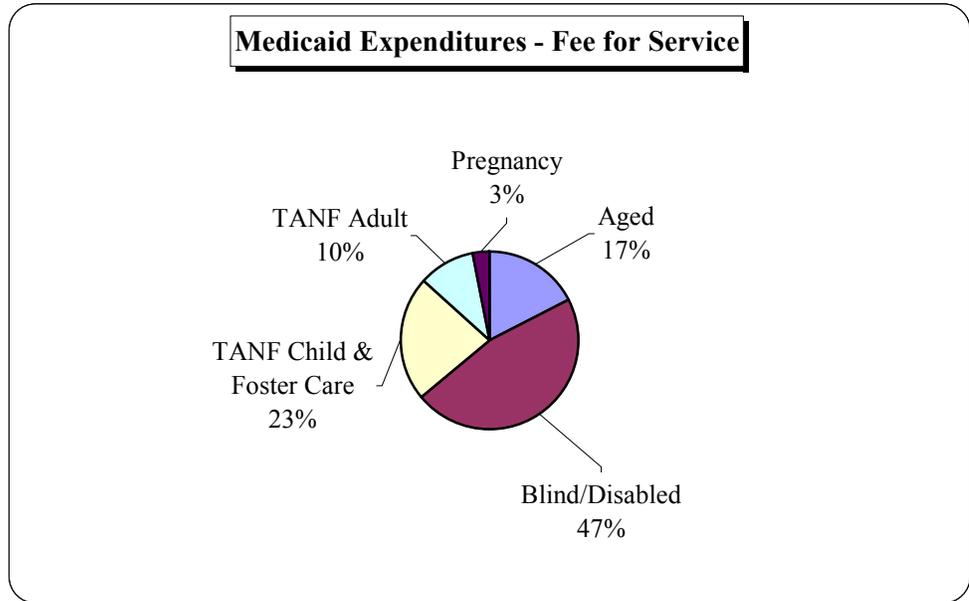
Medicaid Recipients - Fee for Service



Medicaid Recipients - HMOs



Medicaid Expenditures



FY 2002 Medicaid Funding

The 2001 Legislature increased funding for FY 2002 for the Medical Assistance budget to cover the reduction in the Federal funds match rate; inflation; utilization/caseload growth; 18-year olds under 100 percent of poverty; increase reimbursement rates for physicians, dentists, and ambulance providers; breast and cervical cancer screening, and the disabled “return to work” program. The total increase for these items was \$62 million, with \$27.4 million from the General Fund.

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 2001, there was an average number of 12,014 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, 2001, there were 7,560 nursing facility beds which were certified, with a census of 5,600 as shown in the following table.

Nursing Facility Beds		
Private Pay	1,341	23.95%
V A Contract	112	2.00%
Part V A Contract	2	0.04%
M edicaid	3,378	60.32%
M edicare	767	13.70%
T o t a l	5,600	
 Total Certified Beds	 7,560	
 Percent Occupancy	 74.07%	

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 receiving Medicaid services as of June 30, 2001 was 29,178. The 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 over 20 percent of recipients. In FY 2001, this group accounted for 42 percent of total Medicaid expenditures. Institutional care for disabled individuals is included in this category.

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

A special group of nursing facilities is Intermediate Care Facilities for people with Mental Retardation (ICF/MR). These facilities specialize in the care of people with disabilities. The individuals served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/MR are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs 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 private ICFs/MR is near 95 percent and near 80 percent at the USDC. 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 2001 was approximately \$45,990, which is a full-service program (including 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 2001 was 124,450.

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 2001, the Pregnancy Program had a caseload of approximately 6,620. During FY 2001, the caseload averaged around 6,919.

3.2 Medical Assistance - Title XIX Funding for Human Services

Recommendation The Analyst recommends an appropriation of \$150,726,600 for the Title XIX funding for services provided by the Department of Human Services. There is no General Fund in this appropriation.

	2001	2002	2003	Est/Analyst
	Actual	Estimated	Analyst	Difference
Financing				
Federal Funds	104,788,686	104,788,700	104,788,700	
Transfers	45,937,897	45,937,900	45,937,900	
Total	<u>\$150,726,583</u>	<u>\$150,726,600</u>	<u>\$150,726,600</u>	\$0
Expenditures				
Other Charges/Pass Thru	150,726,583	150,726,600	150,726,600	
Total	<u>\$150,726,583</u>	<u>\$150,726,600</u>	<u>\$150,726,600</u>	\$0
FTE/Other				

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

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

The General Fund for these services is appropriated to the various divisions of the Department of Human Services who then "seed" or purchase federal funds through the Division of Health Care Financing. The agencies seeding Medicaid are able to purchase more or less than the amounts appropriated depending on available General Fund, qualifying programs and clients, and the priorities of the program. 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 \$6,884,600 for the Utah Medical Assistance Program (UMAP).

Often, a recipient is deemed Medicaid eligible after services have been provided. When that happens, 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.

	2001	2002	2003	Est/Analyst
	Actual	Estimated	Analyst	Difference
Financing				
General Fund	3,414,500	3,579,800	3,375,800	(204,000)
General Fund, One-time	26,000	(40,400)		40,400
Federal Funds	595,039	395,000	395,000	
Dedicated Credits Revenue	821,934	880,900	880,900	
GFR - Medicaid Restricted	1,400,000	110,000		(110,000)
Transfers	2,061,178	2,242,200	2,232,900	(9,300)
Beginning Nonlapsing		1,268,200		(1,268,200)
Closing Nonlapsing	(1,268,158)			
Lapsing Balance	(26,000)			
Total	\$7,024,493	\$8,435,700	\$6,884,600	(\$1,551,100)
Expenditures				
Personal Services	2,489,308	2,721,300	2,776,400	55,100
In-State Travel	7,763	8,000	8,000	
Out of State Travel	422	100	(100)	(200)
Current Expense	434,054	199,500	209,400	9,900
DP Current Expense	5,895	5,700	5,600	(100)
Other Charges/Pass Thru	4,087,051	5,501,100	3,885,300	(1,615,800)
Total	\$7,024,493	\$8,435,700	\$6,884,600	(\$1,551,100)
FTE/Other				
Total FTE	61.00	63.49	63.99	0.50

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 2001, the medical clinics registered 20,744 patient encounters, while the dental clinics registered 19,005. The value of the medical and dental services totaled nearly \$3 million. Of the \$3 million in services, approximately \$43,400 worth of services were donated by volunteer physicians/chiropractors and dentists. In addition, the medical clinics received over \$270,600 in donated goods.

UMAP has an enrollment of approximately 8,350 persons, of which 5,702 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

	1999	2000	2001	2002	2003
	Actual	Actual	Actual	Estimated	Analyst
Financing					
General Fund	136,852,600	144,994,700	156,591,800	189,699,900	182,781,700
General Fund, One-time		2,800	26,000	(5,197,800)	
Federal Funds	527,797,470	558,182,411	589,884,966	629,224,185	621,768,400
Dedicated Credits Revenue	54,067,818	39,528,755	41,659,646	42,491,900	42,491,900
GFR - Hosp Provider Assess	3,500,000	1,345,500			
GFR - Medicaid Restricted	3,439,000	5,400,200	8,641,200	3,211,600	
GFR - Nursing Facility	4,244,800	4,212,900	4,390,500		
Transfers	26,486,206	51,894,950	72,115,345	61,225,800	63,316,500
Beginning Nonlapsing	134,529	134,529	339,347	1,607,500	
Closing Nonlapsing	(134,529)	(339,347)	(1,607,505)		
Lapsing Balance	(970,831)	(212,363)			
Total	\$755,417,063	\$805,145,035	\$872,041,299	\$922,263,085	\$910,358,500
Programs					
Medicaid Base Program	627,421,087	661,031,542	714,290,223	763,100,785	752,747,300
Title XIX for Human Services	121,061,099	136,210,968	150,726,583	150,726,600	150,726,600
Utah Medical Assistance Program	6,934,877	7,902,525	7,024,493	8,435,700	6,884,600
Total	\$755,417,063	\$805,145,035	\$872,041,299	\$922,263,085	\$910,358,500
Expenditures					
Personal Services	1,991,755	2,255,184	2,489,308	2,721,300	2,776,400
In-State Travel	4,270	7,796	7,763	8,000	8,000
Out of State Travel	768	1,833	422	100	(100)
Current Expense	391,928	352,764	434,054	199,500	209,400
DP Current Expense	380	3,316	5,895	(2,000)	(2,100)
Capital Outlay		7,638			
Other Charges/Pass Thru	753,027,962	802,516,504	869,103,857	919,336,185	907,366,900
Total	\$755,417,063	\$805,145,035	\$872,041,299	\$922,263,085	\$910,358,500
FTE/Other					
Total FTE	51.50	45.00	61.00	63.49	63.99

4.2 Federal Funds

Program		FY 2001 Actual	FY 2002 Estimated	FY 2003 Analyst
Medicaid Base Program	Federal	\$482,830,236	\$522,369,485	\$514,913,700
Title XIX Medicaid	Required State Match	152,344,436	185,378,694	185,306,200
	Total	635,174,672	707,748,179	700,219,900
Medicaid Base Program	Federal	1,671,005	1,671,000	1,671,000
Medicaid Administration	Required State Match	858,864	858,900	858,900
	Total	2,529,869	2,529,900	2,529,900
Title XIX Funding for Human Services	Federal	104,788,686	104,788,700	104,788,700
Title XIX Medicaid	Required State Match	0	0	0
	Total	104,788,686	104,788,700	104,788,700
Utah Medical Assistance Program	Federal	595,039	395,000	395,000
Title XIX Medicaid	Required State Match	3,096,969	3,425,262	3,187,615
	Total	3,692,008	3,820,262	3,582,615
	Federal	589,884,966	629,224,185	621,768,400
	Required State Match	156,300,269	189,662,856	189,352,715
	Total	\$746,185,235	\$818,887,041	\$811,121,115

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 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.

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: <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)

**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.