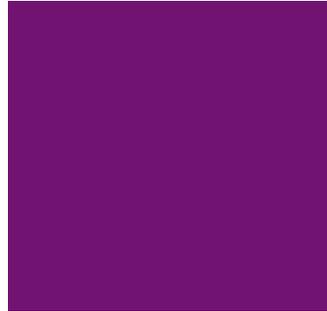


2013

Utah Annual Report of **Medicaid & CHIP**



**STATE FISCAL YEAR 2013
July 2012 - June 2013**

Utah Annual Report of Medicaid & CHIP



State Fiscal Year 2013

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State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

December 23, 2013

Dear Fellow Utahn:

It is my privilege to present to you the 2013 Medicaid and CHIP Annual Report of the Utah Department of Health. This report includes activities from July 2012 to June 2013.

Medicaid is a vital and essential part of Utah's health care infrastructure. During Fiscal Year (FY) 2013, approximately 383,000 Utah citizens turned to Medicaid for help in paying for hospital or nursing home care, physician care, lab tests, prescriptions and other medical services. However, Utah's Medicaid program is more than a vehicle for financing medical care.

- Medicaid ensures the health of Utah's children, with 66 percent of all Medicaid enrollees being children.
- More than 7,000 Utahns with disabilities living in our communities through the support of Medicaid's home and community based waivers, including 123 medically fragile children who are able to receive medical care in their homes rather than being placed in a care facility.
- Medicare premiums were paid for 28,467 low-income Utah seniors through the Medicaid cost-sharing program.
- 28,685 pregnant, low-income women received prenatal care to help ensure healthier birth outcomes.
- Approximately 300 children, ages 2 through 6, with an Autism Spectrum Disorder (ASD) receive in-home services using treatment methods proven effective for children with ASD.

In FY 2013, the number of eligible Medicaid enrollees grew, continuing a multi-year trend of increased eligible enrollees due to the national economic downturn. In the face of these enrollment pressures, Utah Medicaid has sought and implemented innovative practices in order to continue to respond to the health care needs of its citizens in a cost-effective manner, provide access to quality care, and seek to improve health outcomes through innovative initiatives.

The Department looks forward to the continued cooperation with the Governor's Office, the Legislature, the Medicaid provider community and the citizens. Together we can work to ensure Utah's Medicaid program manages its limited resources as efficiently and effectively as possible in order to provide health care services to Utah's most vulnerable populations.

Sincerely,

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing



■ DIVISION OF MEDICAID AND HEALTH FINANCING ■

2013 Division Highlights

Major Initiatives

ACCOUNTABLE CARE ORGANIZATIONS

- Implemented an Accountable Care Organization (ACO) model with the goal of slowing the growth of Medicaid costs, while improving client health outcomes, in response to concerns that the Utah Medicaid growth rate has historically exceeded the State's annual revenue growth rate. Approximately 73 percent of Medicaid clients are enrolled in an ACO. As part of the ACO implementation, the agency incorporated pharmaceutical coverage within the ACO model effective January 1, 2013.

MEDICAID AUTISM WAIVER

- Implemented the Medicaid Autism Waiver, which provided services to more than 300 children with an Autism Spectrum Disorder (ASD) ages 2 through 6, with outcomes from the first six months showing improved behaviors and skills.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) REPLACEMENT

- Contracted with CNSI and Cognosante to begin the process of replacing Utah's 30 year old legacy mainframe system. Over the next 5 years, the team will design, develop, implement and transition to a modern MMIS system with the goal of reducing fraud and abuse, improving health outcomes and delivering high quality health care services for Medicaid recipients, in the most cost effective way.

HEALTH CARE REFORM

- Worked with the Governor's Office to create a Medicaid Expansion Options Community Workgroup under the direction of the Utah Department of Health (DOH) Executive Director. In relation to Medicaid expansion, the workgroup, comprised of business, community and government leaders, legislators, advocates for low-income individuals and families, and other stakeholders from the health care industry, was charged with collecting input from the community, identifying and analyzing factors beyond financial considerations, and considering alternatives to full expansion or the status quo. Together the workgroup prepared and presented nine Medicaid expansion options for the Governor's consideration.
- Commissioned the Public Consulting Group (PCG) to produce a cost-benefit analysis to provide information for policy makers as they consider the pros and cons of potential expansion options for the State's Medicaid program under the Affordable Care Act (ACA).
- Led the DOH team that organized the Governor's Health Summit 2013.
- Supervised work on the State Innovation Models grant and helped staff the five workgroups that developed grant goals and action plans.
- Implemented the mandatory eligibility changes from the ACA. The agency also assisted the Department of Workforce Services in modifying eREP so that it would be compliant with new ACA eligibility rules.

Customer Service

- Answered more than 334,700 calls from Medicaid clients and providers by Medicaid customer service representatives.
- Processed 7.9 million claims.
- Received 730,700 calls through *AccessNow*, an automated eligibility line for providers to verify if their patients are enrolled in Medicaid.
- Enrolled 3,694 new providers (full enrollment); 1,186 providers with limited enrollment; and re-credentialed 6,151 providers.
- Provided education to 68,441 Medicaid enrollees and 20,344 CHIP enrollees on how to properly use their benefits.

- Handled more than 142,000 calls regarding enrollment in managed care.
- Processed more than 35,000 prior authorization requests.

IT and Data Security

- Implemented a real-time electronic Medicaid eligibility inquiry and response system for providers. The Health Insurance Portability and Accountability Act (HIPAA) standard mandates a (maximum) 20 second response.
- Implemented the Pharmacy Provider Portal which gives physicians increased capability to transact business with Medicaid electronically, such as submitting prescription prior authorizations, reviewing drug profile/history, verifying eligibility, and accessing drug formulary information.
- Obtained Centers for Medicare and Medicaid Services (CMS) certification for the agency's pharmacy point-of-sale system. Certification increases the federal reimbursement from 50 percent to 75 percent.
- Implemented real-time HIPAA standards, Version 5010, to be CMS compliant.
- Created and filled new compliance positions for Privacy and Security Officers.
- Completed the Division's Continuity of Operations Plan (COOP).

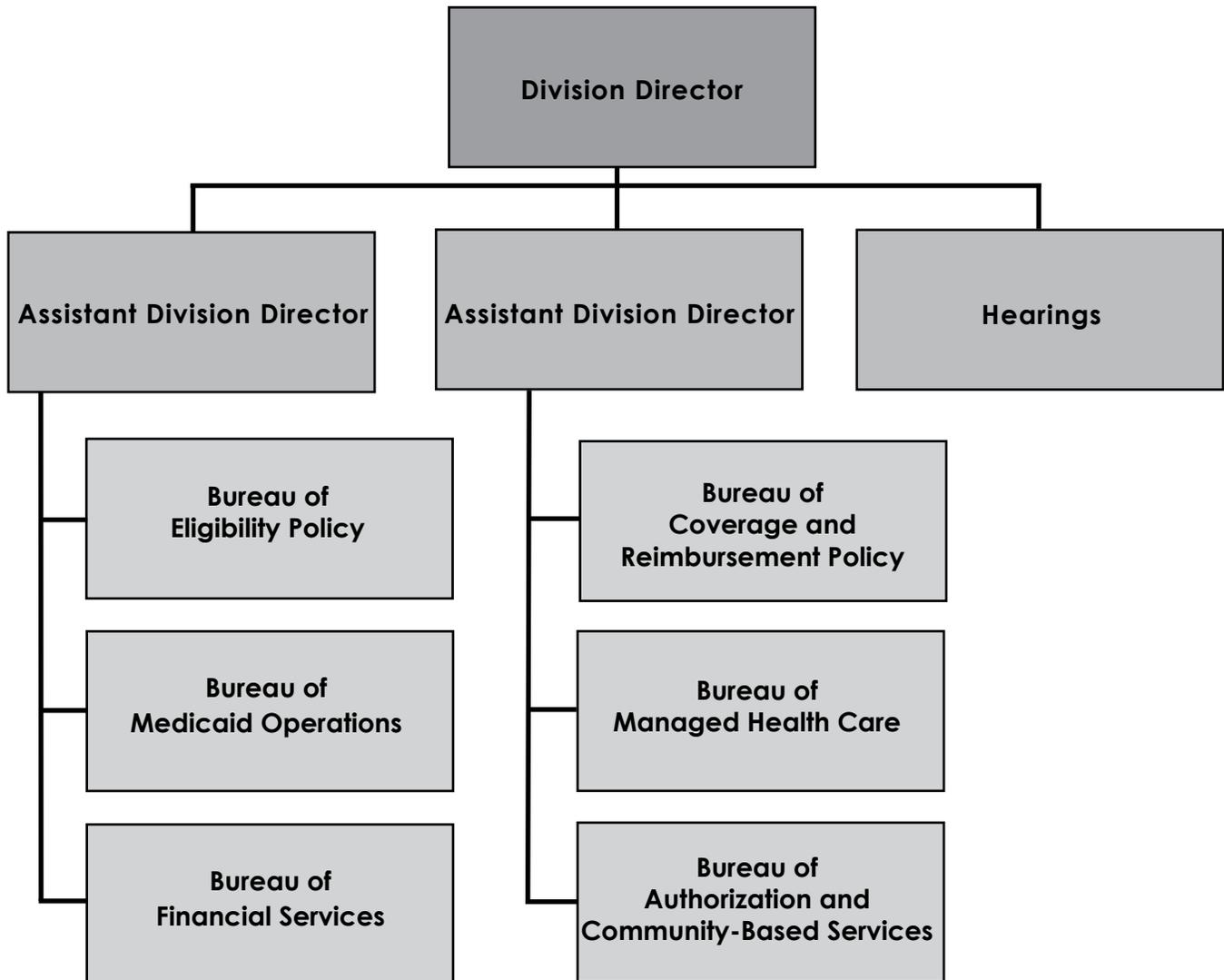
Service Delivery and Payment

- Worked with a contractor to perform the quarterly state maximum allowable cost (SMAC) and pharmaceutical pricing surveys. The Division also engaged in quarterly SMAC pricing updates which helped reduce the prices paid on certain drugs.
- Added 13 new drug classes to the Preferred Drug List (PDL), now totaling 83 classes on the PDL. These drug class additions, combined with savings from existing PDL classes are expected to generate annualized PDL savings of approximately \$44.5 million in state and federal funds with \$13.0 million in general funds.
- Implemented enhanced reimbursement, as required by the ACA, to qualifying physicians for certain Evaluation and Management, and vaccine codes. The enhancement raises Medicaid rates to Medicare rates.
- Incorporated substance use disorder services in capitated full risk managed care contracts.
- Worked with contracted actuaries to set certified rates for the eleven contracted mental health centers, as well as developed capitated rates for San Juan County, which was previously reimbursed fee-for-service.
- Worked with contracted actuaries to develop capitation rates for the ACOs for January 2013 and July 2013. Based on legislative changes to the Utah Hospital Assessment Act, the ACO rates were updated for April 2013.
- Submitted an application for a second Children's Health Insurance Program Reauthorization Act (CHIPRA) Performance Bonus based on enrollment simplification changes completed in 2012.
- Decreased the disability determination process to less than seven days response time.

Mission Statement

The mission of the Division of Medicaid and Health Financing is to provide access to quality, cost effective health care for eligible Utahns.

Organizational Chart



Division Overview

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) administers Medicaid and the Children's Health Insurance Program (CHIP) to provide medical, dental and behavioral health services to needy individuals and families throughout the State. DOH is designated as Utah's Single State Agency for Medicaid.

The administration of Medicaid and CHIP is accomplished through the office of the Division Director and six bureaus. The Division Director administers and coordinates the program responsibilities delegated to develop, maintain and administer the Medicaid program in compliance with Title XIX of the Social Security Act and CHIP in compliance with Title XXI of the Act, the laws of the state of Utah, and the appropriate budget. The Director's office manages and coordinates staff training and development, legacy MMIS projects, SharePoint workflows, security policies and procedures, as well as ACA reform initiatives. In addition, each bureau has the following responsibilities:

BUREAU OF FINANCIAL SERVICES

The objectives and responsibilities of this bureau include monitoring, coordinating and facilitating the Division's efforts to operate economical and cost-effective medical assistance programs. The bureau is responsible for coordinating and monitoring federally mandated financial control systems, including monitoring of the Medicaid, CHIP, Utah's Premium Partnership for Health Insurance (UPP), and Primary Care Network (PCN) programs, providers, and all third-party liability (TPL) activity. The bureau also performs budget forecasting and preparation, development of appropriation requests and legislative presentations, monitoring of medical assistance programs and administration of expenditures and federal reporting.

BUREAU OF MANAGED HEALTH CARE

The primary responsibility of this bureau is to administer all managed care federal waivers and contracts for both Medicaid and CHIP. In addition, the bureau is responsible for staff that provides education and assistance to Medicaid and CHIP beneficiaries regarding selection of managed care plans and appropriate use of Medicaid and CHIP benefits. In addition this bureau monitors the performance of and the quality of services provided by managed care organizations on behalf of Medicaid and CHIP. Managed care includes physical, mental and dental health services. In addition, the bureau is responsible for the oversight of the state's 1115 Primary Care Network Demonstration Waiver, the early periodic screening, diagnosis, and treatment (EPSDT) program that provides well-child health care, the Medicaid restriction program and the School Based Skills Development program. The bureau director also serves as the state CHIP Director.

BUREAU OF AUTHORIZATION AND COMMUNITY-BASED SERVICES

The general responsibilities of this bureau include policy formulation, interpretation and implementation planning of quality, cost-effective long-term care services that meet the needs and preferences of Utah's low-income citizens. In addition, the bureau is responsible for prior authorizations of Medicaid services not provided by managed care organizations on behalf of Medicaid and CHIP.

BUREAU OF MEDICAID OPERATIONS

This bureau's main objectives are to oversee the accurate and expeditious processing of claims submitted for covered services on behalf of eligible beneficiaries and the training of providers regarding allowable Medicaid expenditures and billing practices. The general responsibilities include processing, and adjudication of medical claims; publishing all provider manuals; and being the single point of telephone contact for information about client eligibility, claims processing, and general questions about the Medicaid program.

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY

The general responsibilities of this bureau include benefit policy formulation, interpretation, and implementation planning. This responsibility encompasses scope of service and reimbursement policy for Utah's Medicaid program.

The bureau also oversees the pharmacy program, drug utilization review, the Preferred Drug List, and maintains the State Plan.

BUREAU OF ELIGIBILITY POLICY

The primary responsibility of this bureau is to oversee eligibility determinations for Medicaid and CHIP. This includes: interpreting federal or state regulations and writing medical eligibility policy; providing timely disability decisions based on Social Security Disability criteria; monitoring the accuracy and timeliness of the Medicaid program by reviewing eligibility determinations under guidance from the Centers for Medicare and Medicaid Services (CMS); purchasing private health insurance plans for Medicaid recipients who are at high risk, which saves Medicaid program dollars, and monitoring for program accuracy.

Division Expenditures

Figure 1 shows a breakdown of DMHF FY 2013 expenditures. Medicaid mandatory and optional services comprise 92.5 percent of total expenditures, Medicaid administrative services account for 4.3 percent and CHIP administration and services for 3.2 percent.

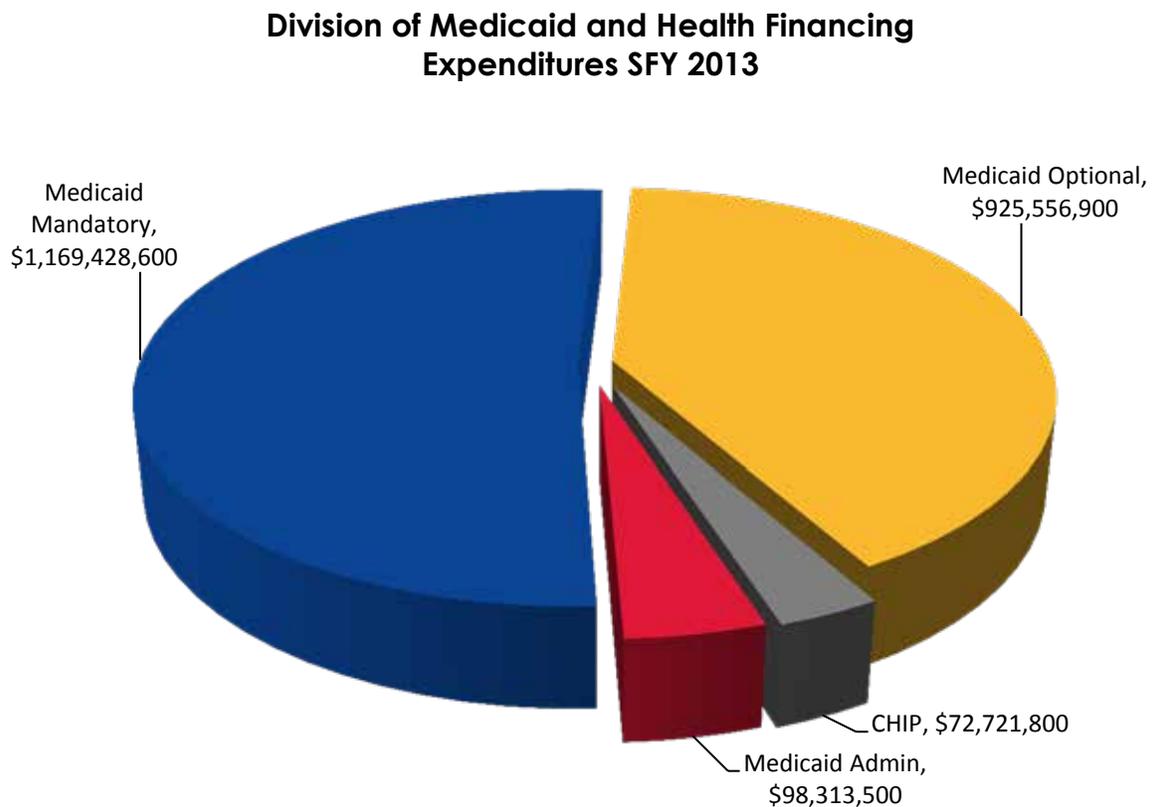


FIGURE 1

Table 1 breaks down the categories in Figure 1 by expenditure types. Approximately 98 percent of the DMHF expenditures are for pass-through charges. Specifically, pass-through charges are incurred for the provision of physical health, behavioral health, dental health and vision care services provided through contracted entities and administrative services provided by other state agencies. Personnel Services account for only one percent of total expenditures. Table 1 provides a break out of these expenditures for state fiscal years (SFY) 2009 to 2013.

Table 1: Division of Medicaid and Health Financing Expenditures SFY 2009 - SFY 2013

Category	Expenditure Type	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Medicaid Admin	Capital Expenditure	\$0	\$0	\$0	\$0	\$0
	Current Expense	\$8,030,800	\$6,336,200	\$4,202,400	\$6,132,600	\$4,824,900
	Data Processing Capital Expenditure	\$0	\$0	\$834,700	\$309,600	\$1,086,500
	Data Processing Current Expense	\$7,790,200	\$7,589,100	\$7,483,400	\$7,799,800	\$8,737,900
	Other Charges/Pass Through	\$81,324,100	\$70,078,300	\$77,942,600	\$67,512,400	\$68,543,700
	Personnel Services	\$17,434,100	\$16,255,300	\$13,814,300	\$14,268,100	\$15,034,000
	Travel/In State	\$69,600	\$32,000	\$20,500	\$23,700	\$24,100
	Travel/Out of State	\$70,700	\$16,000	\$21,600	\$28,900	\$30,400
	Admin Total	\$114,719,500	\$100,306,900	\$104,319,500	\$96,075,100	\$98,313,500
	Medicaid Mandatory	Capital Expenditure	\$0	\$0	\$0	\$72,000
Current Expense		\$881,400	\$3,271,100	\$2,137,900	\$3,154,800	\$4,490,100
Data Processing Current Expense		\$3,300	\$39,700	\$63,200	\$147,200	\$6,133,000
Other Charges/Pass Through		\$896,169,100	\$968,318,100	\$1,020,253,000	\$1,048,141,200	\$1,152,586,900
Personnel Services		\$1,681,100	\$4,985,300	\$5,018,300	\$4,273,600	\$6,153,400
Travel/In State		\$200	\$28,300	\$21,200	\$30,600	\$27,300
Travel/Out of State		\$0	\$0	\$6,200	\$1,500	\$19,200
Trust & Agency Disbursements		\$0	\$0	\$0	\$87,300	(\$3,700)
Mandatory Total	\$898,735,100	\$976,642,500	\$1,027,499,800	\$1,055,908,200	\$1,169,428,600	
Medicaid Optional	Current Expense	\$23,327,600	\$17,152,600	\$3,400,400	\$1,678,900	\$2,088,900
	Data Processing Current Expense	\$25,200	\$2,300	\$2,000	\$20,400	\$2,200
	Other Charges/Pass Through	\$798,176,900	\$789,965,200	\$837,575,600	\$911,658,700	\$923,136,700
	Personnel Services	\$2,998,900	\$114,700	\$392,700	\$119,600	\$308,000
	Travel/In State	\$31,300	\$800	\$0	\$0	\$1,700
	Travel/Out of State	\$300	\$1,200	\$2,000	\$17,200	\$19,400
Optional Total	\$824,560,200	\$807,236,800	\$841,372,700	\$913,494,800	\$925,556,900	
Medicaid Total	\$1,838,014,800	\$1,884,186,200	\$1,973,192,000	\$2,065,478,100	\$2,193,299,000	
CHIP	Current Expense	\$576,600	\$803,600	\$253,200	\$982,800	\$333,000
	Data Processing Capital Expenditure	\$0	\$0	\$21,400	\$2,200	\$26,900
	Data Processing Current Expense	\$30,600	\$18,200	\$18,300	\$43,400	\$25,600
	Other Charges/Pass Through	\$68,749,400	\$75,145,000	\$70,120,400	\$71,328,600	\$71,330,000
	Personnel Services	\$929,200	\$1,016,100	\$924,500	\$1,139,200	\$996,200
	Travel/In State	\$10,400	\$6,600	\$4,200	\$2,700	\$2,500
	Travel/Out of State	\$2,900	\$12,100	\$16,100	\$11,800	\$7,500
	CHIP Total	\$70,299,100	\$77,001,600	\$71,358,100	\$73,510,700	\$72,721,800
Total Expenditures	\$1,908,313,900	\$1,961,187,800	\$2,044,550,100	\$2,138,988,800	\$2,266,020,800	

Medicaid MIS (MMIS) expenditures are included in the "Medicaid Mandatory" category.

Medicaid Finance

The Utah Department of Health (DOH), Division of Medicaid and Health Financing (DMHF) provides Medicaid funding for medical services to needy individuals and families throughout the state of Utah. Medicaid is financed by state and federal resources.

Means of Finance

Medicaid was established by Title XIX of the Social Security Act in 1965. Utah implemented its Medicaid program in 1966 which, at the time, focused on acute and long-term care. DOH is designated as the Single State Agency responsible for making state applications to the federal government for all Medicaid funding and Medicaid-related programs. Medicaid, a partnership program between the federal and state governments, provides coverage for physical health, behavioral health and dental services, as well as long-term care services. Eligibility for the program is based primarily on income and resource levels.

The Medicaid program is administered under the direction of the Centers for Medicare and Medicaid Services (CMS) within the United States Department of Health and Human Services. CMS sets requirements that include funding, qualification guidelines and quality and extent of medical services. CMS also has the responsibility of to provide federal oversight of the program.

Medicaid is funded by a share of both federal and state funds. This percentage of federal versus state funding is based on the Federal Medical Assistance Percentages (FMAP), which are updated every Federal Fiscal Year (FFY). The FFY runs from October 1 to September 30. The FMAP for each state ranges from 50 percent to 73.4 percent of program cost. The funding formula is based on each state’s latest three year average per capita income. Table 2 is an eleven year historical list of Utah FMAP running from 2004 to 2014, modified to match the State Fiscal Year (SFY), which runs from July 1 on one year to June 30 of the following year.

Table 2: Federal Medicaid Assistance Percentages (FMAP) for Utah SFY 2004 – SFY 2014		
SFY	Federal Percentage	State Percentage
2004	71.60%	28.40%
2005	72.04%	27.96%
2006	71.11%	28.89%
2007	70.30%	29.70%
2008	71.26%	28.74%
2009	70.94%	29.06%
2010	71.44%	28.56%
2011	71.27%	28.73%
2012	71.03%	28.97%
2013	69.96%	30.04%
2014	70.16%	29.84%

DMHF receives approximately 70 percent of its funding from the Federal match and 30 percent from the State General fund. During fiscal years 2009 – 2011, the federal government provided a temporary increase to the FMAP as specified in the American Recovery and Reinvestment Act (ARRA). Those increases are not specified in Table 2. Medicaid administrative costs are generally matched at 50 percent by federal funds.

Figure 2 is a breakout of Medicaid program expenditures. The largest component, “Other Charges/Pass Through,” is largely comprised of payments to providers of Medicaid services.

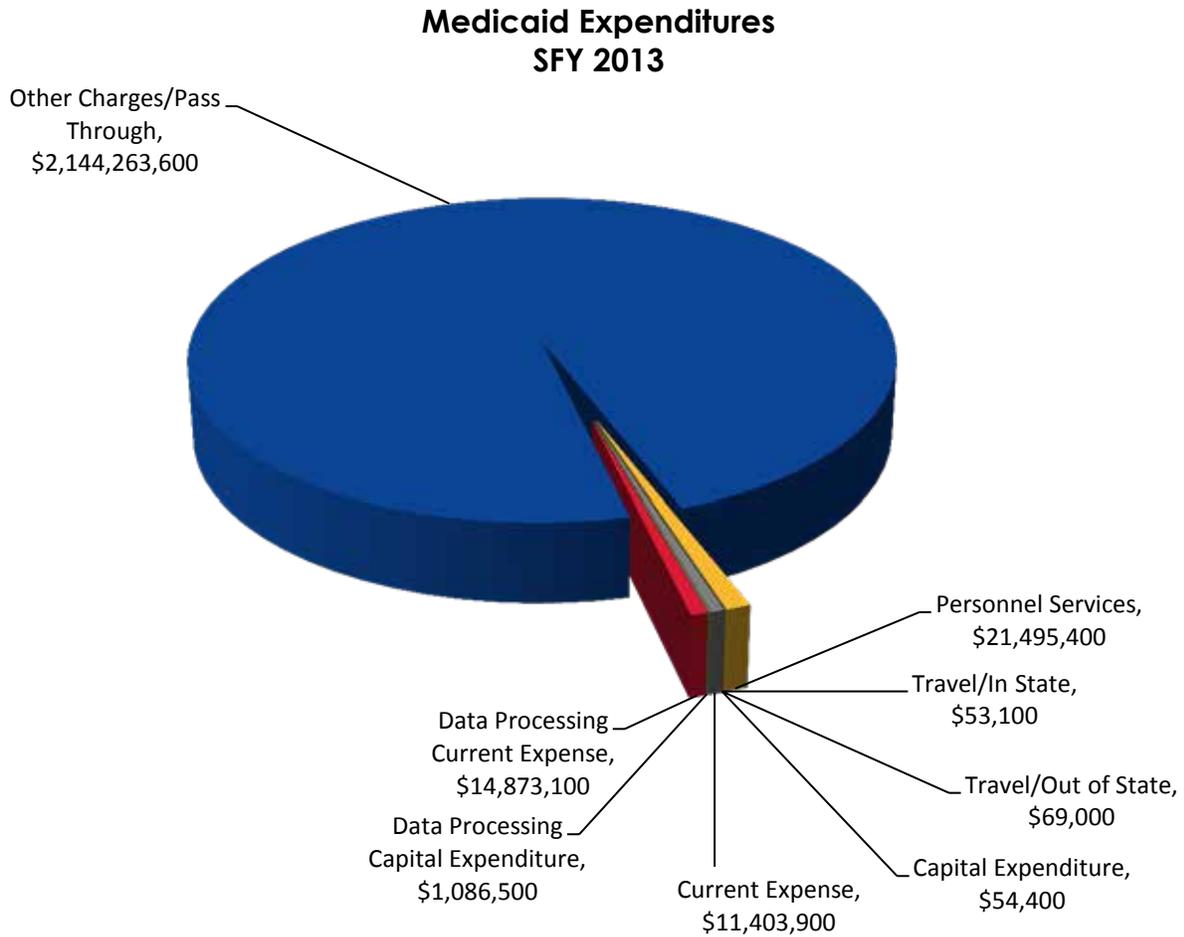


FIGURE 2

DMHF's revenues come from various fund sources, namely the State General Fund, Dedicated Credits, Restricted Revenues, Transfers and the associated Federal Funds. Transfers and most dedicated credits are funds from other state, local county agencies, or school districts often referred to as "seeded funds", which are used to draw down federal matching funds based on the FMAP. Figure 3 shows a breakout of revenue types, sources and amounts in 2013.

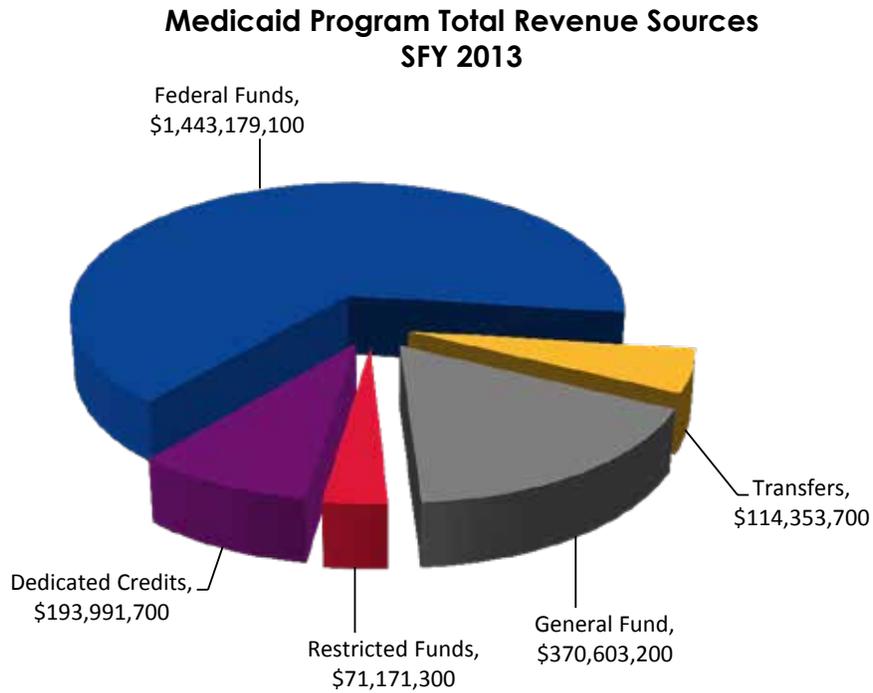


FIGURE 3



Offsets to Medicaid Expenditures

Medicaid expenditures are decreased by means of the following offsets.

CO-PAYMENTS

Medicaid clients are required to pay a portion of the cost for some of the services they receive. For example, clients pay \$3 per prescription up to a maximum of \$15 per month.

THIRD PARTY LIABILITY

The Office of Recovery Services (ORS) identifies commercial insurance coverage for Medicaid enrollees. This information is used by the Division to cost avoid Medicaid expenditures. In some circumstances, federal regulations require the state to pay a claim and pursue collection from the third party insurance. ORS is responsible for coordination of benefits for fee-for-service (FFS) Medicaid enrollees. ORS also pursues collection from third parties in personal injury cases involving Medicaid enrollees and for estate recovery in accordance with federal regulations. Managed care organizations are responsible for coordination of benefits for their Medicaid enrollees. These collections are taken into consideration in the rate setting process.

PHARMACY REBATES

Pharmacy retailers offer volume discount rebates to DOH

SPENDDOWN INCOME

If a potential Medicaid client's income exceeds the eligibility threshold, they have the option to spenddown (or pay part of) their income in order to become eligible for Medicaid.

OTHER COLLECTIONS

The Attorney General's Office (AG) and Office of Medicaid Inspector General (OIG) are actively involved in recovering overpayments.

PRIMARY CARE NETWORK (PCN) PREMIUMS

Adults must pay an annual premium, up to \$50, to be eligible for this program.

Table 3: Expenditure Offsets - FY 2013 - Actual

Category Of Service	Spenddown and Other					Total
	Co-Payment	Third Party	Rebates	Collections	Premiums	
Inpatient Hospital Svcs, General	\$658,000	\$77,041,000	\$0	\$0	\$0	\$77,699,000
Outpatient Hospital Svcs, General	\$249,100	\$29,630,400	\$0	\$0	\$0	\$29,879,500
Nursing Facility III (NF III)	\$0	\$40,300	\$0	\$0	\$0	\$40,300
Nursing Facility I (NF I)	\$0	\$17,642,200	\$0	\$0	\$0	\$17,642,200
Home Health Services	\$0	\$6,318,400	\$0	\$0	\$0	\$6,318,400
Substance Abuse Treatment Svcs	\$0	\$267,300	\$0	\$0	\$0	\$267,300
Independent Lab and/or X-Ray Svcs	\$2,600	\$879,600	\$0	\$0	\$0	\$882,200
Ambulatory Surgical Services	\$2,300	\$1,184,200	\$0	\$0	\$0	\$1,186,500
Contracted Mental Hlth Svcs	\$0	\$121,100	\$0	\$0	\$0	\$121,100
Mental Health Services	\$0	\$1,652,400	\$0	\$0	\$0	\$1,652,400
Rural Health Clinic Services	\$0	\$267,200	\$0	\$0	\$0	\$267,200
ESRD Kidney Dialysis Svcs	\$1,200	\$7,002,300	\$0	\$0	\$0	\$7,003,500
Pharmacy	\$3,544,400	\$7,353,100	\$86,400,800	\$0	\$0	\$97,298,300
Medical Supply Services	\$2,700	\$6,263,700	\$0	\$0	\$0	\$6,266,400
Occupational Therapy	\$700	\$125,300	\$0	\$0	\$0	\$126,000
Medical Transportation	\$0	\$5,720,700	\$0	\$0	\$0	\$5,720,700
Specialized Nursing Svcs	\$0	\$598,600	\$0	\$0	\$0	\$598,600
Well Child Care (EPSDT) Svcs	\$0	\$189,600	\$0	\$0	\$0	\$189,600
Physician Services	\$378,600	\$29,789,800	\$0	\$0	\$0	\$30,168,400
Federally Qualified Health Cntrs	\$6,900	\$153,500	\$0	\$0	\$0	\$160,400
Dental Services	\$121,900	\$1,473,000	\$0	\$0	\$0	\$1,594,900
Pediatric/Family Nurse Pract	\$21,200	\$323,600	\$0	\$0	\$0	\$344,800
Psychologist Services	\$0	\$423,200	\$0	\$0	\$0	\$423,200
Physical Therapy Services	\$11,400	\$738,200	\$0	\$0	\$0	\$749,600
Speech and Hearing Services	\$0	\$81,100	\$0	\$0	\$0	\$81,100
Podiatry Services	\$6,800	\$1,000,400	\$0	\$0	\$0	\$1,007,200
Vision Care Services	\$8,900	\$307,400	\$0	\$0	\$0	\$316,300
Optical Supply Services	\$0	\$29,900	\$0	\$0	\$0	\$29,900
Osteopathic Services	\$86,200	\$2,324,600	\$0	\$0	\$0	\$2,410,800
QMB-Only Services	\$0	\$4,794,100	\$0	\$0	\$0	\$4,794,100
Chiropractic Services	\$200	\$35,400	\$0	\$0	\$0	\$35,600
Nutritional Assessment Counseling	\$0	\$500	\$0	\$0	\$0	\$500
Primary Care Network Premiums	\$0	\$0	\$0	\$0	\$447,900	\$447,900
Attorney General/MFCU	\$0	\$0	\$0	\$11,954,300	\$0	\$11,954,300
Office of Inspector General (OIG)	\$0	\$0	\$0	\$3,099,200	\$0	\$3,099,200
Recovery Audit Contracts (RAC)	\$0	\$0	\$0	\$6,487,800	\$0	\$6,487,800
ORS Collections	\$0	\$14,571,200	\$0	\$16,891,300	\$0	\$31,462,500
TOTAL	\$5,103,100	\$218,343,300	\$86,400,800	\$38,432,600	\$447,900	\$348,727,700

Medicaid Consolidated Report of Expenditures and Revenues

All Medicaid funds are administered by the Utah Department of Health (DOH). As per federal requirements, all funding for Medicaid must flow through the DOH and be governed by a memorandum of understanding for all functions performed by other entities whether state, non-profit, for profit, local government, etc.

As the Medicaid Single State Agency, DOH is ultimately responsible for all aspects of Medicaid and is prohibited from delegating its authority to those other than its own officials. DOH is required to exercise administrative discretion on the administration and supervision of the Medicaid State Plan, issue policies, rules, and regulations relating to Medicaid program matters.

Programs and services for Medicaid are delivered by DOH, the Departments of Human Services (DHS), and a myriad of contracted providers including University of Utah Hospitals (U of U), local health organizations, not-for-profit entities, and for-profit entities. DOH contracts with the Department of Workforce Services (DWS) to determine eligibility for Medicaid (and CHIP) programs. The Office of Inspector General receives Medicaid funding to audit the Medicaid program as well as identify, investigate and prosecute Medicaid fraud and abuse. The Office of Attorney General also receives funding to provide legal support to DOH, review of Medicaid and CHIP contracts and policies and representing Medicaid and CHIP in administrative and judicial proceeding.

This consolidated report section shows how Medicaid appropriations are being spent for administration and services in the following state agencies: DOH, DHS, DWS, U of U, the Office of Attorney General, and the Office of Inspector General. The Governor’s Office of Management and Budget reviews expenditure data from these six state agencies. In addition, DOH passes funding through to local government and other providers.

Figure 4 illustrates Medicaid revenue sources. Table 4 details the composition of the “Other Revenue Sources” pie slice in Figure 4.

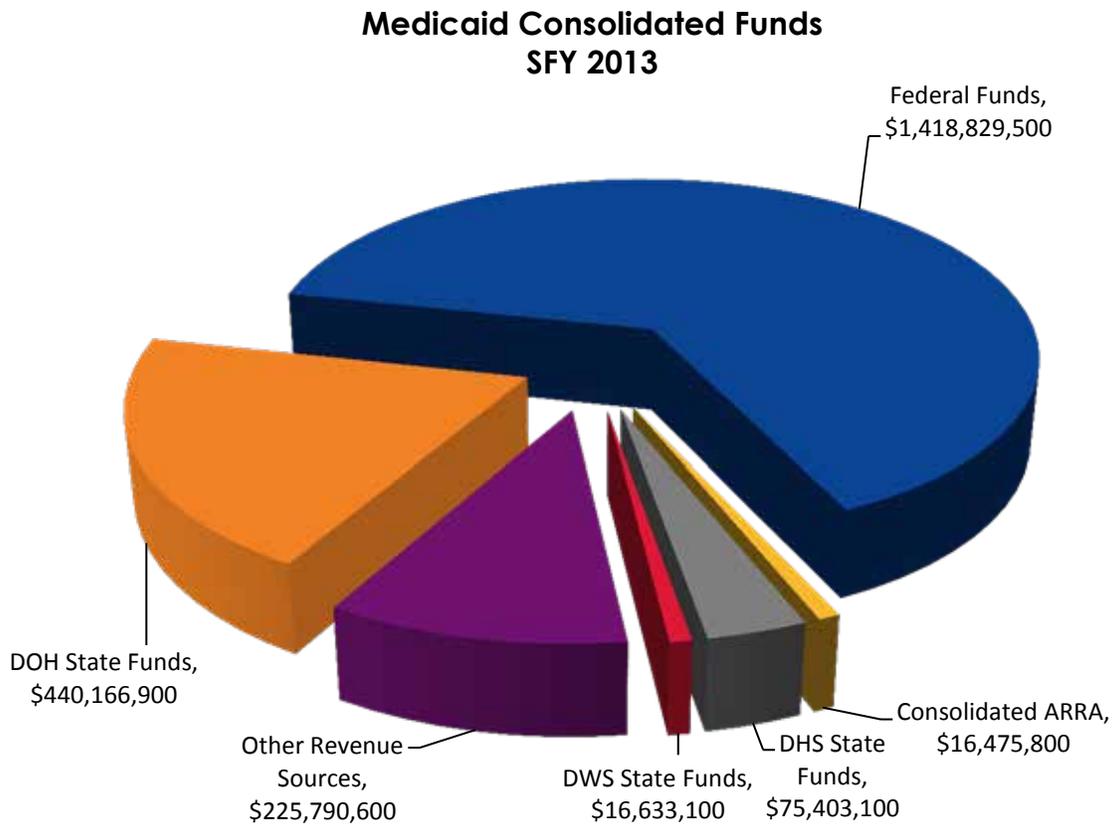


FIGURE 4

Table 4: Other Revenue Sources SFY 2013	
Mental Health Services	\$42,423,100
Substance Abuse	\$5,808,200
Local Health Departments	\$891,500
School Districts	\$12,037,500
Family & Health Preparedness	\$529,700
Healthy U Health Plan	\$2,852,400
Health & Dental Clinics	\$4,716,300
Pharmacy Rebates	\$91,914,500
Physician Enhancement	\$16,667,900
Inpatient UPL Payments	\$29,453,000
Disproportionate Share Hospital	\$8,977,200
Early Intervention	\$161,400
PCN Enrollment Fees	\$655,000
Refugee Relocation	\$1,255,500
CHIP Allocation	\$1,078,000
Disease Control and Prevention	\$1,167,300
Center for Health Data	\$185,000
DHS (Non-Medicaid)	\$2,294,700
Miscellaneous	\$2,722,400
Total	\$225,790,600

Table 5 specifies Medicaid funding at the line item level. Starting in FY 2014, Medicaid Management Information System (MMIS) replacement funding is to be placed under the LHL rather than the LKL line item. This report places the MMIS funding under LHL to be consistent with how the funding will be treated in the future.

Table 6 details mandatory, optional and administrative expenses. Expenses for the MMIS project are included in mandatory expenses.

Table 5: Consolidated Medicaid Revenues SFY2013

Mandatory	LHB - Inpatient Hospital	LHC - Nursing Home	LHD - Managed HealthCare	LHE - Physician Services	LHF - Outpatient Hospital	LHG - Other Mandatory Services	LHH - Crossover Services	LHJ - Medical Supplies	LHK - Primary Care Case Management	LHL - Medicaid MIS Replacement	Total
General Fund	\$31,753,600	\$31,222,100	\$135,893,700	\$22,643,800	\$20,127,900	\$18,480,400	\$3,903,000	\$4,151,700	\$166,700	\$1,607,600	\$269,950,500
Federal Funds	\$187,691,600	\$118,526,300	\$350,167,300	\$54,504,900	\$46,684,300	\$38,089,200	\$9,037,600	\$9,654,000	\$150,500	\$7,874,100	\$822,379,800
Dedicated Credits	\$0	\$0	\$13,377,600	\$803,600	\$0	\$1,142,000	\$0	\$0	\$0	\$0	\$15,323,200
Restricted Revenue	\$47,800,600	\$19,818,300	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$67,618,900
Transfers	\$308,900	\$0	(\$100)	\$273,000	\$254,400	\$1,982,700	\$100	\$20,100	\$0	\$0	\$2,839,100
Beginning Balance	\$15,266,700	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$15,266,700
Closing Balance	(\$23,949,600)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	(\$23,949,600)
Lapsing Balance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	\$258,871,800	\$169,566,700	\$499,438,500	\$78,225,300	\$67,066,600	\$59,694,300	\$12,940,700	\$13,825,800	\$317,200	\$9,481,700	\$1,169,428,600

Optional	LJA - Pharmacy	LJB - Home & Community Based Waivers	LJC - Capitated Mental Health Services	LJD - Buy In/Out	LJE - Dental Services	LJF - Intermediate Care Facilities for Mental Health	LJG - Vision Care	LJH - Other Optional Services	LJJ - Mental Health Inpatient Hospital	LJK - Non-Service Expenses	LJL, LJM, & LJN - Hospice, DSH & Clawback	Total
General Fund	\$17,503,500	\$24,400	\$2,156,500	\$17,121,000	\$12,609,400	\$9,460,100	\$571,800	\$12,568,500	\$0	\$100	\$55,499,800	\$127,515,100
Federal Funds	\$35,230,400	\$122,398,800	\$101,100,500	\$24,886,800	\$29,275,400	\$55,150,800	\$1,334,700	\$74,498,600	\$0	\$88,323,400	\$12,506,600	\$544,706,000
Dedicated Credits	\$86,404,100	\$0	\$31,507,400	\$0	\$0	\$0	\$0	\$13,200,500	\$0	\$38,321,600	\$939,900	\$170,373,500
Restricted Revenue	\$0	\$0	\$0	\$0	\$0	\$1,654,300	\$0	\$0	\$0	\$0	\$1,197,000	\$2,851,300
Transfers	\$53,700	\$52,811,000	\$9,592,900	\$0	\$23,800	\$13,858,400	\$9,000	\$6,339,800	\$0	(\$8,590,600)	\$7,920,300	\$82,018,300
Beginning Balance	\$7,646,000	\$4,203,800	\$279,300	\$0	\$0	\$0	\$0	\$16,900	\$0	\$0	\$0	\$12,146,000
Closing Balance	(\$9,995,200)	(\$4,058,100)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	(\$14,053,300)
Lapsing Balance	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	\$136,842,500	\$175,379,900	\$144,636,600	\$42,007,800	\$41,908,600	\$80,123,600	\$1,915,500	\$106,624,300	\$0	\$118,054,500	\$78,063,600	\$925,556,900

Services	Admin	Total
General Fund	\$4,374,100	\$401,839,700
Federal Funds	\$55,782,800	\$1,422,868,600
Dedicated Credits	\$8,288,600	\$193,985,300
Restricted Revenue	\$701,100	\$71,171,300
Transfers	\$29,496,300	\$114,353,700
Beginning Balance	\$693,500	\$28,106,200
Closing Balance	(\$475,000)	(\$38,477,900)
Lapsing Balance	(\$547,900)	(\$547,900)
	\$98,313,500	\$2,193,299,000

Table 6: Consolidated Medicaid Expenditures SFY2013

Mandatory	DOH	DHS	U of U	DWS	AG	OIG	Total
Inpatient Hospital	\$224,633,800	\$0	\$34,238,000	\$0	\$0	\$0	\$258,871,800
Nursing Home	\$169,566,700	\$0	\$0	\$0	\$0	\$0	\$169,566,700
Contracted Health Plan Services	\$429,539,500	\$0	\$69,899,000	\$0	\$0	\$0	\$499,438,500
Physician Services	\$75,813,900	\$0	\$2,411,400	\$0	\$0	\$0	\$78,225,300
Outpatient Hospital	\$52,389,700	\$0	\$14,676,900	\$0	\$0	\$0	\$67,066,600
Crossovers	\$12,940,700	\$0	\$0	\$0	\$0	\$0	\$12,940,700
Medical Supplies	\$13,825,800	\$0	\$0	\$0	\$0	\$0	\$13,825,800
State Run PCCM	\$317,200	\$0	\$0	\$0	\$0	\$0	\$317,200
Other Mandatory Services	\$62,003,800	\$0	\$7,172,400	\$0	\$0	\$0	\$69,176,200
Subtotal	\$1,041,031,100	\$0	\$128,397,700	\$0	\$0	\$0	\$1,169,428,800
Optional	DOH	DHS	U of U	DWS	AG	OIG	Total
Pharmacy	\$136,842,500	\$0	\$0	\$0	\$0	\$0	\$136,842,500
Home & Community Based Waivers	(\$14,659,600)	\$190,039,500	\$0	\$0	\$0	\$0	\$175,379,900
Other Optional Services - DOH HCBS	\$27,137,500	\$0	\$0	\$0	\$0	\$0	\$27,137,500
Mental Health Services	\$138,027,400	\$6,609,200	\$0	\$0	\$0	\$0	\$144,636,600
Buy In / Out	\$42,007,800	\$0	\$0	\$0	\$0	\$0	\$42,007,800
Dental Services	\$41,908,600	\$0	\$0	\$0	\$0	\$0	\$41,908,600
Intermediate Care Facilities	\$49,849,900	\$30,273,700	\$0	\$0	\$0	\$0	\$80,123,600
Vision Care	\$1,859,100	\$0	\$56,400	\$0	\$0	\$0	\$1,915,500
Hospice Care Services	\$17,742,400	\$0	\$0	\$0	\$0	\$0	\$17,742,400
Other Optional Services	\$79,478,100	\$0	\$8,600	\$0	\$0	\$0	\$79,486,700
Non-Service Expenditures	\$47,894,400	\$0	\$0	\$0	\$0	\$0	\$47,894,400
Disproportionate Share Hospital	\$0	\$0	\$29,284,100	\$0	\$0	\$0	\$29,284,100
Clawback Payments	\$0	\$0	\$31,037,200	\$0	\$0	\$0	\$31,037,200
Graduate Medical Education	\$1,804,300	\$0	\$4,532,200	\$0	\$0	\$0	\$6,336,500
Inpatient UPL Payments	(\$6,337,400)	\$0	\$58,415,700	\$0	\$0	\$0	\$52,078,300
UUMG Physician Enhancement	(\$5,355,500)	\$0	\$17,100,600	\$0	\$0	\$0	\$11,745,100
Subtotal	\$558,199,500	\$226,922,400	\$140,434,800	\$0	\$0	\$0	\$925,556,700
Administrative	DOH	DHS	U of U	DWS	AG	OIG	Total
	\$44,188,800	\$16,112,500	\$0	\$35,277,400	\$271,600	\$2,463,200	\$98,313,500
Total Expenditures	\$1,643,419,400	\$243,034,900	\$268,832,500	\$35,277,400	\$271,600	\$2,463,200	\$2,193,299,000

Note: Other Optional Services appropriation was divided into two categories, Other Optional Services – DOH HCBS and Other Optional Services. The New Choices Waiver and Technology Dependent Waiver expenditures are being reported under Other Optional Services – DOH HCBS; whereas the remaining Other Optional Services are reported under Other Optional Services.

Each agency in state government that participates in Medicaid service delivery has provided the following summary information.

UTAH DEPARTMENT OF HEALTH - DIVISION OF MEDICAID AND HEALTH FINANCING

The Utah Department of Health (DOH) was created in 1981 to protect the public's health by preventing avoidable illness, injury, disability and premature death; assure access to affordable, quality health care; promote healthy lifestyles; and monitor health trends and events.

Table 7 shows Medicaid expenditures for SFY 2013 managed within the DOH by mandatory and optional services, and by administrative costs. For a more comprehensive information about DMHF, refer to pages 6-12.

Table 7: Utah Department of Health / Division of Medicaid and Health Financing		
Service Expenditures - Actual		
Mandatory	Total Exp	Percent of Total
Inpatient Hospital	\$224,633,800	14%
Nursing Home	\$169,566,700	10%
Contracted Health Plan Services	\$429,539,500	26%
Physician Services	\$75,813,900	5%
Outpatient Hospital	\$52,389,700	3%
Crossovers	\$12,940,700	1%
Medical Supplies	\$13,825,800	1%
State Run PCCM	\$317,200	<1%
Other Mandatory Services	\$62,003,800	4%
Total Mandatory	\$1,041,031,100	63%
Optional	Total Exp	Percent of Total
Pharmacy	\$136,842,500	8%
Home & Community Based Waivers	(\$14,659,600)	-1%
Mental Health Services	\$138,027,400	8%
Buy In / Out	\$42,007,800	3%
Dental Services	\$41,908,600	3%
Intermediate Care Facilities	\$49,849,900	3%
Vision Care	\$1,859,100	<1%
Other Optional Services	\$160,559,500	10%
Graduate Medical Education	\$1,804,300	<1%
Total Optional	\$558,199,500	34%
Total Service Expenditures UDOH/DMHF	\$1,599,230,600	97%
Administrative Expenditures - Actual		
Responsibilities:		
<i>Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.</i>		
	Total Exp	Percent of Total
Personal Services	\$15,034,000	1%
Travel - In State	\$17,800	<1%
Travel - Out of State	\$24,200	<1%
Current Expense	\$4,824,800	<1%
Data Processing Current Expense	\$8,734,800	1%
Capital Outlay	\$1,121,500	<1%
Other Charges/Pass Through	\$14,431,700	1%
Total Admin Expenditures UDOH/DMHF	\$44,188,800	3%
TOTAL	\$1,643,419,400	100%
Total UDOH Budget	\$2,460,164,700	
Medicaid as a % of Overall Budget		67%

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS), authorized under UCA 62A-1-102, provides direct and contracted social services to persons with disabilities, children and families in crisis, juveniles in the criminal justice system, individuals with mental health or substance abuse issues, vulnerable adults, and the elderly. In addition, DHS is responsible for the administration of the child support services program.

Table 8 shows Medicaid expenditures by DHS by category of service and funding source, as well as administrative costs.

Table 8: Department of Human Services				
<i>Service Expenditures - Actual (Through DHS)</i>	<i>Federal Funds</i>	<i>State Funds</i>	<i>Total</i>	<i>Percent of Total</i>
People with Disabilities	140,514,500	60,587,400	201,101,900	82.7%
Utah State Hospital	9,750,600	4,213,400	13,964,000	5.7%
Total Service Expenditures DHS	150,265,100	64,800,800	215,065,900	88.5%
Administrative Expenditures - Actual				
Total Administrative Expenditures DHS	8,471,400	7,641,100	16,112,500	6.6%
Total Expenditures (Through DHS)	158,736,500	72,441,900	231,178,400	95.1%
Service Expenditures - Direct Billed to DOH (State participation from DHS to DOH)				
Child and Family Services			4,791,700	2.0%
Juvenile Justice System			1,817,500	0.7%
Substance Abuse and Mental Health			3,963,800	1.6%
Aging and Adult Services			1,283,500	0.5%
Total Expenditures Direct Billed			\$11,856,500	4.9%
Total Expenditures			\$243,034,900	100%
Total DHS Budget				
			\$674,710,800	
Medicaid as a % of Overall Budget				
				36%

Divisions within DHS, which affect services within the Medicaid expenditures, are as follows:

Division of Services for People with Disabilities - The mission of the Division of Services for People with Disabilities (DSPD) is to promote opportunities and provide support for persons with disabilities to lead self-determined lives.

Division of Child and Family Services - The mission of the Division of Child and Family Services (DCFS) is to protect children at risk of abuse, neglect, or dependency. The Division does this by working with families to provide safety, nurturing, and permanence. The Division partners with the community in this effort.

Division of Substance Abuse and Mental Health - The Division of Substance Abuse and Mental Health (DSAMH) is responsible for ensuring that substance abuse and mental health services are available statewide. A continuum of substance abuse services that includes prevention and treatment is available for adults and youth. The goal is to ensure that treatment is available for adults with serious mental illness and for children with serious emotional disturbance. Services are offered statewide through 13 local authorities who either provide services or contract with private providers.

Office of Recovery Services - The Office of Recovery Services (ORS) serves children and families by promoting independence through responsible parenthood and ensures public funds are used appropriately, which reduces costs to public assistance programs. ORS works with parents, employers, federal, state and private agencies, professional associations, community advocates, the legal profession and other stakeholders and customers. The office works within the bounds of state and federal laws and limited resources to provide services on behalf of children and families.

The Office provides services to reimburse the State for costs of supporting children placed in its care and/or custody. Financial and medical support is obtained by locating parents, establishing paternity and support obligations, and enforcing those obligations when necessary. The Office also collects medical reimbursement from responsible third parties to reimburse the State and avoid additional Medicaid costs.

Division of Aging and Adult Services - The Division of Aging and Adult Services (DAAS) provides leadership and advocacy pertaining to issues that impact older Utahns, and serves the elderly and adults with disabilities needing protection from abuse, neglect or exploitation. DAAS offers choices for independence by facilitating the availability of a community-based independent living in both urban and rural areas of the state. DAAS encourages citizen involvement in planning and delivering services.

Child Protection Ombudsman - The Child Protection Ombudsman investigates consumer complaints regarding DCFS, and assists in achieving fair resolution of complaints, promoting changes that will improve the quality of services provided to the children and families of Utah, and building bridges with partners to effectively work for the children of Utah.

Office of Fiscal Operations - The Office of Fiscal Operations establishes sound fiscal practices, which provide useful information, and maintains reliable program and fiscal controls.

Office of Public Guardian - The Office of Public Guardian provides court-ordered guardian and conservator services to incapacitated adults who are unable to make basic daily living or medical decisions for themselves. The Office provides training and education to health and social services professionals, as well as the general public on the services available and appropriate criteria to look for in determining alternatives to court ordered public guardianship/conservatorship if available. The Office conducts intakes and assessments for court petition processes.

Office of Services Review - The Office of Services Review assesses whether DCFS is adequately protecting children and providing appropriate services to families. The Office accomplishes this by conducting in-depth reviews of practice, identifying problem areas, reporting results and making recommendations for improvement to DCFS. The Office performs similar functions for other divisions and offices at DHS.

Utah State Hospital - Utah State Hospital is a 24-hour inpatient psychiatric facility which serves people who experience severe and persistent mental illness. It has the capacity to provide active psychiatric treatment services to 359 patients (including a five-bed acute unit). The hospital serves all age groups and all geographic regions of the state.

Division of Juvenile Justice Services - The Division of Juvenile Justice Services (JJS) serves youth offenders with a comprehensive array of programs, including home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, and youth parole. JJS is a division within the DHS but has been assigned to the Executive Offices and Criminal Justice Appropriations Subcommittee for Legislative oversight. Prior to SFY 2004, it was known as the Division of Youth Corrections.

JJS is responsible for all youth offenders committed by the State’s Juvenile Court for secure confinement or supervision and treatment in the community. JJS also operates receiving centers and youth services centers for non-custodial and non-adjudicated youth.

Programs within JJS include:

- Administration
- Early Intervention Services
- Community Programs
- Correctional Facilities
- Rural Programs

DEPARTMENT OF WORKFORCE SERVICES

The Department of Workforce Services (DWS) was created in 1997, per UCA 35A-1-103(1), to provide employment and support services for customers to improve their economic opportunities. Costs of DWS for the Eligibility Services Division are computed by taking a random moment time sample. DWS eligibility workers are sampled and asked to record the time they spent on fourteen public assistance programs. Total costs are allocated on a quarterly basis to the various programs based on the percent of time derived from the sample.

Table 9 shows DWS Medicaid administrative expenditures in SFY 2013 by cost type and funding source.

Table 9: Department of Workforce Services				
<i>Administrative Expenditures - Actual</i>	<i>Federal Funds</i>	<i>State Funds</i>	<i>Total</i>	<i>Percent of Total</i>
Direct Costs	\$15,888,700	15,888,700	31,777,400	90%
Allocated Costs	\$2,755,600	\$744,400	\$3,500,000	10%
Total Admin Expenditures DWS	\$18,644,300	\$16,633,100	\$35,277,400	100%
Total DWS Budget				
Medicaid as a % of Overall Budget				
	\$1,113,133,200			3%

Divisions and budget areas within DWS are as follows:

Eligibility Services Division - The Eligibility Services Division was created in 2009 to centralize the State’s public assistance eligibility process using eREP to process applications. The Division determines eligibility for the Medicaid, CHIP, and other federal and state public assistance programs.

Eligibility for the different medical programs varies depending upon the program. Some major elements of consideration include: income level, assets, and the presence of dependents in the home. Generally, those who receive coverage must submit documentation annually to confirm continued eligibility.

Medical Programs - Medical Programs is a specific budget area at DWS and includes Medicaid, CHIP, PCN, and UPP eligibility. Prior to SFY 2008, DOH conducted about 60 percent of medical determinations, including all of the CHIP and UPP determinations. DWS performed about 40 percent of the determinations. In SFY 2008, the entire eligibility determination component of these programs was transferred from DOH to DWS. General administration and oversight of these programs remains within DOH.

Medical Programs are funded by General Fund and Federal Funds for Medicaid, CHIP, PCN and UPP. DWS receives funding to provide eligibility determinations within each of these programs. All payments for medical services are made by DOH.

Medical Programs Performance Measures - DWS performance on behalf of Medicaid and CHIP is measured in several ways. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disabled Medicaid. However, federal policy allows extensions for the applicant to provide proof of eligibility. DWS has established a timeliness benchmark of 30 days for its internal processes, similar to other DWS administered programs, such as the Supplemental Nutritional Assistance Program (formerly known as Food Stamps).

OFFICE OF THE ATTORNEY GENERAL

The Division of Child and Family Support, Health Unit, within the Office of Attorney General also provides legal support to DOH, reviews Medicaid and CHIP contracts and policies, and represents Medicaid and CHIP in administrative and judicial proceeding. Table 10 shows the Office of the Attorney General Medicaid Expenditures for SFY 2013.

Table 10: Office of the Attorney General			
<i>Administrative Expenditures - Actual</i>	<i>Federal Funds</i>	<i>State Funds</i>	<i>Total</i>
AG Total Administrative Expenditures	\$135,800	\$135,800	\$271,600

OFFICE OF THE INSPECTOR GENERAL

The Office of Inspector General (OIG) is an independent office of program evaluation and review located within the Department of Administrative Services. The purpose of this office is to ensure adequate internal controls are in place and effective policies and procedures are established and followed in the Medicaid program. Table 11 shows Medicaid administrative expenditures. OIG expenditures are considered 100 percent Medicaid related.

Table 11: Office of the Inspector General			
<i>Administrative Expenditures - Actual</i>	<i>Federal Funds</i>	<i>State Funds</i>	<i>Total</i>
OIG Total Administrative Expenditures	\$1,398,100	\$1,065,100	\$2,463,200

UNIVERSITY OF UTAH MEDICAL CENTER

The University of Utah is involved in four Medicaid program areas:

1. Inpatient Disproportionate Share Hospital – These funds come from finite federal allocation to states and are used to pay hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospitals costs in serving these clients.
2. Direct Graduate Medical Education (GME) – These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are subject to the calculated Upper Payment Limit (UPL) authorized by CMS. The non-federal share of GME is provided by DOH.
3. Inpatient UPL Supplemental Payments– These funds reimburse the hospital up to the Medicare upper limit. The funds help offset some of the clinical care costs. All of the UPL funds are matched by the University and are subject to the calculated UPL as authorized by CMS.
4. University of Utah Medical Group (UUMG) Supplemental Payments – These funds supplement the physician payments up to the average commercial rate. The non-federal share is provided by UUMG to be matched to the extent allowed by CMS.

Table 12 shows where the University of Utah expended Medicaid funds during SFY 2013.

Table 12: University of Utah Medical Center		
Service Expenditures - Actual		
Mandatory	Expenditures	Percent of Total
Inpatient Services	\$34,238,000	13%
Contracted Health Plan	\$69,899,000	26%
Physician Services	\$2,411,400	1%
Outpatient Hospital	\$14,676,900	5%
Other Mandatory Services	\$7,172,400	3%
Total Mandatory	\$128,397,700	48%
Optional	Expenditures	Percent of Total
Vision Care	\$56,400	<1%
Disproportionate Share Hospital	\$29,177,200	11%
Graduate Medical Education	\$4,532,200	2%
Clawback Payments	\$31,037,200	12%
Inpatient UPL Payments	\$58,415,700	22%
UUMG Physician Enhancement	\$17,100,600	6%
Other Optional Services	\$8,600	<1%
Total Optional	\$140,327,900	52%
U of U Total Medicaid Service Expenditures	\$268,725,600	100%

Medicaid Enrollment

The enrollment process and eligibility determinations for Medicaid are made primarily by the Department of Workforce Services (DWS), with a limited number completed by the Department of Human Services (DHS). Eligibility requirements for Medicaid are based on Title XIX of the Social Security Act. There are more than 30 types of Medicaid classifications, each with varying eligibility requirements. Household income is a primary consideration for eligibility. Eligibility for most programs is limited by the amount of assets an individual or a household possesses. For this report, the Medicaid classifications are summarized in the following aid groups:

- Children (individuals under age 19)
- Parents (adults in families with dependent children)
- Pregnant women
- Individuals with disabilities (individuals who have been determined disabled by Social Security)
- The elderly (individuals aged 65 or older)
- Visually impaired individuals (individuals of any age who meet Social Security's criteria for statutory blindness)
- Women with breast or cervical cancer
- Individuals who participate in a Medicare Cost-Sharing Program
- Primary Care Network (PCN) program (low-income adults who do not meet criteria for any of the above listed groups)

Medicaid serves as the nation's primary source of health insurance coverage for low-income populations. Medicaid provides funding for individuals and families who meet the eligibility criteria established by the state of Utah and approved by CMS. Providers of health care services delivered to Medicaid enrollees are reimbursed by DMHF.

In order to receive federal funding participation, the state of Utah agrees to cover certain groups of individuals (mandatory groups) and offer a minimum set of services (mandatory services). Through waivers, the state of Utah is also able to receive federal matching funds to cover additional services (optional services), as well as additional qualifying groups of individuals (optional groups).

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts toward that limit. Family size plays a part in the financial qualification for Medicaid. See Appendix A for the 2013 HHS Federal Poverty Levels (FPL).

Medicaid enrollment numbers and corresponding expenditures are impacted by economic and demographic factors. The percentage of the Utah population living under the Federal Poverty Levels (FPL) influences the level of state reliance on the Medicaid program services. See Appendix A for details.

Medicaid Benefits

Medicaid benefits vary, from person to person, depending on differences in:

- Age
- Pregnancy
- Category of Assistance

Differences in benefits include:

- PCN covers only primary care services
- Individuals who are not pregnant or are not a child may have co-payment or cost-sharing requirements

Income and asset tests are primary factors in determining eligibility. The Medicaid program is required to provide medical services to “Categorically Needy” individuals. Many categorically needy optional groups and medically needy individuals are covered in Utah as a state option. “Medically Needy” individuals have enough income to meet basic living costs, but are unable to afford vital medical care. In previous years, all supplemental payments were coded to the Elderly category of assistance. Since supplemental payments are paid on behalf of all populations, supplemental payments were carved out of the analysis and then distributed proportionally. This accounts for the proportional reduction of the Elderly category versus this figure in previous versions of the annual report.

Enrollment Statistics

A Medicaid enrollee is defined as an individual who meets the established eligibility criteria of the program, who has applied and has been approved by Medicaid to receive services, regardless of whether the enrollee received any service or any claim has been filed on his or her behalf.

AVERAGE MEMBERS PER MONTH BY CATEGORY OF ASSISTANCE

“Member months” are defined as the number of Medicaid eligibles enrolled in each month over a fiscal year. Individuals, in this measure, can be counted multiple times depending on the number of months they are eligible to receive Medicaid services. The average members per month (the average monthly enrollment) in a fiscal year is computed by dividing total member months by 12.

Figure 5a shows the average members per month for all categories of assistance combined. Figure 5b illustrates the year to year growth rate of average member months.

Average Members per Month: All Categories

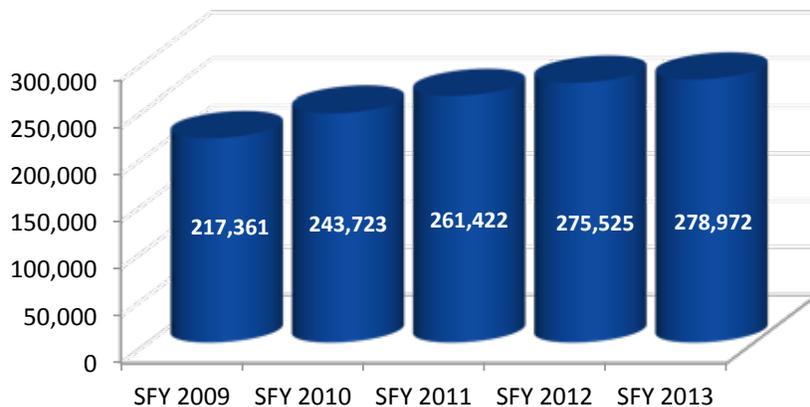


FIGURE 5a

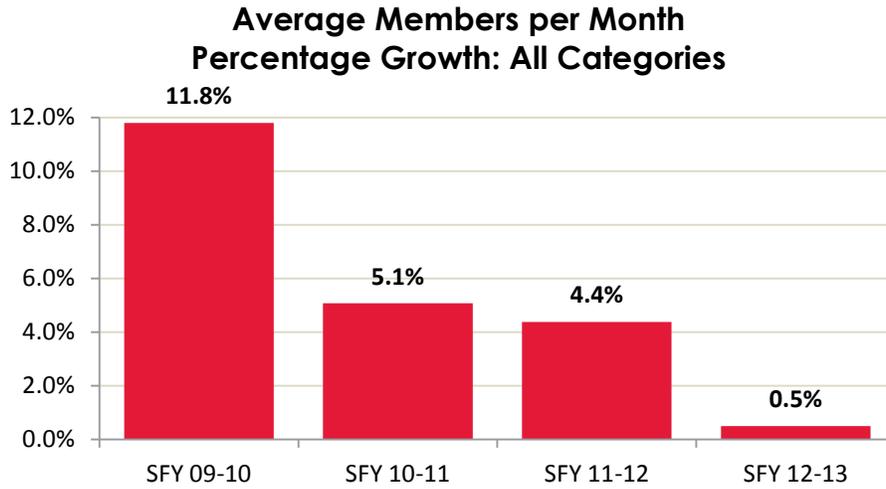


FIGURE 5b

Figure 6a provides a look at average monthly adult enrollees. Figure 6b shows that the year over year growth rate in adult enrollees per month increased by double digits during the recessionary years and then decreased to less than three percent between FY 2012 and FY 2013.

Average Members per Month: Adult Enrollees

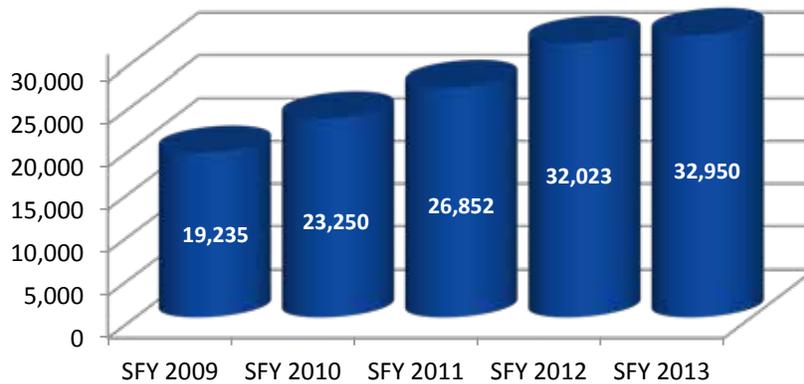


FIGURE 6a

Average Members per Month Percentage Growth: Adult Enrollees

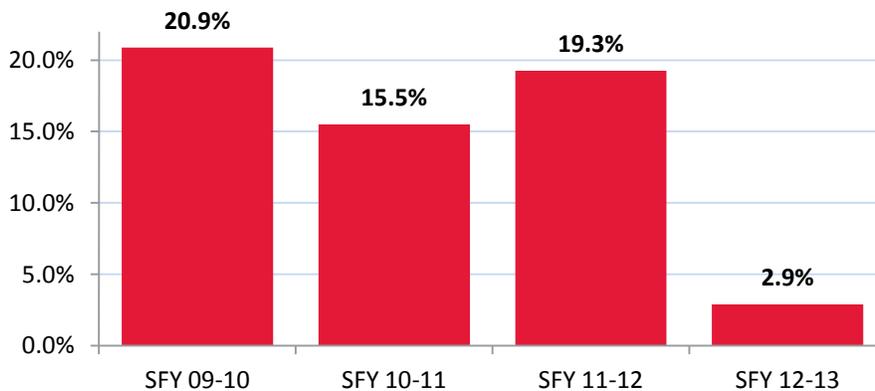


FIGURE 6b

Figure 7a illustrates the average monthly for enrollment for individuals aged 65 and older. Figure 7b shows the year to year percent growth in the number of enrolled elderly individuals peaked during FY10-11 and the rate has declined every year since.

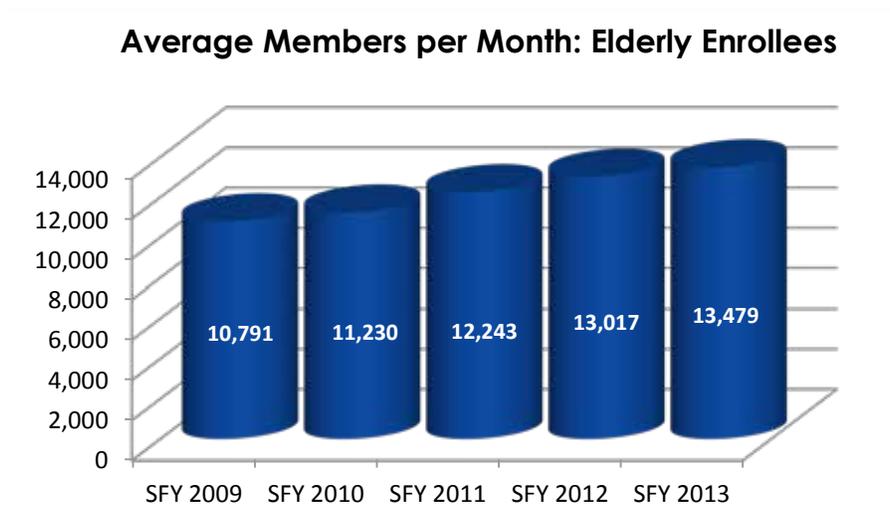


FIGURE 7a

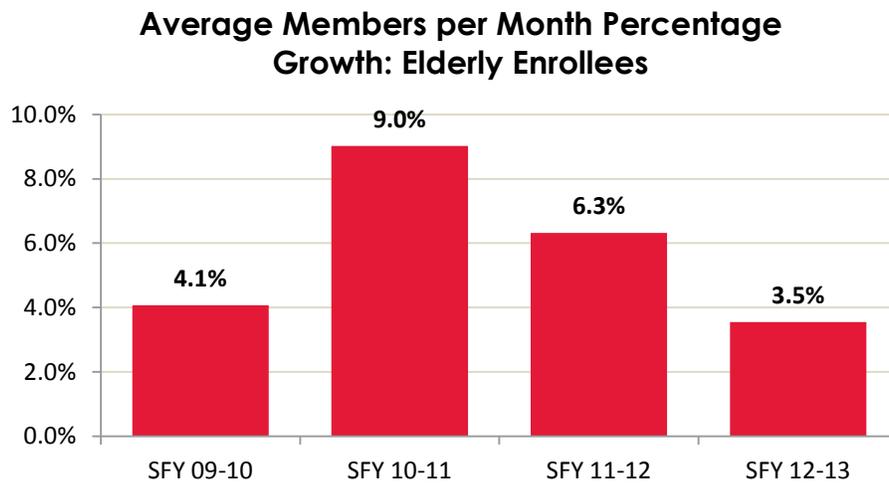


FIGURE 7b

Figure 8a shows average monthly enrollment for the visually impaired and people with disabilities. According to Figure 8b, enrollment continues to grow but at a decreasing rate.

Average Members per Month: Visually Impaired and People with Disabilities

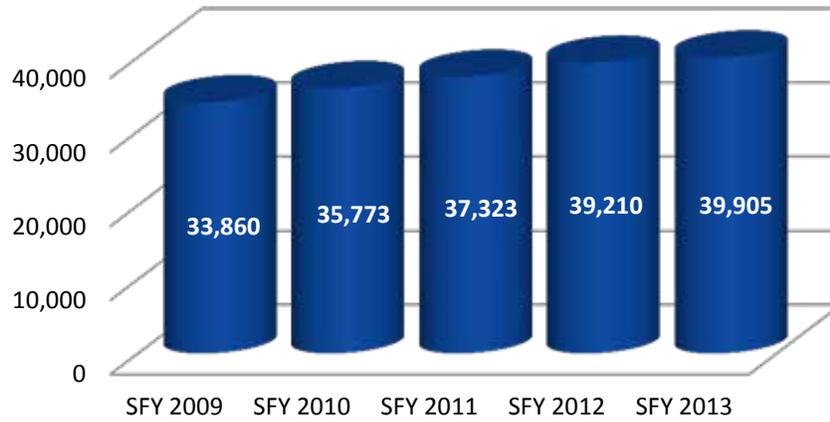


FIGURE 8a

Average Members per Month Percentage Growth: Visually Impaired and People with Disabilities

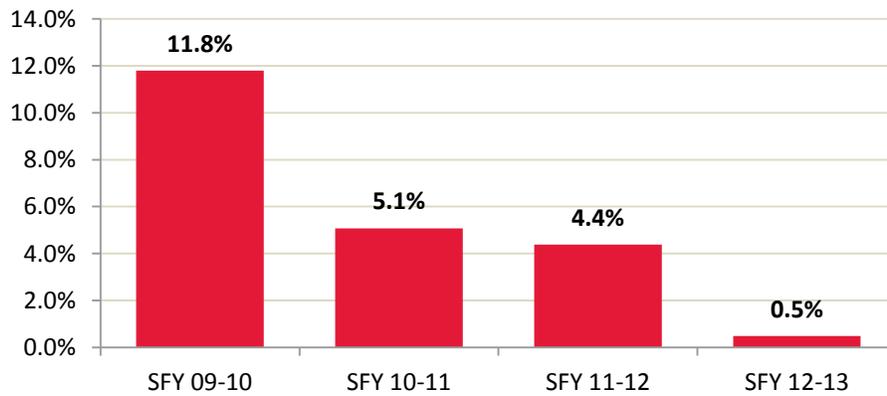
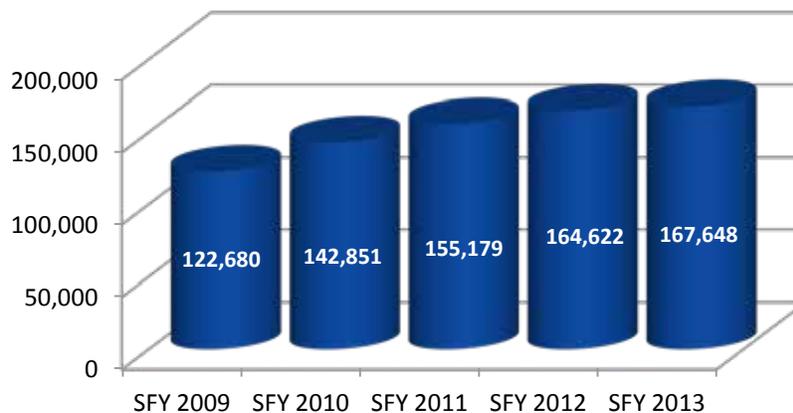


FIGURE 8b

Figure 9a depicts the average members per month for Medicaid enrolled children. Figure 9b shows the year to year rate of growth in this category to be on a declining trend.

Average Members per Month: Children Enrollees



Average Members per Month Percentage Growth: Children Enrollees

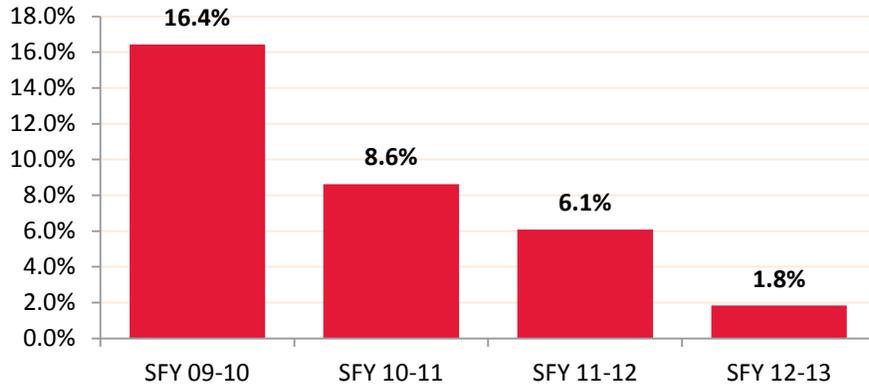


FIGURE 9b

Figure 10a portrays the average monthly enrollment of pregnant women. Enrollees have been declining the past several years, but the rate of decline has slowed (see Figure 10b).

Average Members per Month: Pregnant Women Enrollees

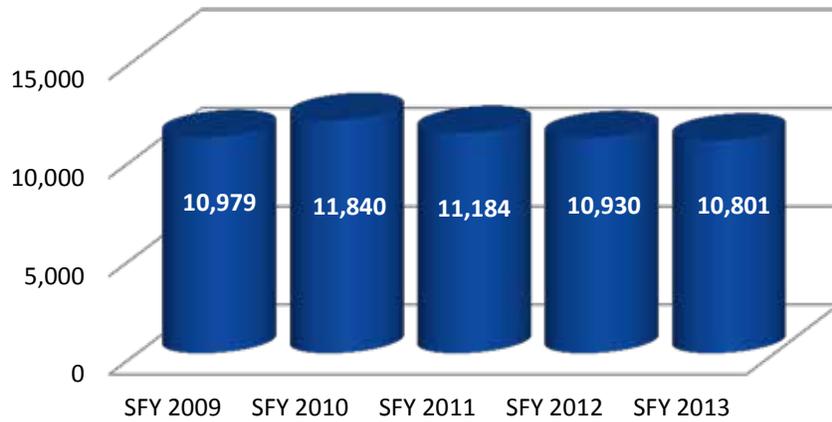


FIGURE 10a

Average Members per Month Percentage Growth: Pregnant Women Enrollees

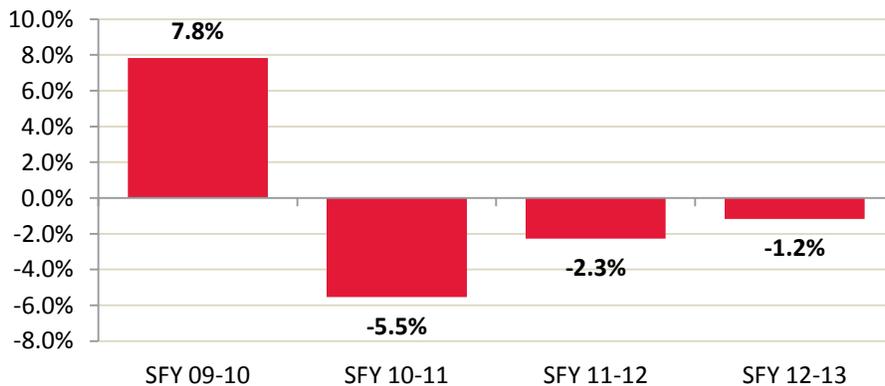


FIGURE 10b

Figure 11a show the average members per month for PCN enrollees. Figure 10b illustrates the year to year percent growth (decline) in this category. Unlike other aid categories, the number of PCN member months is dependent on the number of open enrollment events.

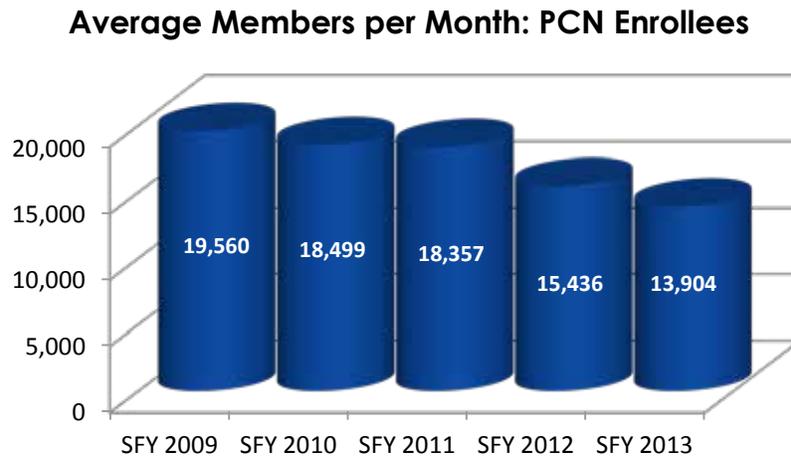


FIGURE 11a

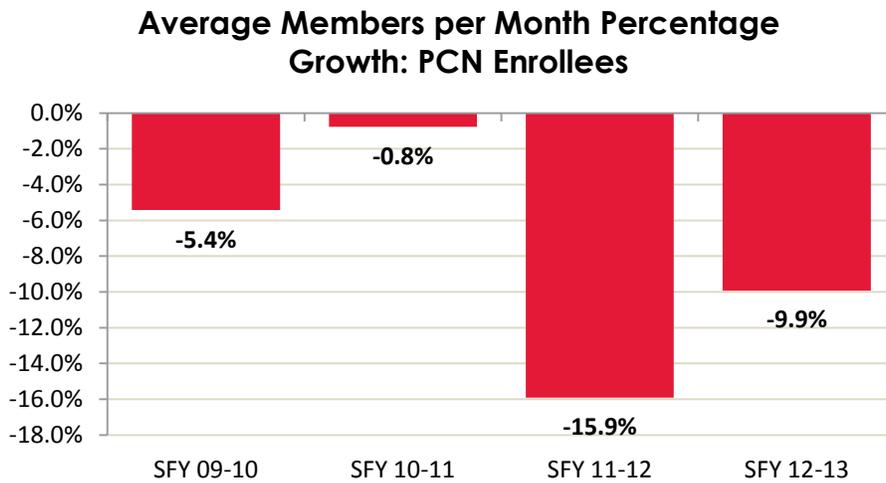


FIGURE 11b

Table 13 provides a county level look at the average monthly Medicaid enrollment as a percent of population.

Table 13: Average Monthly Enrollment as a Percent of County Population					
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
BEAVER	11.2%	11.5%	12.0%	11.8%	12.1%
BOX ELDER	8.0%	8.6%	8.9%	9.4%	9.8%
CACHE	8.4%	9.0%	9.1%	9.3%	9.3%
CARBON	13.8%	14.3%	14.5%	14.7%	15.3%
DAGGETT	3.4%	4.9%	4.4%	4.0%	4.5%
DAVIS	5.8%	6.4%	6.8%	7.1%	7.1%
DUCHESNE	10.5%	11.4%	11.5%	11.9%	11.0%
EMERY	11.0%	10.9%	10.6%	11.0%	11.1%
GARFIELD	9.2%	9.3%	8.6%	8.2%	9.1%
GRAND	12.9%	12.6%	12.0%	12.1%	11.6%
IRON	12.2%	13.1%	14.1%	14.6%	14.3%
JUAB	10.4%	11.1%	11.3%	11.2%	11.1%
KANE	8.0%	8.5%	8.5%	9.0%	8.9%
MILLARD	11.6%	12.3%	12.4%	11.7%	11.7%
MORGAN	2.6%	3.1%	3.4%	3.7%	3.6%
PIUTE	17.0%	15.9%	15.1%	14.4%	13.0%
RICH	5.6%	7.2%	9.0%	8.2%	7.5%
SALT LAKE	8.1%	9.1%	9.7%	10.2%	10.2%
SAN JUAN	19.9%	20.5%	21.8%	23.5%	23.8%
SANPETE	10.9%	11.2%	11.7%	12.0%	11.8%
SEVIER	12.4%	12.8%	13.0%	13.4%	13.5%
SUMMIT	2.7%	3.5%	3.7%	3.8%	3.6%
TOOELE	7.7%	8.6%	9.1%	9.7%	10.0%
UINTAH	7.0%	8.4%	8.5%	8.7%	8.5%
UTAH	7.4%	8.2%	8.5%	8.7%	8.6%
WASATCH	4.5%	5.4%	6.0%	6.2%	6.3%
WASHINGTON	9.3%	10.7%	11.5%	12.2%	12.0%
WAYNE	7.6%	8.2%	8.8%	8.4%	7.9%
WEBER	9.4%	10.1%	10.7%	11.4%	11.5%

UNDUPLICATED MEDICAID ENROLLMENT

An unduplicated enrollee is one who is counted only once within a specific fiscal year, regardless of the number of months that individual was eligible for Medicaid services. Thus an individual who was eligible for 12 months of service will be counted the same as an individual who was eligible for only one month of service.

Figure 12a is an illustration of the unduplicated number of enrollees who eligible for Medicaid services.

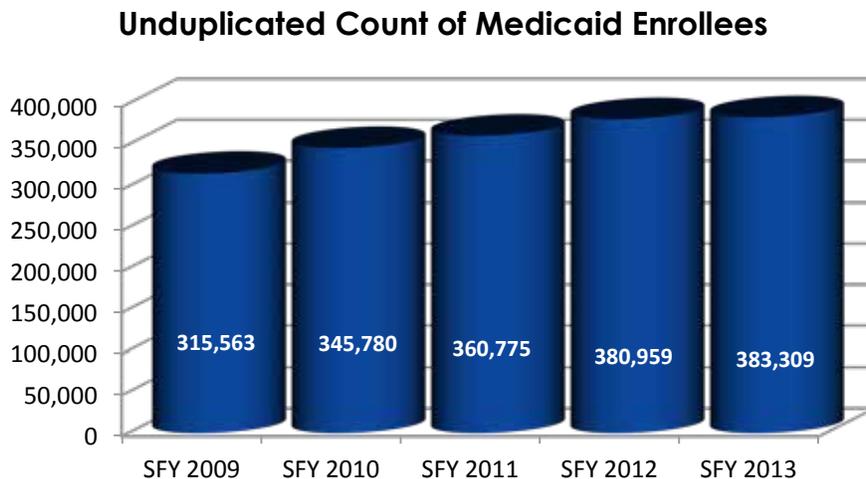


FIGURE 12a

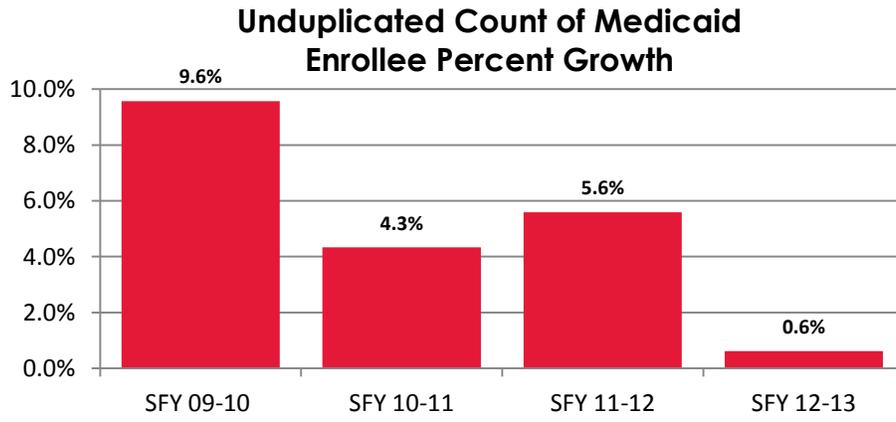


FIGURE 12b

Table 14 breaks down the unduplicated enrollment count by race, age group and gender.



Table 14: Enrollment by Race, Age Group and Gender SFY 2009 -SFY 2013

Race	Age	Gender	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Asian	Age < 19	F	1,677	1,916	1,740	1,690	1,658
		M	1,676	1,962	1,913	1,834	1,784
	Age < 19 Total		3,366	3,895	3,653	3,524	3,442
	Age 19 - 64	F	2,741	2,925	1,801	1,888	2,000
		M	907	1,032	999	1,163	1,180
	Age 19 - 64 Total		3,648	3,957	2,800	3,051	3,180
	Age 65 or Older	F	703	740	747	761	778
		M	402	420	438	441	454
Age 65 or Older Total		1,105	1,160	1,185	1,202	1,232	
Asian Total			8,106	8,995	7,638	7,777	7,854
Black	Age < 19	F	3,056	3,258	3,170	3,079	3,019
		M	3,251	3,448	3,394	3,323	3,263
	Age < 19 Total		6,342	6,746	6,564	6,402	6,282
	Age 19 - 64	F	1,941	2,030	2,042	2,105	2,251
		M	1,109	1,229	1,207	1,310	1,412
	Age 19 - 64 Total		3,050	3,259	3,249	3,415	3,663
	Age 65 or Older	F	128	136	134	138	141
		M	76	80	84	93	105
	Age 65 or Older Total		204	216	218	231	246
	Black Total			9,561	10,181	10,031	10,048
Native American	Age < 19	F	3,269	3,406	3,378	3,425	3,272
		M	3,381	3,560	3,530	3,524	3,387
	Age < 19 Total		6,696	7,005	6,909	6,949	6,659
	Age 19 - 64	F	660	701	790	958	974
		M	296	349	364	465	459
	Age 19 - 64 Total		956	1,050	1,154	1,423	1,433
	Age 65 or Older	F	395	396	405	418	414
		M	216	196	189	216	208
Age 65 or Older Total		611	592	594	634	622	
Native American Total			8,217	8,608	8,656	9,006	8,714
Pacific Islander	Age < 19	F	1,405	1,717	1,744	1,730	1,740
		M	1,553	1,864	1,891	1,866	1,876
	Age < 19 Total		2,971	3,591	3,635	3,596	3,616
	Age 19 - 64	F	818	914	886	852	943
		M	316	406	400	455	461
	Age 19 - 64 Total		1,134	1,320	1,286	1,307	1,404
	Age 65 or Older	F	80	93	91	92	91
		M	60	77	72	68	73
Age 65 or Older Total		140	170	163	160	164	
Pacific Islander Total			4,232	5,071	5,084	5,063	5,184
White	Age < 19	F	79,409	88,326	84,941	79,623	74,204
		M	83,407	92,892	89,529	84,152	78,439
	Age < 19 Total		163,909	182,146	174,470	163,775	152,646
	Age 19 - 64	F	74,855	77,865	74,817	76,024	76,699
		M	34,599	36,004	35,636	37,370	36,909
	Age 19 - 64 Total		109,454	113,869	110,453	113,394	113,609
	Age 65 or Older	F	8,739	8,886	8,724	8,800	8,808
		M	3,682	3,822	3,768	3,873	3,912
Age 65 or Older Total		12,421	12,708	12,492	12,673	12,720	
White Total			284,691	307,795	297,415	289,842	278,971
Other	Age < 19	F	175	1,530	10,792	20,857	26,881
		M	135	1,499	11,245	21,972	28,261
	Age < 19 Total		310	3,029	22,037	42,829	55,144
	Age 19 - 64	F	353	1,550	6,597	10,134	10,105
		M	77	368	2,236	4,244	4,698
	Age 19 - 64 Total		430	1,918	8,833	14,378	14,803
	Age 65 or Older	F	10	130	723	1,330	1,659
		M	6	53	358	686	791
Age 65 or Older Total		16	183	1,081	2,016	2,450	
Other Total			756	5,130	31,951	59,223	72,395
Grand Total			315,563	345,780	360,775	380,959	383,309

Figure 13 shows each of the categories of assistance as a percent of total, statewide unduplicated Medicaid enrollment for FY 2013.

Percent of Medicaid Enrollees by Category of Assistance SFY 2013

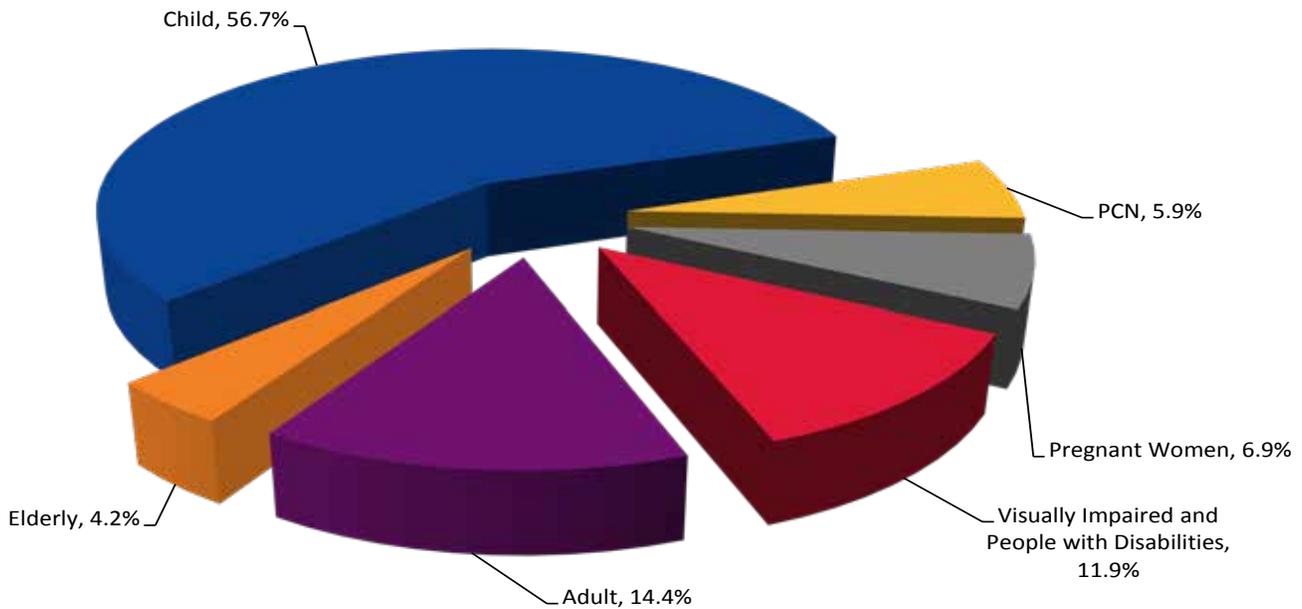


FIGURE 13

Table 15 presents the same information as Figure 13 from FY 2009 to FY 2013.

Table 15: Statewide Medicaid Enrollment Composition					
Category of Assistance	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Adult	10.6%	11.8%	12.7%	14.1%	14.4%
Elderly	4.0%	4.0%	4.0%	4.1%	4.2%
Child	54.6%	56.3%	57.3%	57.0%	56.7%
PCN	9.8%	7.5%	6.5%	6.1%	5.9%
Pregnant Women	8.9%	8.6%	7.6%	7.0%	6.9%
Visually Impaired and People with Disabilities	12.2%	11.9%	11.8%	11.7%	11.9%
Statewide Total	100.0%	100.0%	100.0%	100.0%	100.0%

Table 16 breaks out each category of assistance as a percent of each county’s Medicaid enrollment. Table 15 in conjunction with Table 16 allows for comparisons between each county’s Medicaid enrollment composition with the state.

Table 16: Medicaid Enrollment Composition by County

County	Category of Assistance	FY2009	FY2010	FY2011	FY2012	FY2013
BEAVER	PCN	16.9%	13.0%	12.9%	12.2%	13.1%
	Pregnant Women	8.4%	9.5%	8.8%	6.9%	6.3%
	Adult (Ages 19-64)	8.3%	9.3%	10.0%	11.4%	11.6%
	Chidren	48.0%	50.9%	52.3%	53.5%	50.3%
	Visually Impaired and People with Disabilities	10.6%	10.9%	10.2%	10.5%	12.1%
	The Elderly (Ages 65+)	7.8%	6.4%	5.8%	5.5%	6.7%
BOX ELDER	PCN	11.4%	9.0%	8.3%	7.4%	6.8%
	Pregnant Women	7.8%	7.6%	6.8%	6.5%	6.5%
	Adult (Ages 19-64)	11.1%	12.0%	12.0%	13.3%	14.2%
	Chidren	55.0%	57.0%	57.6%	57.3%	56.4%
	Visually Impaired and People with Disabilities	11.4%	11.3%	12.1%	12.1%	12.8%
	The Elderly (Ages 65+)	3.3%	3.1%	3.2%	3.3%	3.4%
CACHE	PCN	9.8%	7.6%	6.1%	5.4%	5.4%
	Pregnant Women	10.7%	10.7%	10.2%	9.8%	9.7%
	Adult (Ages 19-64)	10.5%	11.7%	12.3%	13.8%	14.4%
	Chidren	57.1%	58.0%	59.1%	58.9%	58.2%
	Visually Impaired and People with Disabilities	9.2%	9.3%	9.5%	9.5%	9.6%
	The Elderly (Ages 65+)	2.7%	2.7%	2.8%	2.7%	2.6%
CARBON	PCN	12.0%	9.3%	8.1%	7.3%	7.3%
	Pregnant Women	6.3%	6.6%	6.5%	6.3%	5.8%
	Adult (Ages 19-64)	13.3%	14.4%	14.9%	15.3%	15.9%
	Chidren	46.3%	47.1%	47.6%	48.6%	48.4%
	Visually Impaired and People with Disabilities	17.6%	17.8%	18.2%	18.1%	18.0%
	The Elderly (Ages 65+)	4.5%	4.7%	4.7%	4.5%	4.7%
DAGGETT	PCN	21.4%	9.6%	4.7%	11.4%	13.0%
	Pregnant Women	8.9%	9.6%	7.1%	2.5%	4.3%
	Adult (Ages 19-64)	5.4%	11.0%	17.6%	20.3%	13.0%
	Chidren	41.1%	52.1%	58.8%	54.4%	56.5%
	Visually Impaired and People with Disabilities	14.3%	13.7%	8.2%	8.9%	8.7%
	The Elderly (Ages 65+)	8.9%	4.1%	3.5%	2.5%	4.3%
DAVIS	PCN	9.5%	7.4%	6.5%	5.9%	5.9%
	Pregnant Women	7.8%	7.7%	7.2%	6.6%	6.5%
	Adult (Ages 19-64)	12.1%	13.2%	13.6%	15.1%	15.4%
	Chidren	55.4%	57.0%	58.0%	57.7%	57.1%
	Visually Impaired and People with Disabilities	12.1%	11.7%	11.7%	11.6%	11.8%
	The Elderly (Ages 65+)	3.0%	2.9%	3.0%	3.1%	3.4%
DUCHESNE	PCN	9.4%	6.9%	5.2%	4.9%	5.0%
	Pregnant Women	7.2%	7.1%	7.4%	6.8%	6.5%
	Adult (Ages 19-64)	11.5%	12.1%	12.8%	15.0%	13.8%
	Chidren	52.2%	53.8%	54.3%	53.9%	54.4%
	Visually Impaired and People with Disabilities	15.1%	15.1%	14.8%	14.7%	15.4%
	The Elderly (Ages 65+)	4.7%	5.0%	5.4%	4.7%	4.9%
EMERY	PCN	14.0%	11.6%	9.8%	7.8%	7.1%
	Pregnant Women	5.5%	6.2%	6.1%	6.1%	5.4%
	Adult (Ages 19-64)	9.3%	10.4%	11.7%	12.2%	13.0%
	Chidren	52.5%	53.4%	54.0%	55.7%	56.7%
	Visually Impaired and People with Disabilities	13.4%	13.6%	13.7%	13.5%	12.9%
	The Elderly (Ages 65+)	5.4%	5.0%	4.8%	4.7%	4.9%
GARFIELD	PCN	25.0%	19.1%	17.1%	17.1%	14.9%
	Pregnant Women	7.4%	7.8%	6.4%	6.5%	7.8%
	Adult (Ages 19-64)	6.1%	7.3%	9.4%	10.9%	10.4%
	Chidren	44.5%	47.2%	46.5%	47.1%	48.7%
	Visually Impaired and People with Disabilities	11.4%	11.5%	12.3%	11.7%	12.1%
	The Elderly (Ages 65+)	5.6%	7.1%	8.3%	6.8%	6.1%

Table 16: Medicaid Enrollment Composition by County

County	Category of Assistance	FY2009	FY2010	FY2011	FY2012	FY2013
GRAND	PCN	20.7%	15.9%	13.6%	10.4%	9.3%
	Pregnant Women	7.8%	7.7%	7.0%	6.5%	7.7%
	Adult (Ages 19-64)	9.0%	10.9%	11.5%	12.7%	12.8%
	Children	44.6%	47.8%	48.7%	50.3%	49.2%
	Visually Impaired and People with Disabilities	13.4%	12.9%	14.4%	14.3%	14.4%
	The Elderly (Ages 65+)	4.6%	4.8%	4.9%	5.8%	6.6%
IRON	PCN	15.3%	12.6%	10.9%	10.0%	9.7%
	Pregnant Women	9.4%	9.0%	8.1%	7.7%	7.2%
	Adult (Ages 19-64)	9.8%	11.5%	12.9%	14.4%	14.8%
	Children	53.2%	54.0%	54.6%	54.4%	53.7%
	Visually Impaired and People with Disabilities	9.5%	10.0%	10.6%	10.6%	11.5%
	The Elderly (Ages 65+)	2.7%	2.8%	2.9%	2.9%	3.1%
JUAB	PCN	10.1%	7.7%	6.1%	5.6%	4.7%
	Pregnant Women	7.7%	7.6%	6.4%	5.6%	5.4%
	Adult (Ages 19-64)	10.6%	11.2%	11.9%	12.0%	13.3%
	Children	54.0%	57.1%	58.0%	59.1%	58.2%
	Visually Impaired and People with Disabilities	13.5%	12.5%	13.5%	13.5%	14.0%
	The Elderly (Ages 65+)	4.1%	4.0%	4.0%	4.2%	4.4%
KANE	PCN	18.1%	12.9%	11.6%	11.2%	11.6%
	Pregnant Women	8.0%	8.0%	7.9%	7.7%	7.4%
	Adult (Ages 19-64)	7.0%	9.2%	10.6%	13.8%	11.8%
	Children	47.1%	49.5%	50.0%	47.7%	48.3%
	Visually Impaired and People with Disabilities	13.4%	13.3%	13.0%	12.1%	13.5%
	The Elderly (Ages 65+)	6.4%	7.0%	7.0%	7.5%	7.5%
MILLARD	PCN	17.7%	13.5%	12.0%	10.7%	10.1%
	Pregnant Women	6.5%	7.5%	6.2%	5.1%	5.4%
	Adult (Ages 19-64)	7.7%	8.8%	9.7%	12.4%	12.6%
	Children	52.4%	54.7%	55.8%	57.2%	56.4%
	Visually Impaired and People with Disabilities	10.3%	10.3%	10.8%	9.8%	10.4%
	The Elderly (Ages 65+)	5.4%	5.2%	5.6%	4.9%	5.2%
MORGAN	PCN	14.0%	8.9%	11.5%	10.5%	9.6%
	Pregnant Women	9.8%	9.3%	8.7%	8.9%	8.6%
	Adult (Ages 19-64)	6.8%	9.1%	9.8%	12.0%	13.8%
	Children	54.4%	60.3%	56.7%	56.2%	54.4%
	Visually Impaired and People with Disabilities	12.3%	9.7%	10.8%	10.4%	10.6%
	The Elderly (Ages 65+)	2.8%	2.6%	2.5%	2.0%	3.0%
PIUTE	PCN	24.2%	22.8%	18.5%	18.2%	19.5%
	Pregnant Women	3.9%	5.3%	3.5%	2.2%	4.3%
	Adult (Ages 19-64)	6.9%	8.2%	11.0%	9.7%	10.2%
	Children	51.1%	50.5%	52.8%	53.0%	48.5%
	Visually Impaired and People with Disabilities	10.8%	9.0%	10.7%	12.9%	13.5%
	The Elderly (Ages 65+)	3.1%	4.2%	3.5%	4.1%	4.0%
RICH	PCN	10.6%	9.6%	9.5%	6.7%	6.6%
	Pregnant Women	11.1%	9.2%	8.9%	6.7%	5.1%
	Adult (Ages 19-64)	7.4%	8.5%	13.2%	13.8%	14.7%
	Children	56.0%	59.2%	57.2%	59.1%	60.3%
	Visually Impaired and People with Disabilities	12.0%	11.0%	8.6%	11.4%	11.8%
	The Elderly (Ages 65+)	2.8%	2.5%	2.5%	2.3%	1.5%
SALT LAKE	PCN	8.2%	6.3%	5.6%	5.5%	5.3%
	Pregnant Women	9.1%	8.6%	7.2%	6.5%	6.4%
	Adult (Ages 19-64)	10.9%	11.8%	12.8%	14.1%	14.3%
	Children	53.3%	55.3%	56.5%	56.2%	56.0%
	Visually Impaired and People with Disabilities	13.6%	13.2%	13.0%	12.8%	12.9%
	The Elderly (Ages 65+)	4.9%	4.8%	4.9%	5.0%	5.2%

Table 16: Medicaid Enrollment Composition by County

County	Category of Assistance	FY2009	FY2010	FY2011	FY2012	FY2013
SAN JUAN	PCN	5.7%	4.5%	4.9%	5.9%	6.8%
	Pregnant Women	5.6%	6.1%	5.4%	5.2%	5.5%
	Adult (Ages 19-64)	12.3%	13.7%	13.9%	17.1%	16.6%
	Children	53.2%	53.5%	54.1%	51.7%	51.9%
	Visually Impaired and People with Disabilities	11.6%	11.3%	11.0%	10.3%	9.8%
	The Elderly (Ages 65+)	11.7%	10.9%	10.6%	9.8%	9.3%
SANPETE	PCN	16.7%	12.2%	10.5%	9.4%	9.1%
	Pregnant Women	6.7%	7.2%	6.5%	6.2%	6.1%
	Adult (Ages 19-64)	8.3%	9.7%	10.6%	11.5%	11.9%
	Children	53.3%	56.3%	57.5%	57.7%	57.8%
	Visually Impaired and People with Disabilities	11.7%	11.0%	11.0%	11.3%	11.2%
	The Elderly (Ages 65+)	3.4%	3.6%	4.0%	3.9%	3.9%
SEVIER	PCN	15.0%	11.5%	10.3%	10.2%	9.8%
	Pregnant Women	7.3%	7.9%	6.9%	5.6%	5.6%
	Adult (Ages 19-64)	10.8%	11.8%	12.6%	14.5%	15.5%
	Children	50.5%	52.8%	53.3%	53.0%	51.4%
	Visually Impaired and People with Disabilities	11.7%	11.6%	12.5%	12.0%	12.8%
	The Elderly (Ages 65+)	4.7%	4.3%	4.4%	4.7%	5.0%
SUMMIT	PCN	9.7%	6.5%	5.2%	5.1%	5.5%
	Pregnant Women	12.0%	10.6%	8.1%	7.0%	6.8%
	Adult (Ages 19-64)	4.8%	7.6%	9.4%	11.2%	10.4%
	Children	62.5%	65.3%	66.7%	65.7%	65.0%
	Visually Impaired and People with Disabilities	8.5%	7.7%	8.1%	8.2%	9.3%
	The Elderly (Ages 65+)	2.5%	2.3%	2.4%	2.7%	3.1%
TOOELE	PCN	9.1%	7.1%	6.3%	5.8%	5.6%
	Pregnant Women	7.1%	7.7%	6.8%	6.5%	6.3%
	Adult (Ages 19-64)	12.7%	13.7%	14.2%	15.2%	15.9%
	Children	55.2%	55.6%	57.0%	57.2%	56.5%
	Visually Impaired and People with Disabilities	12.6%	12.5%	12.3%	12.1%	12.6%
	The Elderly (Ages 65+)	3.3%	3.4%	3.3%	3.2%	3.1%
UINTAH	PCN	7.3%	5.3%	4.4%	3.9%	3.6%
	Pregnant Women	9.0%	8.7%	8.5%	7.5%	7.8%
	Adult (Ages 19-64)	11.4%	13.8%	14.2%	15.7%	15.2%
	Children	55.6%	56.7%	57.1%	57.7%	58.7%
	Visually Impaired and People with Disabilities	12.4%	11.5%	11.4%	11.1%	10.7%
	The Elderly (Ages 65+)	4.3%	3.9%	4.4%	4.2%	3.9%
UTAH	PCN	10.2%	7.7%	6.2%	5.9%	5.5%
	Pregnant Women	10.0%	9.9%	9.1%	8.4%	8.4%
	Adult (Ages 19-64)	10.1%	11.5%	12.6%	13.9%	14.3%
	Children	57.2%	59.0%	60.1%	59.6%	59.3%
	Visually Impaired and People with Disabilities	10.0%	9.5%	9.5%	9.6%	9.7%
	The Elderly (Ages 65+)	2.4%	2.4%	2.5%	2.7%	2.8%
WASATCH	PCN	11.5%	8.9%	7.6%	6.6%	5.6%
	Pregnant Women	10.3%	9.3%	8.0%	7.2%	6.8%
	Adult (Ages 19-64)	6.3%	8.6%	10.6%	12.7%	12.8%
	Children	58.0%	60.6%	61.2%	61.4%	62.6%
	Visually Impaired and People with Disabilities	10.3%	9.4%	9.4%	9.3%	9.4%
	The Elderly (Ages 65+)	3.5%	3.2%	3.2%	2.9%	2.8%
WASHINGTON	PCN	11.9%	9.1%	7.8%	7.1%	6.8%
	Pregnant Women	9.3%	8.9%	7.7%	7.1%	6.7%
	Adult (Ages 19-64)	7.6%	9.9%	11.8%	13.6%	14.1%
	Children	58.5%	59.8%	60.5%	59.9%	59.8%
	Visually Impaired and People with Disabilities	8.6%	8.4%	8.4%	8.5%	8.6%
	The Elderly (Ages 65+)	4.1%	3.9%	3.8%	3.9%	3.9%

Table 16: Medicaid Enrollment Composition by County

County	Category of Assistance	FY2009	FY2010	FY2011	FY2012	FY2013
WAYNE	PCN	17.2%	10.5%	9.2%	10.3%	10.9%
	Pregnant Women	8.6%	9.2%	7.9%	4.6%	5.8%
	Adult (Ages 19-64)	6.0%	10.2%	11.9%	13.1%	12.1%
	Children	55.2%	57.5%	58.3%	58.5%	53.9%
	Visually Impaired and People with Disabilities	8.3%	8.7%	8.4%	9.3%	12.1%
	The Elderly (Ages 65+)	4.6%	3.9%	4.2%	4.1%	5.2%
WEBER	PCN	8.5%	6.6%	6.1%	5.5%	5.4%
	Pregnant Women	7.8%	7.6%	6.8%	6.1%	6.2%
	Adult (Ages 19-64)	11.1%	12.1%	12.9%	14.8%	14.9%
	Children	53.7%	54.9%	55.4%	55.1%	54.9%
	Visually Impaired and People with Disabilities	14.8%	14.6%	14.5%	14.3%	14.4%
	The Elderly (Ages 65+)	4.2%	4.1%	4.2%	4.2%	4.2%



Medicaid Delivery and Payment of Services

Medicaid expenditures are related to the enrollment levels which, in turn, are affected by economic, demographic and age-mix factors. Services are provided to Medicaid enrollees either directly by licensed providers (fee-for-service) or through contracts with managed care organizations (MCO).

Under federal law, participating providers must accept the reimbursement level as payment in full. Several methods are used to determine provider reimbursement, including limited fees-for-service, negotiated capitation rates, and client acuity-based rates for nursing home services.

Services covered by Medicaid can be classified into the following major service groups:

- **Hospital Care** – Services delivered through inpatient and outpatient hospital facilities.
- **Physicians** – All physician-delivered services.
- **Pharmacy** – Prescription drug products.
- **Other Services** – Includes a wide range of medical services, such as vision care, home health care, rural health clinics and prenatal care.
- **Long-Term Care** – Services provided to individuals who are either elderly or have a disability. Services can be provided in either a facility-based or community-based setting.



Providers

Medical services are provided to Medicaid clients by any willing provider who bills DMHF directly. Table 17 provides a unique count of providers by category of service.

Table 17: Number of Participating Providers by Category of Service					
Category of Service	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Aging Waiver Service	193	180	192	230	321
Ambulatory Surgical Services	48	46	48	43	42
Buy Out	1,392	1,602	1,312	1,316	1,312
Chiropractic Services	238	209	205	192	183
Contracted Mental Hlth Svcs	185	185	320	239	192
Custody Medical	314	124	134	140	134
Dental Services	723	715	728	782	820
Early Intervention	16	17	17	16	16
ESRD Kidney Dialysis Svcs	38	42	43	42	41
Federally Qualified Health Cntrs	23	25	27	27	27
HIT Dual Elig Hosp Yr1 Meaningful Use	0	0	0	0	16
HIT Elig Prov Yr1 Adopt	0	0	0	105	218
HIT Elig Prov Yr2 Meaningful Use	0	0	0	0	17
Home Health Services	150	160	161	183	189
Home/Comm Waiver Contract Svcs	212	240	238	253	371
ICF/ID1 (LOC 4)	17	16	15	15	15
Independent Lab and/or X-Ray Svcs	86	89	95	110	107
Inpatient Hospital Svcs, General	174	188	164	192	205
Intensive Skilled Care	0	11	12	12	16
Medical Supply Services	547	541	485	481	472
Medical Transportation	125	122	113	129	116
Mental Health Services	0	0	11	15	78
New Choices Waiver Svcs	444	190	192	212	256
Nursing Facility I (NF I)	114	115	118	112	109
Nursing Facility II (NF II)	91	98	95	91	84
Nursing Facility III (NF III)	91	101	101	95	96
Occupational Therapy	47	52	40	36	36
Osteopathic Services	349	337	322	373	386
Other	82	87	50	65	58
Outpatient Hospital Svcs, General	353	367	379	397	382
Pediatric/Family Nurse Pract	178	177	188	215	229
Personal Care	60	47	59	53	59
Pharmacy	555	592	580	580	583
Physical Therapy Services	293	242	229	252	247
Physician Services	3,431	3,443	3,526	3,835	3,626
Podiatry Services	132	118	111	123	117
Psychologist Services	86	84	93	104	112
QMB-Only Services	175	162	160	215	204
Rural Health Clinic Services	18	17	17	23	23
Skills Development	30	32	32	33	34
Specialized Nursing Svcs	152	123	115	129	125
Speech and Hearing Services	101	96	75	88	95
Substance Abuse Treatment Svcs	35	35	34	48	55
Targeted Case Mngmnt Svcs	23	0	38	28	26
Vision Care Services	274	264	256	263	259
Well Child Care (EPSDT) Svcs	650	643	646	603	546
Total	12,245	11,934	11,776	12,495	12,655

Table 18 shows the reimbursement amounts to fee-for-service (FFS) providers by category of service.

Table 18: Reimbursement Amounts to Fee-for-Service Providers by Category of Service					
Category of Service	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Aging Waiver Service	\$4,068,900	\$3,524,300	\$3,544,200	\$4,215,300	\$4,249,500
Ambulatory Surgical Services	\$7,812,700	\$9,656,600	\$7,893,300	\$6,769,800	\$5,885,100
Buy Out	\$486,000	\$517,900	\$418,300	\$398,700	\$393,500
Chiropractic Services	\$200,600	\$155,200	\$145,700	\$131,100	\$114,600
Contracted Mental Hlth Svcs	\$55,201,300	\$47,809,800	\$16,496,300	\$16,796,600	\$16,840,200
Custody Medical	\$85,000	\$131,700	\$153,400	\$54,300	\$48,600
Dental Services	\$34,267,000	\$31,857,500	\$35,651,300	\$38,795,500	\$42,161,800
Early Intervention	\$6,312,700	\$6,544,100	\$9,089,600	\$8,173,900	\$8,594,600
ESRD Kidney Dialysis Svcs	\$2,339,200	\$2,286,600	\$1,323,800	\$1,900,100	\$1,621,100
Federally Qualified Health Cntrs	\$5,430,500	\$5,354,400	\$6,022,800	\$5,706,300	\$5,404,700
HIT Dual Elig Hosp Yr1 Meaningful Use	\$0	\$0	\$0	\$0	\$9,870,800
HIT Elig Prov Yr1 Adopt	\$0	\$0	\$0	\$3,987,900	\$5,301,200
HIT Elig Prov Yr2 Meaningful Use	\$0	\$0	\$0	\$0	\$289,000
Home Health Services	\$26,480,700	\$27,856,800	\$27,511,200	\$27,502,500	\$30,611,500
Home/Comm Waiver Contract Svcs	\$155,537,200	\$154,201,800	\$154,214,200	\$160,007,200	\$171,057,500
ICF/MR1 (LOC 4)	\$30,241,800	\$30,730,100	\$31,509,700	\$32,305,100	\$31,741,700
Independent Lab and/or X-Ray Svcs	\$2,898,600	\$3,064,100	\$3,228,400	\$3,118,900	\$2,971,900
Inpatient Hospital Svcs, General	\$334,820,000	\$332,696,000	\$509,246,700	\$511,698,100	\$410,531,100
Intensive Skilled Care	\$0	\$0	\$0	\$0	\$17,829,500
Medical Supply Services	\$12,042,900	\$12,934,500	\$14,389,400	\$15,895,400	\$13,973,800
Medical Transportation	\$6,366,300	\$6,188,500	\$6,429,600	\$6,621,500	\$7,010,700
Mental Health Services	\$0	\$0	\$0	\$121,756,700	\$119,774,200
New Choices Waiver Svcs	\$19,243,700	\$18,972,700	\$21,991,500	\$24,780,800	\$29,608,000
Nursing Facility I (NF I)	\$14,809,200	\$8,507,600	\$7,046,000	\$6,222,600	\$4,707,500
Nursing Facility II (NF II)	\$64,795,800	\$61,654,700	\$54,022,400	\$46,548,300	\$27,487,300
Nursing Facility III (NF III)	\$63,374,700	\$71,317,300	\$86,360,000	\$102,670,200	\$120,422,400
Occupational Therapy	\$66,200	\$86,300	\$111,900	\$109,900	\$77,700
Osteopathic Services	\$6,283,300	\$7,128,900	\$7,982,500	\$7,975,600	\$7,506,700
Other	\$165,172,100	\$159,172,900	\$181,927,400	\$56,003,400	\$35,900,900
Outpatient Hospital Svcs, General	\$112,023,900	\$119,076,500	\$107,156,800	\$103,533,700	\$70,227,400
Pediatric/Family Nurse Pract	\$579,500	\$532,900	\$523,000	\$506,200	\$482,600
Personal Care	\$1,414,000	\$1,883,500	\$2,068,300	\$2,768,400	\$3,456,800
Pharmacy	\$143,120,000	\$158,605,600	\$172,956,500	\$183,388,900	\$137,387,000
Physical Therapy Services	\$397,300	\$411,900	\$476,300	\$472,900	\$354,600
Physician Services	\$101,065,900	\$114,613,100	\$112,655,800	\$101,608,500	\$86,853,100
Podiatry Services	\$433,300	\$432,900	\$457,700	\$453,900	\$480,500
Psychologist Services	\$259,100	\$269,000	\$315,200	\$305,600	\$322,400
QMB-Only Services	\$511,000	\$352,500	\$320,200	\$389,700	\$419,100
Rural Health Clinic Services	\$1,139,500	\$1,329,500	\$1,250,500	\$1,186,500	\$1,225,400
Skills Development	\$18,610,700	\$20,430,100	\$25,359,800	\$22,487,400	\$26,905,000
Specialized Nursing Svcs	\$3,052,000	\$3,153,200	\$3,369,100	\$3,077,600	\$2,559,600
Speech and Hearing Services	\$487,300	\$299,300	\$348,000	\$373,300	\$321,700
Substance Abuse Treatment Svcs	\$10,002,900	\$9,775,900	\$9,730,600	\$10,687,100	\$18,744,400
Targeted Case Mngmnt Svcs	\$62,400	\$0	\$55,400	\$50,100	\$60,000
Vision Care Services	\$2,064,600	\$2,036,400	\$2,278,400	\$2,219,700	\$1,903,100
Well Child Care (EPSDT) Svcs	\$9,525,300	\$10,929,200	\$11,272,700	\$10,849,900	\$8,423,900
Grand Total	\$1,423,085,100	\$1,446,481,800	\$1,637,303,900	\$1,654,505,100	\$1,492,113,700

Managed Care

Managed care has been part of the Medicaid service delivery system since the 1990's. In a managed care delivery system, Medicaid recipients receive their health care through an organization under contract with DMHF to provide Medicaid covered services. DMHF uses waiver authority under Section 1915 (b) of the Social Security Act to implement managed care delivery systems.

Utah's 1915 (b) Choice of Health Care Delivery Program waiver grants authority to the Department to require Medicaid recipients living in Weber, Davis, Salt Lake, and Utah counties to select a health plan. Health plans are responsible to provide Medicaid services through their provider network. Some health plans are available in other counties of the state. Enrollment in a health plan outside the Wasatch Front is voluntary.

The 1915(b) Prepaid Mental Health Plan waiver allows Medicaid to enroll all Medicaid recipients in behavioral health plans statewide. Behavioral health services are provided under full risk capitated contracts administered under the statutory authority of the local county mental health and substance abuse authorities.

In September 2013, the DMHF implemented the 1915(b) Dental Choices waiver which requires Medicaid recipients eligible for full dental services, (pregnant women and children) in Weber, Davis, Salt Lake and Utah counties to enroll in a managed care dental plan.

Figure 14a illustrates the monthly average number of Medicaid recipients receiving services through managed care.

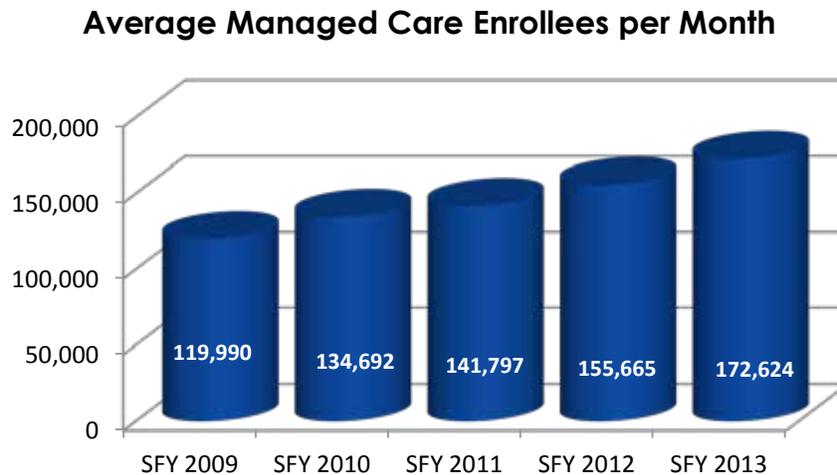


FIGURE 14a

Average Managed Care Enrollees per Month Percentage Change

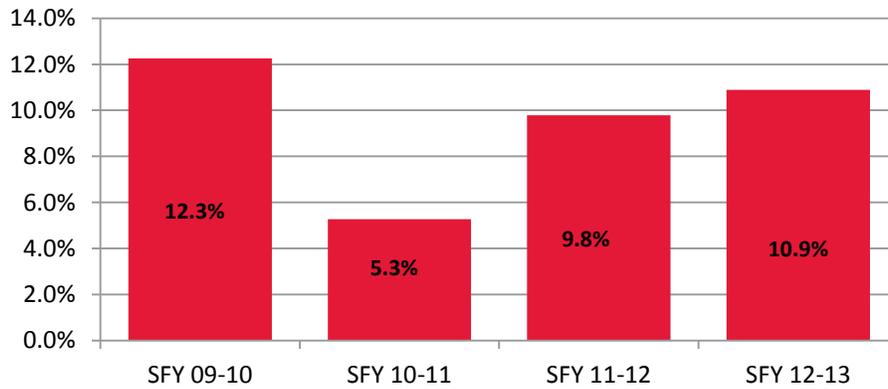


FIGURE 14b

Figure 15a illustrates statewide managed care expenditures by fiscal year. The large year to year percent growth during FY 12-13, seen in Figure 15b, is attributed to the shift to ACOs. With this shift, some of the recipients and expenditures that were previously attributed to FFS hospital care services, FFS physician services, FFS pharmacy services, other fee-for-services and long-term care services, have been moved into the managed care services category.

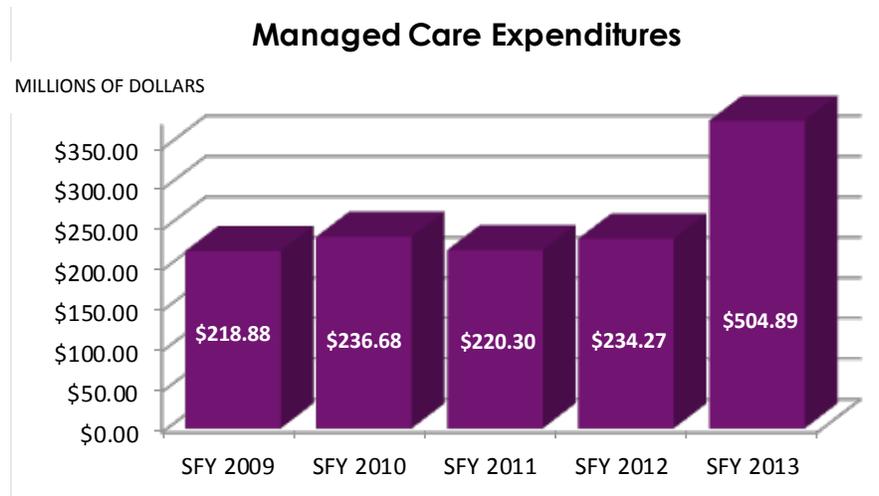


FIGURE 15a

Managed Care Expenditures Percentage Growth

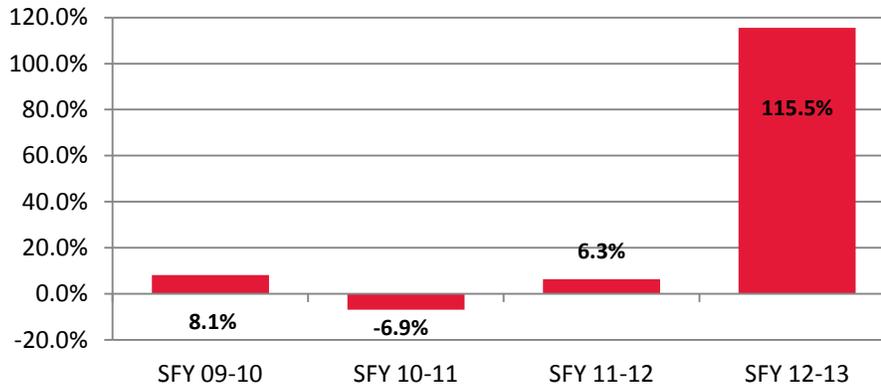


FIGURE 15b

MANAGED CARE: ACCOUNTABLE CARE ORGANIZATIONS

In response to concerns that the Utah Medicaid growth rates exceeded the State’s annual revenue growth rate for the past two decades and concerns about the long-term sustainability of the Medicaid program, Senate Bill 180, Medicaid Reform, was passed during the General Legislative Session in 2011. In part, the Bill requires that: “The Department shall develop a proposal to amend the State Plan for the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models.” In order to maximize replacement of the fee-for-service delivery model, Senate Bill 180 provides some specific goals and guidance:

1. Restructure the program’s provider payment provisions to reward health care providers for delivering the most appropriate service at the lowest cost that maintains or improves recipient health status. The Legislation included:
 - (a) Identifying evidence-based practices and other mechanisms necessary to reward providers for delivering the most appropriate services at the lowest cost;
 - (b) Paying providers for packages of services delivered over entire episodes of illness;
 - (c) Rewarding providers for delivering services that make the most positive contribution to maintaining and improving a recipient’s health status;
 - (d) Using providers that deliver the most appropriate services at the lowest cost; and
2. Restructure the program to bring the rate of growth in Medicaid more in line with the overall growth in General Funds.
3. Restructure the program’s cost sharing provisions and add incentives to reward recipients for personal efforts to maintain and improve their health status.

To achieve these goals, effective January 2013, the Division implemented Accountable Care Organizations (ACOs). There are four ACOs currently operating on behalf of Medicaid: HealthChoice Utah, Healthy U, Molina Healthcare of Utah and SelectHealth Community Care.

The goals of the ACOs are to maintain quality of care and improve health outcomes for Medicaid recipients and to control costs by keeping the Medicaid cost growth rate from exceeding the State General Fund growth rate. All managed care contracts are full risk capitated contracts and therefore assume the risk for all health care costs for their enrollees. The Division contracts with a nationally recognized actuarial firm to develop member per month rates paid to a managed care organization, which must be actuarially certified and approved by CMS.

Figure 16 is a breakdown of the monthly average number of Medicaid recipients by rate cell served by all ACOs. The children from ages one to 18 years old, both male and female together, constitute about 60 percent of ACO recipients. Non-traditional females (ages 19 through 64) makes up about 8.2 percent, which is about 2.4 times more than non-traditional males. Males and females of all ages with disabilities account for about 14 percent of all recipients, followed by the birth to one year old category at 7.6 percent. All of the other rate cells, aggregated, compose about 4.2 percent of the recipient total.

ACO Average Members per Month by Rate Category

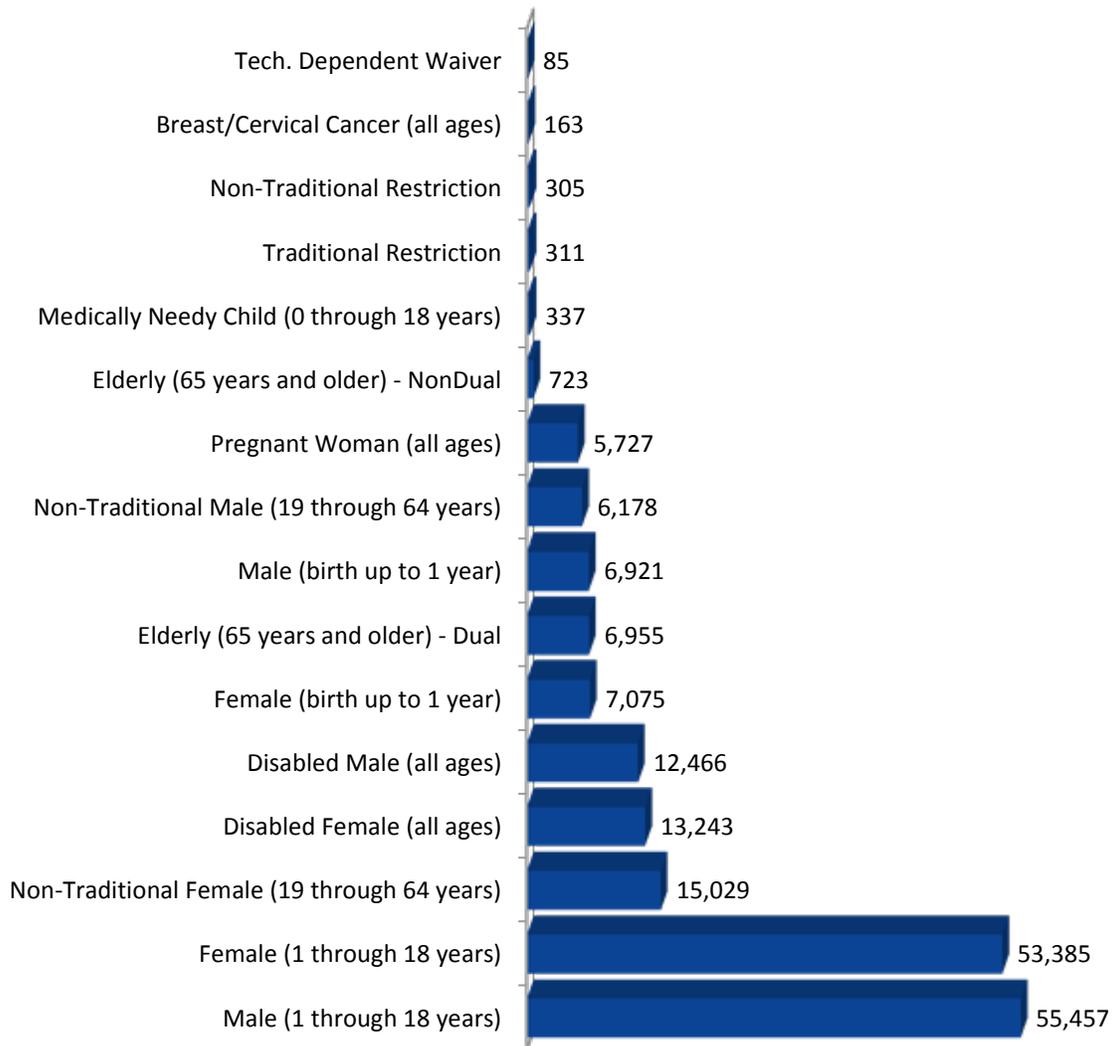


FIGURE 16

Figure 17 shows the weighted average base rates for each rate cell. The Technology Dependent Waiver rate cell has the largest base rate but the least amount of member months. By contrast the males and females between the ages of 1 and 18 account for the lowest base rates but the highest number of member months.

ACO Weighted Average Base Rates

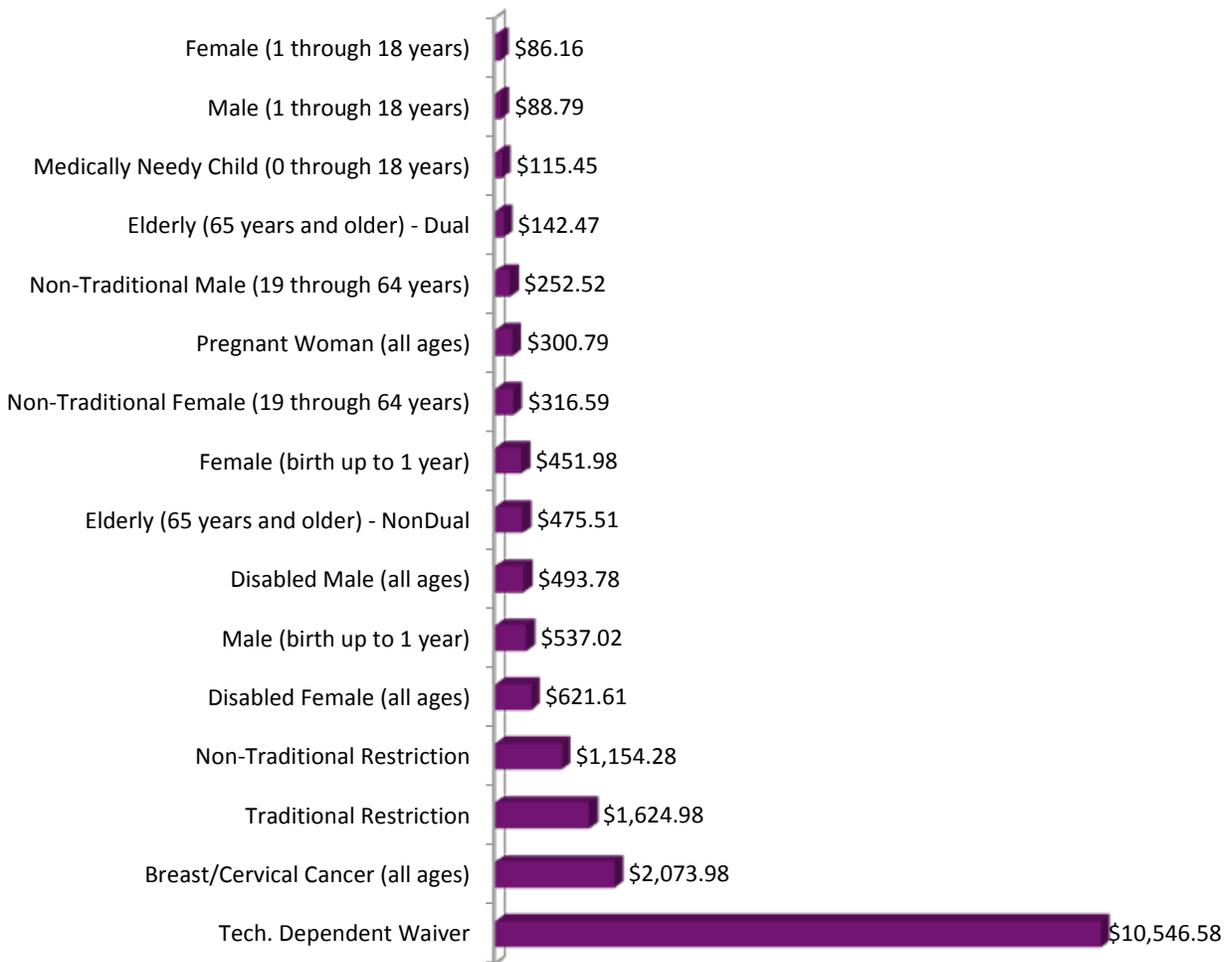


FIGURE 17

MANAGED CARE: BEHAVIORAL HEALTH

The Utah Legislature appropriates state funds to the Utah Department of Human Services (DHS), specifically the Division of Substance Abuse and Mental Health (DSAMH), the State’s mental health and substance abuse authority. The DSAMH allocates these state general funds to the local county mental health and substance abuse authorities. In accordance with Utah Code Annotated, 17-43-301 and 17-43-201, the local county mental health authorities and substance abuse authorities are statutorily responsible for the provision of public mental health and substance abuse services to citizens in their respective counties.

Local county authorities provide the Medicaid state matching share for Medicaid behavioral health services except for inpatient services. Therefore, as these are optional Medicaid services, the state has entered into contracts with the local county authorities or their contracted entities for the provision of Medicaid mental health and substance abuse services. The local county authorities provide the state match share to fund the outpatient portion of Pre-paid Mental Health Plan premiums. The state share of inpatient services is directly appropriated to the DSAMH.

Table 19 shows the average monthly behavioral health enrollment. The counties are grouped in accordance with their shared providers. For instance, since Bear River Mental Health provides behavioral health services to the residents of Cache, Box Elder and Rich Counties, these counties are grouped together in Table 19.

Table 19: Behavioral Health Average Monthly Enrollment by County					
County	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
CARBON, EMERY & GRAND	4,390	4,607	4,749	4,911	5,041
DAVIS	15,184	17,320	18,967	20,405	20,875
CACHE, BOX ELDER & RICH	11,323	12,761	13,657	14,346	14,702
JUAB, MILLARD, PIUTE, SANPETE, SEVIER & WAYNE	6,844	7,502	7,959	8,142	8,177
SALT LAKE, SUMMIT & TOOELE	77,266	89,704	98,626	105,137	107,944
UTAH & WASATCH	31,709	37,133	40,611	42,806	43,219
MORGAN & WEBER	19,274	21,230	23,229	25,175	25,701
DAGGET, DUCHESNE & UINTAH	3,653	4,418	4,614	4,848	4,800
BEAVER, GARFIELD, IRON, KANE & WASHINGTON	16,578	19,312	21,547	23,327	23,724

Fee-for-Service

FEE-FOR-SERVICE: HOSPITAL CARE

Medicaid covers services performed in an inpatient setting at a hospital. There is an annual co-payment for inpatient services for non-emergent stays. Most outpatient services are covered on a referral basis and may be subject to prior approval.

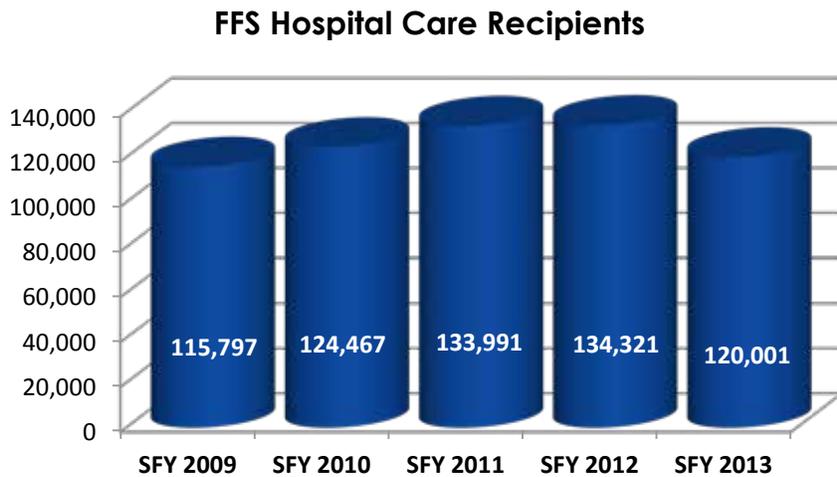


FIGURE 18

Figure 18 shows the number of recipients who utilized fee-for-service (FFS) hospital care services in both inpatient and outpatient hospital facilities. Figure 19 shows expenditures for FFS hospital care services. The dramatic drop during SFY 12-13 is largely attributable to the implementation of ACOs.

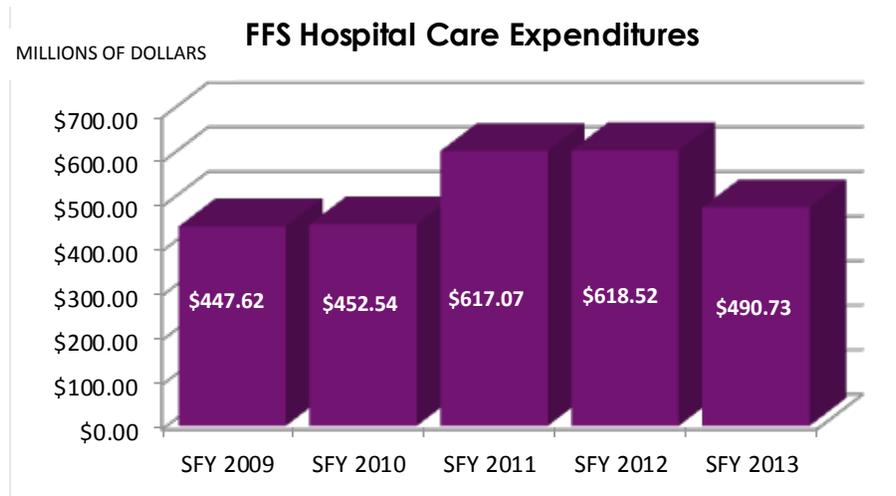


FIGURE 19

FEE-FOR-SERVICE: PHYSICIAN SERVICES

Medicaid pays for each Medicaid eligible to see a Primary Care Provider (PCP) when the eligible is having health problems. Most of the time treatment can be provided by the PCP in the office. If the PCP feels the problem is too serious to treat in the office, a referral is made to a specialist.

Figure 20 displays a statewide look at the number of Medicaid recipients who have utilized FFS physician services. The decline for FY12-13 is due to the ACO shift explained previously.

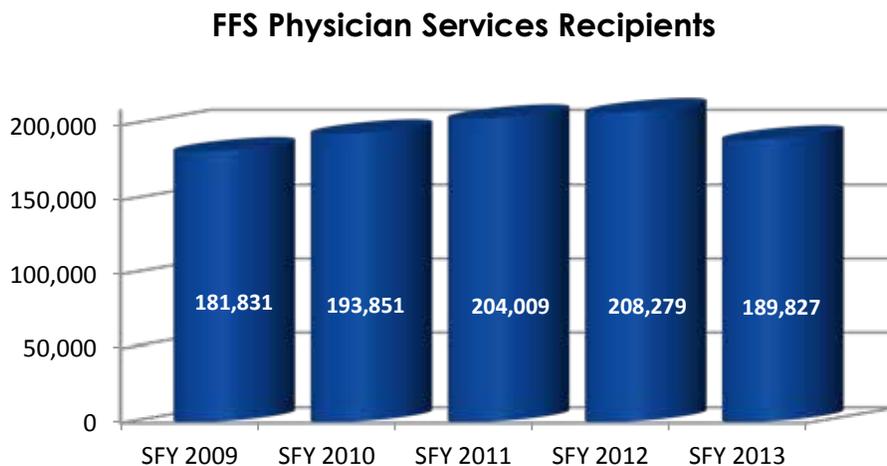


FIGURE 20

Figure 21 provides a look at statewide FFS physician services associated expenditures.

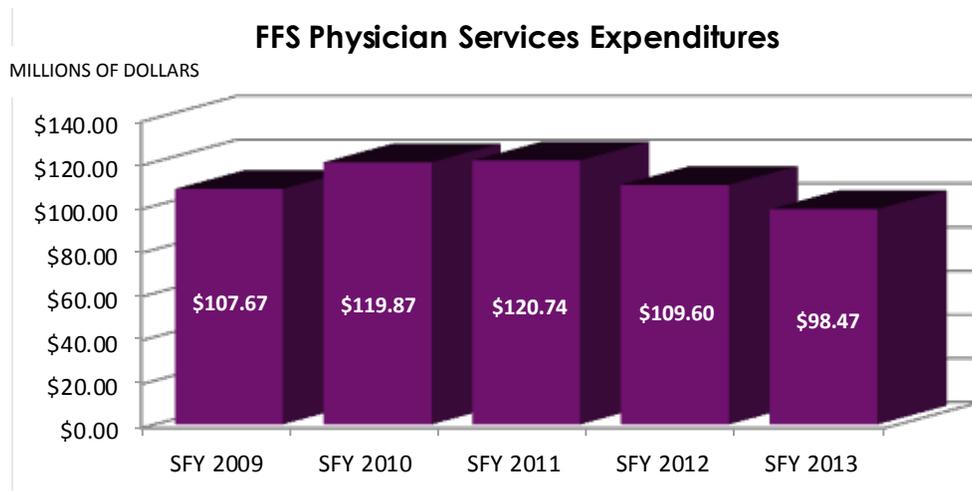


FIGURE 21

FEE-FOR-SERVICE: PHARMACY SERVICES

The Division of Medicaid and Health Financing provides coverage for nearly all available prescription drugs approved by the Food and Drug Administration (FDA).

To manage the costs of prescription drugs, the Division of Medicaid and Health Financing has a generic-first requirement. If a generic product is available in a drug class and it is not more expensive than the brand name product, then the pharmacy must dispense the generic. If a generic brand for the drug does not exist, then a name brand is often used. Some prescriptions require prior approval.

The Division also employs a Preferred Drug List (PDL) program with prior authorization. Following a determination of safety and efficacy by the Pharmacy and Therapeutics Committee, preferred drugs are selected based upon recommendations by the Committee and the net cost of the drugs. In many cases, the manufacturers of these products provide a secondary rebate to Medicaid.

Figure 22 shows the number of recipients utilizing FFS pharmacy services. This information does not capture pharmacy utilization by recipients enrolled in ACOs.

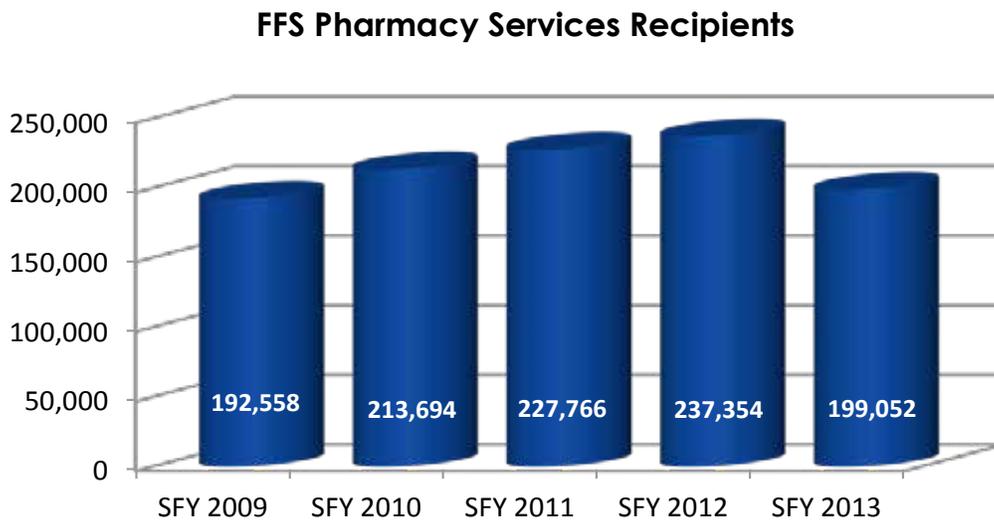


FIGURE 22

Figure 23 illustrates statewide expenditures on FFS pharmacy services. The decline during FY 12-13, is in large part, due to the implementation of the ACO model. ACO capitation payments include pharmacy payments.

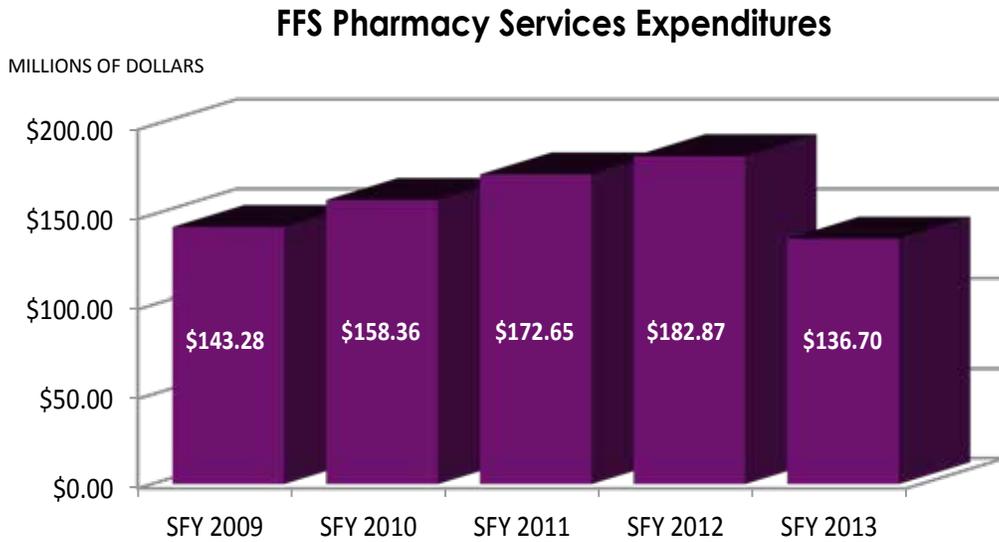


FIGURE 23

FEE-FOR-SERVICE: OTHER SERVICES

Figure 24 illustrates the number of recipients, statewide, utilizing all other FFS. The “other” group includes services provided via outpatient hospitals, home health services/hospices, mental health facilities, dental facilities, vision care, occupational therapists, rural health facilities, physical therapists, podiatrists, chiropractors, nutritionists and psychologists. Utilization of these services followed largely the same trend as physician services.

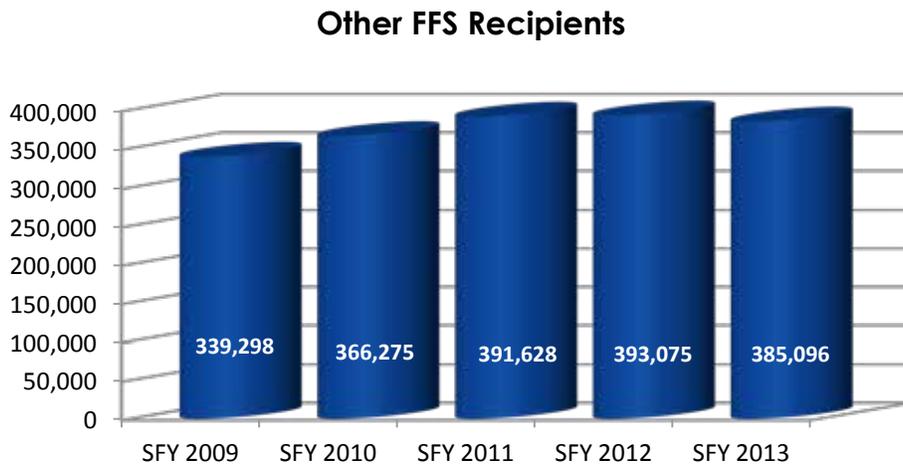


FIGURE 24

Figure 25 depicts statewide expenditures on the other services category.

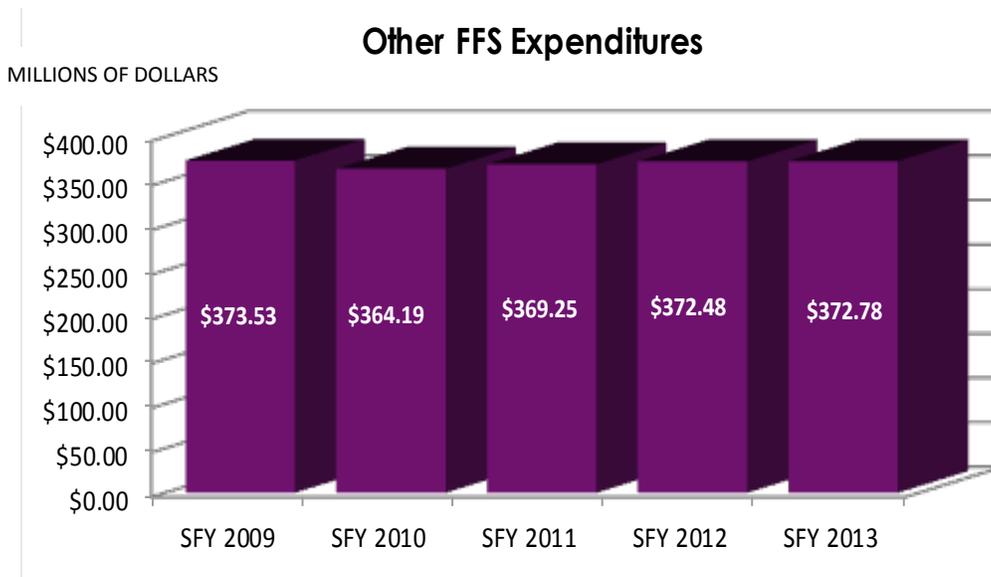


FIGURE 25

Long-Term Care

Long-term care (LTC) includes a variety of services that help meet the needs of individuals with chronic illnesses or disabilities. Long-term care services can be provided in homes and community-based (HCBS) settings or nursing facilities. Eligibility for receiving long-term care services is dependent on assessments performed to determine whether the level-of-care provided in the long-term care program is essential. Individuals are re-assessed periodically, either annually or other routinely scheduled basis, to assess the need for continued LTC services.

Figure 26a illustrates statewide long-term care related expenditures.

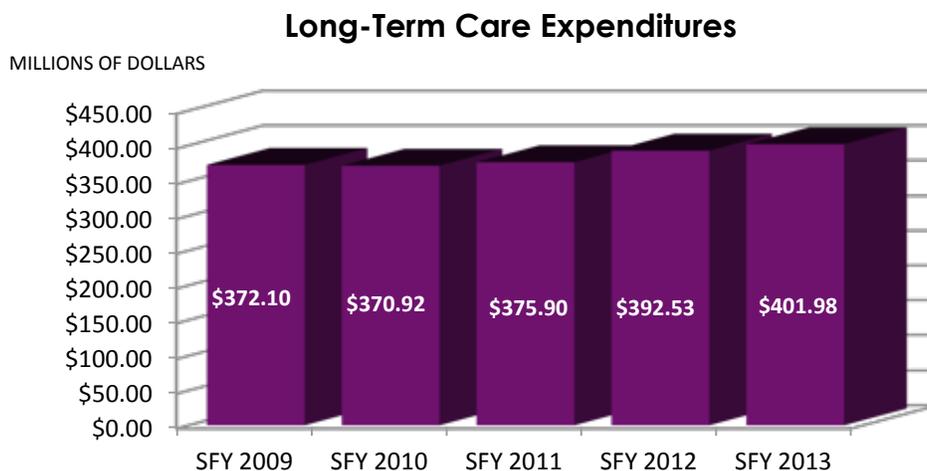


FIGURE 26a

Long-Term Care Expenditures Percentage Growth

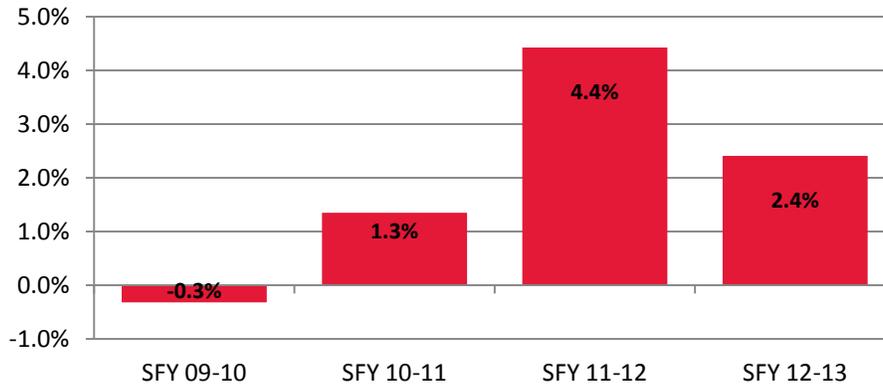


FIGURE 26b

Table 20 provides a county level detail of long-term care expenditures. Expenditures for these services declined in 10 counties between FY 2012 and FY 2013, all of which were non-Wasatch Front counties.

Table 20: Long-Term Care Expenditures by County					
County	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
BEAVER	\$1,272,000	\$1,159,000	\$1,009,200	\$1,098,700	\$968,300
BOX ELDER	\$5,434,200	\$5,725,700	\$5,484,400	\$5,956,600	\$5,903,700
CACHE	\$14,236,200	\$13,829,600	\$14,027,200	\$13,813,400	\$13,756,500
CARBON	\$5,682,500	\$7,361,900	\$5,545,000	\$6,082,100	\$6,471,000
DAGGETT	\$26,300	\$31,400	\$33,000	\$0	\$0
DAVIS	\$30,697,000	\$30,852,200	\$31,990,100	\$34,808,600	\$36,283,300
DUCHESNE	\$3,231,700	\$3,490,200	\$3,556,700	\$4,224,800	\$3,669,700
EMERY	\$1,512,300	\$1,404,500	\$1,294,900	\$1,560,600	\$1,577,700
GARFIELD	\$979,600	\$1,020,100	\$1,053,300	\$971,900	\$959,300
GRAND	\$677,800	\$711,200	\$784,600	\$1,311,600	\$1,140,300
IRON	\$6,773,900	\$7,263,300	\$7,396,000	\$7,922,400	\$8,317,000
JUAB	\$2,735,800	\$2,830,100	\$2,653,800	\$2,694,200	\$2,966,900
KANE	\$772,900	\$774,200	\$740,600	\$696,000	\$607,300
MILLARD	\$1,809,900	\$1,914,200	\$2,269,600	\$2,152,300	\$1,819,300
MORGAN	\$118,800	\$94,500	\$120,600	\$145,700	\$218,500
PIUTE	\$35,300	\$37,200	\$123,200	\$110,200	\$51,100
RICH	\$84,000	\$118,800	\$71,700	\$87,800	\$124,800
SALT LAKE	\$135,557,200	\$133,566,100	\$138,689,000	\$145,277,000	\$148,291,100
SAN JUAN	\$4,057,900	\$3,966,600	\$4,068,400	\$4,088,700	\$3,893,500
SANPETE	\$3,044,000	\$3,001,600	\$2,794,100	\$2,824,700	\$2,921,000
SEVIER	\$3,078,200	\$3,046,800	\$3,254,100	\$4,126,100	\$4,192,700
SUMMIT	\$780,700	\$817,400	\$795,700	\$776,700	\$972,300
TOOELE	\$2,994,500	\$3,551,800	\$3,201,700	\$3,136,800	\$3,838,600
UINTAH	\$4,615,800	\$4,833,200	\$5,012,000	\$5,083,400	\$5,456,300
UTAH	\$87,880,000	\$86,622,600	\$87,339,100	\$89,874,800	\$91,623,400
WASATCH	\$2,031,600	\$1,928,500	\$1,959,000	\$1,814,000	\$1,845,100
WASHINGTON	\$16,476,700	\$15,721,100	\$16,675,800	\$17,080,200	\$17,331,500
WAYNE	\$41,600	\$55,300	\$40,400	\$70,000	\$23,800
WEBER	\$35,435,700	\$35,169,900	\$33,921,200	\$34,738,400	\$36,754,200
Long-Term Care Total	\$372,104,900	\$370,916,800	\$375,904,000	\$392,534,700	\$401,978,200

LONG-TERM CARE: NURSING HOME SERVICES

These services provide a full array of care on a 24-hour basis in licensed, skilled or intermediate care facilities including specialized facilities for people with intellectual disabilities. Services provided in the various facilities include: medical treatment to residents whose medical conditions are unstable and/or complex; medical treatment to residents whose medical conditions are stable but still require nursing care; supervision and assistance with daily living activities such as bathing, dressing and eating; and active treatment and health-related services to residents with intellectual disabilities in a supervised environment.

Table 21 provides nursing home expenditures for the Wasatch Front (Davis, Salt Lake, Utah and Weber Counties) and non-Wasatch Front Counties.

Table 21: Nursing Home Expenditures by Locality					
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
DAVIS	\$17,319,900	\$17,795,500	\$17,733,400	\$19,545,900	\$20,008,800
SALT LAKE	\$70,488,400	\$69,741,400	\$75,010,700	\$80,224,600	\$78,576,400
UTAH	\$59,599,600	\$58,326,800	\$59,688,900	\$60,810,700	\$60,960,100
WEBER	\$21,221,100	\$21,930,200	\$21,395,000	\$22,264,500	\$24,015,400
All Other Counties	\$43,863,300	\$45,376,200	\$44,314,000	\$45,436,100	\$42,935,900
Total	\$212,492,300	\$213,170,100	\$218,142,000	\$228,281,800	\$226,496,600

LONG-TERM CARE: HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS

The State operates seven HCBS waivers. HCBS waivers provide LTC services in home and community-based settings as an alternative to nursing home services or services provided in an intermediate care facility for individuals with intellectual disabilities. The day-to-day administration and state funding of four of the HCBS waivers is provided by the Department of Human Services (DHS): 1) Waiver for Individuals Aged 65 and Older, 2) Waiver for Individuals with Acquired Brain Injuries, 3) Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, and 4) the Waiver for Individuals with Physical Disabilities. The New Choices Waiver and Technology Dependent Waiver are managed internally and funded through the Division of Medicaid and Health Financing (DMHF). The Medicaid Autism Waiver is funded through DMHF and the day-to-day operations are managed by DHS. DMHF retains final administrative oversight of the HCBS waivers in its role as the State Medicaid Agency.

Waiver for Individuals Aged 65 and Older (Aging Waiver) – This program’s primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS Division of Aging and Adult Services oversees the day-to-day operation and provides the state funding for this program.

Waiver for Individuals with Acquired Brain Injuries – This program’s primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual’s own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions – This program’s primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual’s own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with intellectual disabilities (ICF/ID). DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Waiver for Individuals with Physical Disabilities – This program’s primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual’s own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS Division of Services for People with Disabilities oversees the day-to-day operation and provides the state funding of this program.

Medicaid Autism Waiver Pilot Program – This program serves children with autism spectrum disorders, 2 through 6 years old. The primary service provided in this program is Applied Behavior Analysis (ABA). ABA involves teaching skills that facilitate development by breaking the skill into small parts and working on one sub-skill at a time until mastery is achieved. ABA services are provided primarily in the child’s home. The DHS Division of Services for People with Disabilities oversees the day-to-day operations and the DMHF provides the state funding for the program.

New Choices Waiver – The purpose of this waiver is to assist individuals who are currently residing in nursing facilities or licensed assisted living facilities to have the option to receive community-based services in the setting of their choice rather than in a nursing facility. DMHF oversees the day-to-day operations and provides the state funding for this program.

Technology Dependent Waiver – This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State Plan services) necessary to assist technology dependent individuals with complex medical needs, allowing them to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by DMHF and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). The Division of Medicaid and Health Financing provides the state matching funds for this program.

Figure 27a shows the expenditures associated with Home and Community Based Services (HCBS).

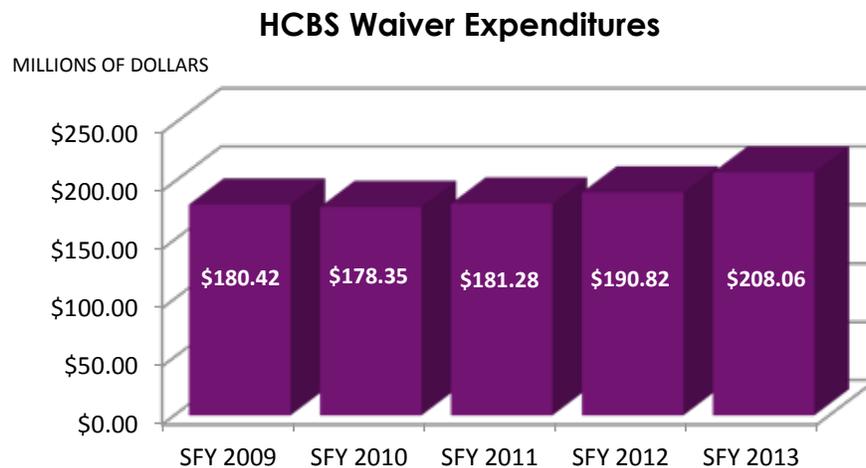


FIGURE 27a

HCBS Waiver Expenditures Percentage Growth

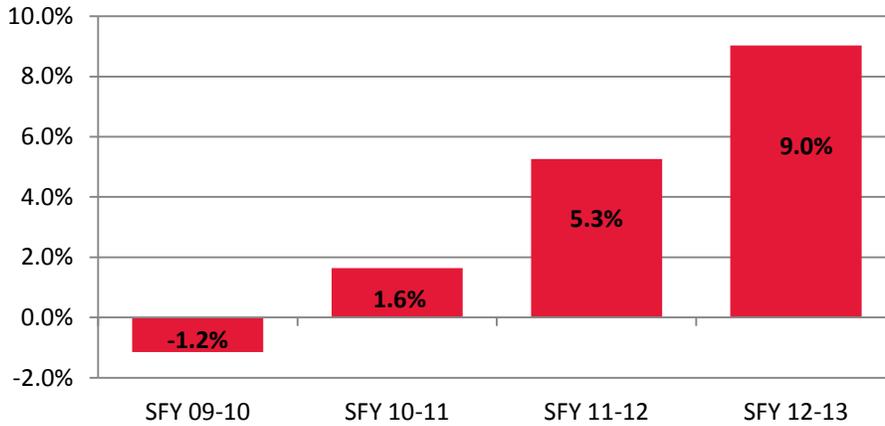


FIGURE 27b

The values in Table 22 reflect the year to year variability in Utah’s FMAP rate, which is detailed in Table 3.

Table 22: HCBS Waiver Expenditures					
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Acquired Brain Injury Waiver	\$2,451,400	\$2,673,400	\$2,642,600	\$2,690,400	\$3,406,200
Aging Waiver	\$4,055,900	\$3,489,900	\$3,482,900	\$4,142,300	\$4,225,300
Community Supports Waiver	\$151,048,400	\$149,592,400	\$149,681,700	\$155,357,800	\$165,675,900
New Choices Waiver	\$18,794,000	\$18,714,300	\$21,688,900	\$24,712,300	\$29,570,900
Physical Disabilities Waiver	\$2,037,400	\$1,937,900	\$1,889,900	\$1,959,200	\$2,125,100
Tech Dependent Waiver	\$2,037,400	\$1,937,900	\$1,889,900	\$1,959,200	\$2,125,100
Autism Waiver	\$0	\$0	\$0	\$0	\$929,700
Grand Total	\$180,424,500	\$178,345,800	\$181,275,900	\$190,821,200	\$208,058,200

Table 23 details the information provided in Figure 27a by waiver category.

Table 23: Utah Medicaid Long Term Care Institutional and Non-Institutional State Fund Expenditure Comparison						
Fiscal Year	Institutional Total State Costs	Non-Institutional Total State Costs	Total Combined State Costs	Difference between Non-Institutional and Institutional Total	Institutional Percentage of Total Costs	Non-Institutional Percentage of Total Costs
SFY 2009	\$62,503,800	\$61,867,300	\$124,371,100	(\$636,500)	50.3%	49.7%
SFY 2010	\$59,391,400	\$57,865,400	\$117,256,800	(\$1,526,000)	50.7%	49.3%
SFY 2011	\$61,811,300	\$63,354,800	\$125,166,100	\$1,543,500	49.4%	50.6%
SFY 2012	\$64,589,300	\$64,434,500	\$129,023,800	(\$154,800)	50.1%	49.9%
SFY 2013	\$66,530,100	\$71,795,400	\$138,325,500	\$5,265,300	48.1%	51.9%

Institutional costs include nursing facility and ICF/ID expenditures. Non-Institutional costs include home and community based waivers, personal care, private duty nursing and home health expenditures.

■ CHILDREN'S HEALTH INSURANCE PROGRAM ■

The Utah Department of Health (DOH) manages the Children's Health Insurance Program (CHIP) through the Division of Medicaid and Health Finance (DMHF). All eligibility actions are handled through the Department of Workforce Services (DWS).

CHIP is a state-sponsored health insurance plan for uninsured children from households with income 200 percent or less of the federal poverty level (FPL). In 2013, a family of four with an income of \$47,100 or less would qualify (See Appendix A).

In accordance with Section 26-40-106, Utah Code Annotated, CHIP benefits for fiscal year 2013 were actuarially equivalent to the benefits received by enrollees in Select Health's Small Business Account plan; the commercial plan with the largest enrollment in the State. In SFY 2013, CHIP contracted with two managed care plans to provide medical services: Molina Healthcare of Utah and SelectHealth.

CHIP contracted with two dental providers, Premier Access and DentaQuest, to provide dental services for all CHIP enrollees. Premier Access is available statewide, while DentaQuest is available in Salt Lake, Weber, Davis, and Utah counties.

Utah's Premium Partnership for Health Insurance (UPP)

In an effort to create private health insurance opportunities for individuals that qualify for CHIP, DOH obtained federal approval to offer families the ability to purchase their employer-sponsored health insurance rather than enroll their children in CHIP. Beginning November 1, 2006, qualified families were eligible to receive a rebate when they purchased health coverage through their work. In addition, qualified families also receive an additional rebate if they purchase dental coverage through their work.

In December 2009, UPP was given approval by CMS to help low-income individuals and families pay for their COBRA coverage. Now families who are either COBRA eligible or who are already enrolled in COBRA may qualify to receive up to \$150 per adult each month and up to \$140 per child each month to help subsidize their monthly COBRA premium payment.

As directed by state law, DOH petitioned the federal government to approve an amendment that would allow UPP to provide rebates to families that purchase private, non-group coverage. This amendment was originally submitted in September 2008. DOH also included this amendment request in a waiver renewal request submitted in February 2010. In spite of an aggressive three year effort to obtain approval for this amendment, CMS rejected DOH's proposal citing a lack of controls in the insurance industry and concerns that low-income families may be taken advantage of in this process.

On March 24, 2010, the President of the United States issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to the new health insurance exchanges. DOH determined that the Executive Order in conjunction with the intent of state law regarding the use of public funds for abortion created new expectations in regards to the UPP subsidy. An emergency rule, effective April 1, 2010, was filed to prohibit UPP from reimbursing families that were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). In order to be eligible for UPP, the insurance plan the family wishes to enroll in must meet the definition of "creditable coverage" as defined in Utah Administrative Code.

Means of Finance

CHIP receives approximately 80 percent of its funding from the federal government under Title XXI of the Social Security Act with the other 20 percent coming from state matching funds. From SFY 2001 to SFY 2007, state funds came exclusively from the proceeds of the Master Settlement Agreement between the State and Tobacco companies. In SFY 2008 to SFY 2013, the state funding also included an appropriation from the General Fund.

- For SFY 2001, the Legislature appropriated \$5.5 million from Tobacco Settlement funds in State match.
- For SFY 2004, the Legislature increased CHIP funding to \$7.0 million to cover more children on the program and to restore dental services.
- For SFY 2006, the Legislature increased the state share of CHIP funding to \$10.3 million to cover more children on the program.
- For SFY 2008, the Legislature added \$2.0 million in ongoing General Fund and \$2.0 million in one-time Tobacco Settlement Restricted Fund to cover more children on the program. For SFY 2008 the total appropriation of state funds was \$14.3 million (\$12.3 million in Tobacco Settlement Restricted Fund and \$2.0 million in General Fund.)
- For SFY 2009, the total appropriation in state funds was \$14.3 million (\$10.3 million in Tobacco Settlement Restricted Fund, \$2.0 million in General Fund and \$2.0 million carried forward from SFY 2008).
- For SFY 2010, the Legislature decreased the ongoing General Fund to \$0.5 million and increased the Tobacco Settlement Restricted Fund to \$14.1 million to cover the loss in the General Fund. The program also had \$2.9 million carried forward from SFY 2009.
- For SFY 2011, the Legislature appropriated an additional \$2.4 million of one-time General Fund dollars for a total of \$2.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to \$11.7 million. The program was not allowed to carry forward the \$2.9 million from SFY 2009. However, the program was allowed to carry forward \$0.6 million into SFY 2012 through non-lapsing authority.
- For SFY 2012, the Legislature appropriated an additional \$3.0 million of one-time General Fund dollars for a total of \$4.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to \$11.1 million. The program was allowed to carry forward the \$0.6 million from SFY 2011. The program was also allowed to carry forward \$2.9 million into SFY 2013 through non-lapsing authority.
- For SFY 2013, the Legislature appropriated \$5.4 million in General Fund and \$11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2012 of \$2.9 million. The program was also allowed to carry forward \$1.4 million into SFY 2014 through non-lapsing authority.

Cost Sharing Benefits

In SFY 2013, families paid a premium of up to \$75 per quarter for enrollment in CHIP. The amount of premium varied depending upon a family's income. Native American families and families with incomes below 100 percent FPL do not pay quarterly premiums. As of July 1, 2009, premiums for families from 151 to 200 percent FPL increased from \$60 to \$75. In addition, the Department began charging a \$15 late fee if families failed to pay their premiums on time. In SFY 2012, CHIP collected \$2 million in premiums and late fees. Premiums are used to fund the CHIP program and are appropriated as dedicated credits in the annual CHIP budget.

In FY 2013, most CHIP families paid co-payments in addition to their quarterly premiums. Native American families are not required to make co-payments. As established in federal regulations, no family on CHIP is required to spend more than five percent of their family's annual gross income on premiums, co-payments and other out-of-pocket costs combined during their eligibility certification period.

Federal guidelines allow states to select from several options in creating a benchmark for CHIP coverage. As of July 1, 2008, CHIP moved to a commercial health plan benefit for its benchmark. In addition, as of July 1, 2010, CHIP adopted the commercial dental plan for its dental benchmark.

Major Budget Categories

MEDICAL

CHIP contracts with two different managed care organizations. Both health plans are full risk plans, offering a comprehensive medical coverage plan with CHIP funds paying the cost of a monthly capitated rate.

DENTAL

CHIP utilizes two dental plans to manage the dental program. Both dental plans are risk-based with CHIP funds paying a monthly capitated rate for dental coverage.

UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP)

UPP is an effort to offer families premium assistance when they enroll their children in their employer-sponsored health plan rather than CHIP. The current rebate is up to \$120 per child per month for medical coverage and an additional \$20 per month for dental coverage.

CHIP Expenditures

Table 24 shows CHIP expenditures in SFY 2013. Total CHIP expenditures declined by 1.1 percent between FY 2012 and FY 2013. Without the SelectHealth CHIP risk corridor repayment and some personal injury collections, CHIP expenditures would instead have increased by 1.7 percent.

Table 24: CHIP Expenditures SFY 2013		
Service Expenditures - Actual	TOTAL	Percent of Total
Capitated Managed Health Care		
SelectHealth	\$35,067,800	48%
SelectHealth and CHIP Restitution Payments	-\$2,069,900	-3%
Molina	\$18,996,900	26%
Dental Services		
Premier Access	\$8,226,800	11%
DentaQuest	\$1,622,800	2%
Immunization Services		
Other Services	\$1,107,700	2%
Total CHIP--General Services	\$64,709,700	89%
CHIP--UPP Services	\$357,600	0%
Total Service Expenditures	\$65,067,300	89%
Administrative Expenditures		
DOH	\$4,154,500	6%
DWS	\$3,500,000	5%
Total Administrative Expenditures	\$7,654,500	11%
TOTAL	\$72,721,800	100%

See table 1 at the beginning of the report for a five year history of CHIP expenditures.

Eligibility Requirements and the Enrollment Process

As required by Utah Code 26-40-105, CHIP is required to keep enrollment continuously open. Applications for CHIP can be submitted through the mail, in-person, and online. A simplified renewal form and process is used to reduce unnecessary barriers for the families being served.

Basic eligibility criteria:

1. Gross family income cannot be higher than 200 percent FPL (for a family of four, 200 percent FPL is \$47,100).
2. The child must be a resident of the state of Utah, and a U.S. citizen or legal alien.
3. The child must be 18 years of age or younger.
4. The child must be uninsured and not eligible for Medicaid.

Enrollment Statistics

Figure 28a shows the unduplicated count of CHIP enrollment between FY 2009 and FY 2013.

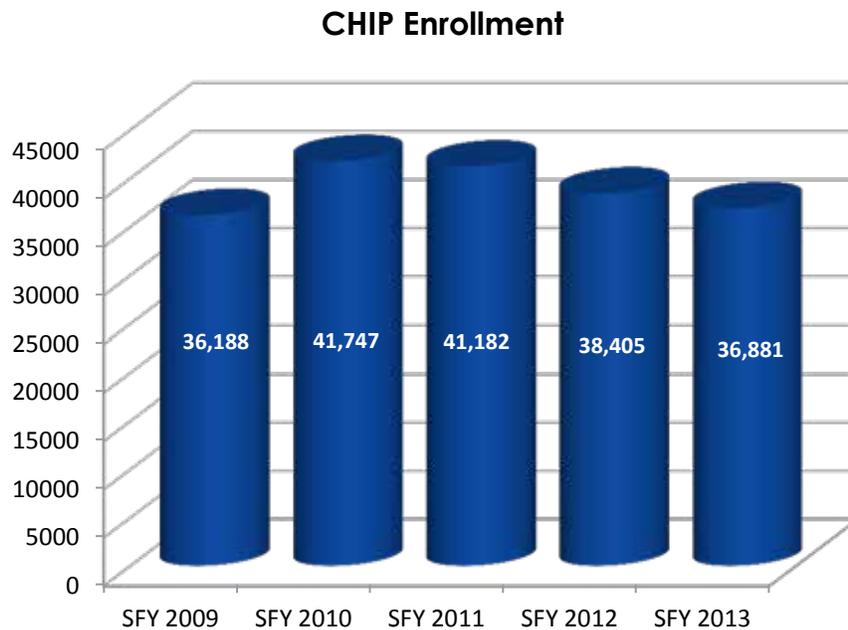


FIGURE 28a

CHIP Enrollment Percentage Growth

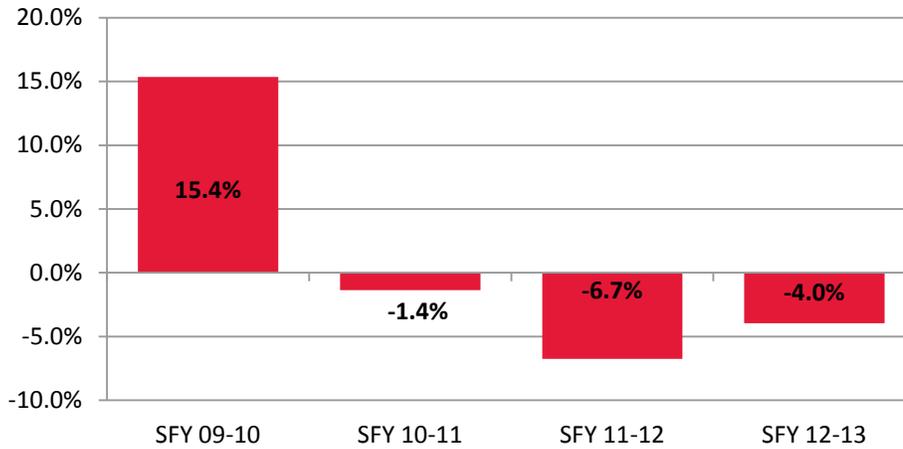


FIGURE 28b

Figure 29 breaks out CHIP enrollment by FPL.

CHIP Enrollment by Federal Poverty Level, SFY 2013

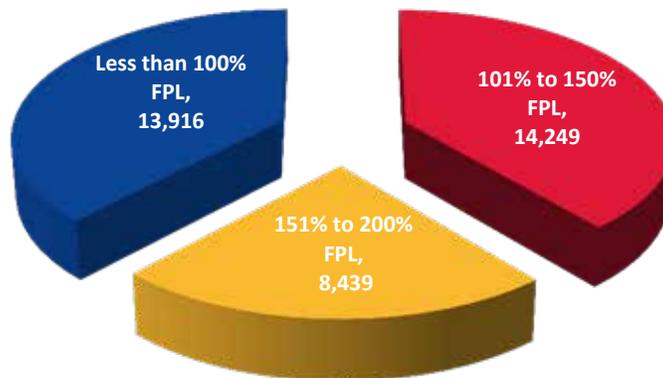


FIGURE 29

Table 25: Annual Unduplicated CHIP Enrollment by Location and FPL

Location	Federal Poverty Level	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Non-Wasatch Front	101% to 150% FPL	4,912	5,280	4,679	4,435	4,215
	151% to 200% FPL	3,703	3,488	2,923	2,652	2,530
	Less than 100% FPL	3,981	4,899	5,476	4,972	4,495
	UPP	155	151	106	73	56
Non-Wasatch Front Total		12,751	13,818	13,184	12,132	11,296
Wasatch Front	101% to 150% FPL	9,369	10,917	10,325	10,003	10,034
	151% to 200% FPL	7,409	7,444	6,442	5,929	5,909
	Less than 100% FPL	6,441	9,199	10,915	10,078	9,421
	UPP	218	369	316	263	221
Wasatch Front Total		23,437	27,929	27,998	26,273	25,585
Grand Total		36,188	41,747	41,182	38,405	36,881

Table 25 shows that sixty-nine percent of CHIP children reside in the Wasatch Front (Davis, Salt Lake, Weber, and Utah counties). Thirty-one percent reside in the remaining 25 counties.

Total CHIP enrollment increased 15.3 percent between FY 2009 and FY 2010, then decreased by 1.4 percent between FY 2010 and FY 2011, declined further by 6.7 percent between FY 2011 and FY 2012, and once again by 4.0 percent between FY 2012 and FY 2013.

Figure 30 shows the urban and rural percentages of enrollment between FY 2009 and FY 2013.

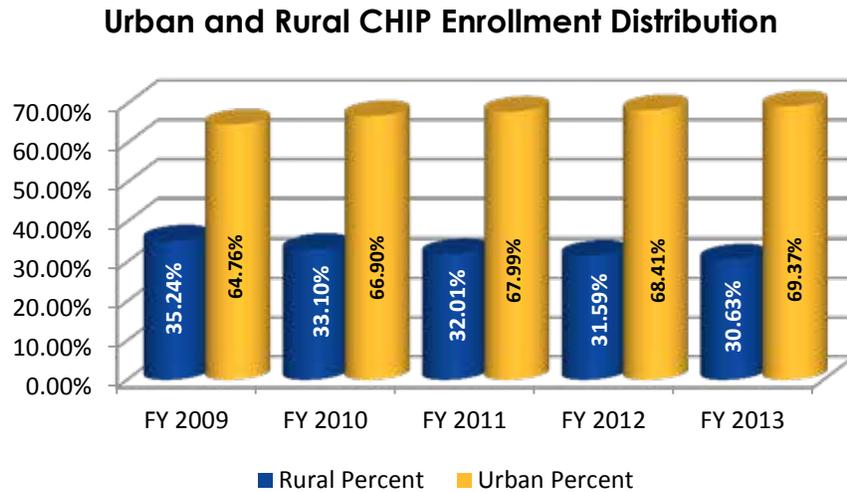


FIGURE 30

Figure 31 shows how CHIP enrollment is distributed by age range.

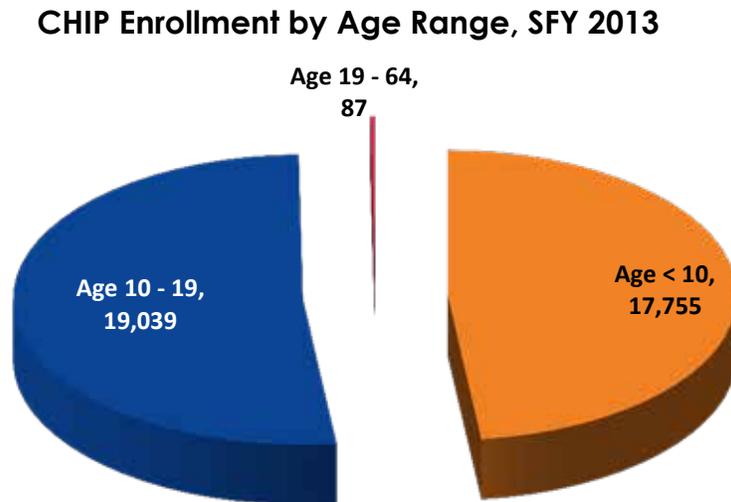


FIGURE 31

Figure 32 illustrates CHIP enrollment distribution by race.

CHIP Enrollment by Race, SFY 2013

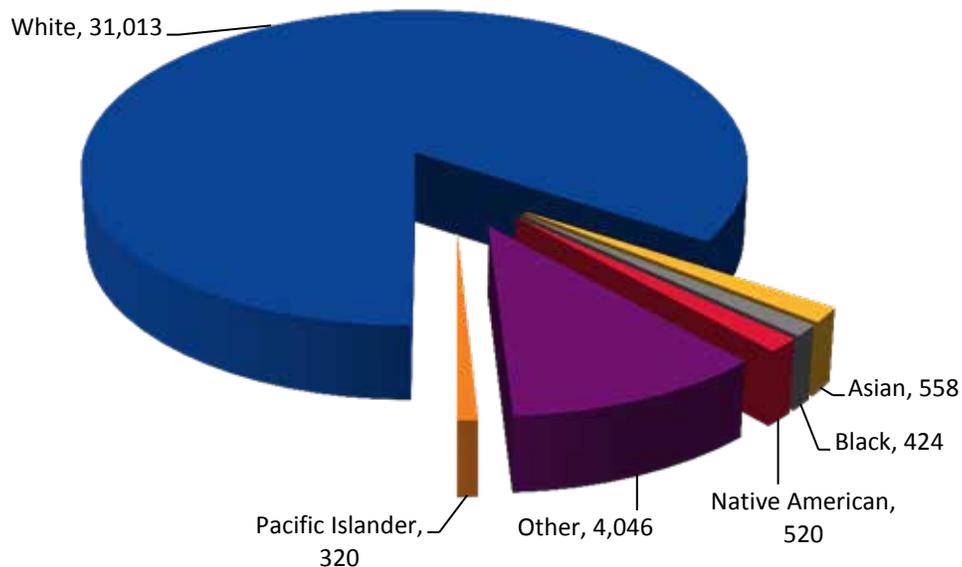


FIGURE 32

Table 26 presents CHIP enrollment by age and race. There was a decline in aggregate enrollment between FY 2012 and FY 2013. Most of the races and age groups also declined. The exception was the “other” race category, which actually increased by 57.1 percent in the less-than-ten age group, and by 38.6 percent in the 10 to 19 age group.

Table 26: CHIP Enrollment by Age Range and Race						
Age Range	Race	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
Age < 10	Asian	256	324	290	250	220
	Black	274	271	273	201	176
	Native American	288	282	272	208	200
	Other	15	15	461	1,675	2,631
	Pacific Islander	189	236	256	198	145
	White	19,359	21,044	19,278	16,211	14,383
Age < 10 Total		20,381	22,172	20,830	18,743	17,755
Age 10 - 19	Asian	286	359	397	377	338
	Black	234	260	266	267	248
	Native American	324	371	385	345	320
	Other	27	21	269	1,021	1,415
	Pacific Islander	138	180	239	217	175
	White	14,798	18,384	18,796	17,435	16,630
Age 10 - 19 Total		15,807	19,575	20,352	19,662	19,126
Grand Total		36,188	41,747	41,182	38,405	36,881

CHIP Benefits

MEDICAL

CHIP provides a comprehensive insurance which covers the following medical benefits:

- Well-child exams
- Immunizations
- Doctor visits
- Specialist visits
- Medical emergency services
- Ambulance
- Urgent care
- Ambulatory surgical
- Inpatient and outpatient hospital services
- Lab & x-rays
- Prescriptions
- Hearing and vision screening exams
- Mental health services

DENTAL

CHIP provides the following benefits up to an annual maximum of \$1,000:

- Preventive services
- Fillings
- Extractions
- Oral surgery
- Crowns
- Bridges
- Dentures
- Endodontics
- Periodontics
- Orthodontics



Appendix A: Federal Poverty Levels

Table A cross references household size with the percent of Federal Poverty Levels and corresponding annual income. The Federal Poverty Level percentages are set by the United States Department of Health and Human Services.

Table A: 2013 HHS Poverty Levels				
Persons in family/household	100% FPL	133% FPL	150% FPL	200% FPL
1	\$11,490	\$15,282	\$17,235	\$22,980
2	\$15,510	\$20,628	\$23,265	\$31,020
3	\$19,530	\$25,975	\$29,295	\$39,060
4	\$23,550	\$31,322	\$35,325	\$47,100
5	\$27,570	\$36,668	\$41,355	\$55,140
6	\$31,590	\$42,015	\$47,385	\$63,180
7	\$35,610	\$47,361	\$53,415	\$71,220
8	\$39,630	\$52,708	\$59,445	\$79,260
For each additional person, add:	\$4,020	\$5,347	\$6,030	\$8,040

Figure A summarizes income requirements for many of the Medicaid programs and CHIP. As shown in the eligibility chart, maximum income levels exist for different groupings. Although most eligibility categories allow access to the full array of Medicaid services, there are economic and medical circumstances that assign enrollees to limited sets of benefits. For example, a pregnant woman may be eligible for medical assistance if her annual income is less than or equal to 133 percent of the Federal Poverty Level (FPL). A child eligible for CHIP will have a different level of cost sharing if the family income is less than 100 percent FPL than a CHIP eligible child from a family with income between 150 percent and 200 percent FPL.

Income Limits for Medical Assistance & Medicaid Cost-Sharing Programs

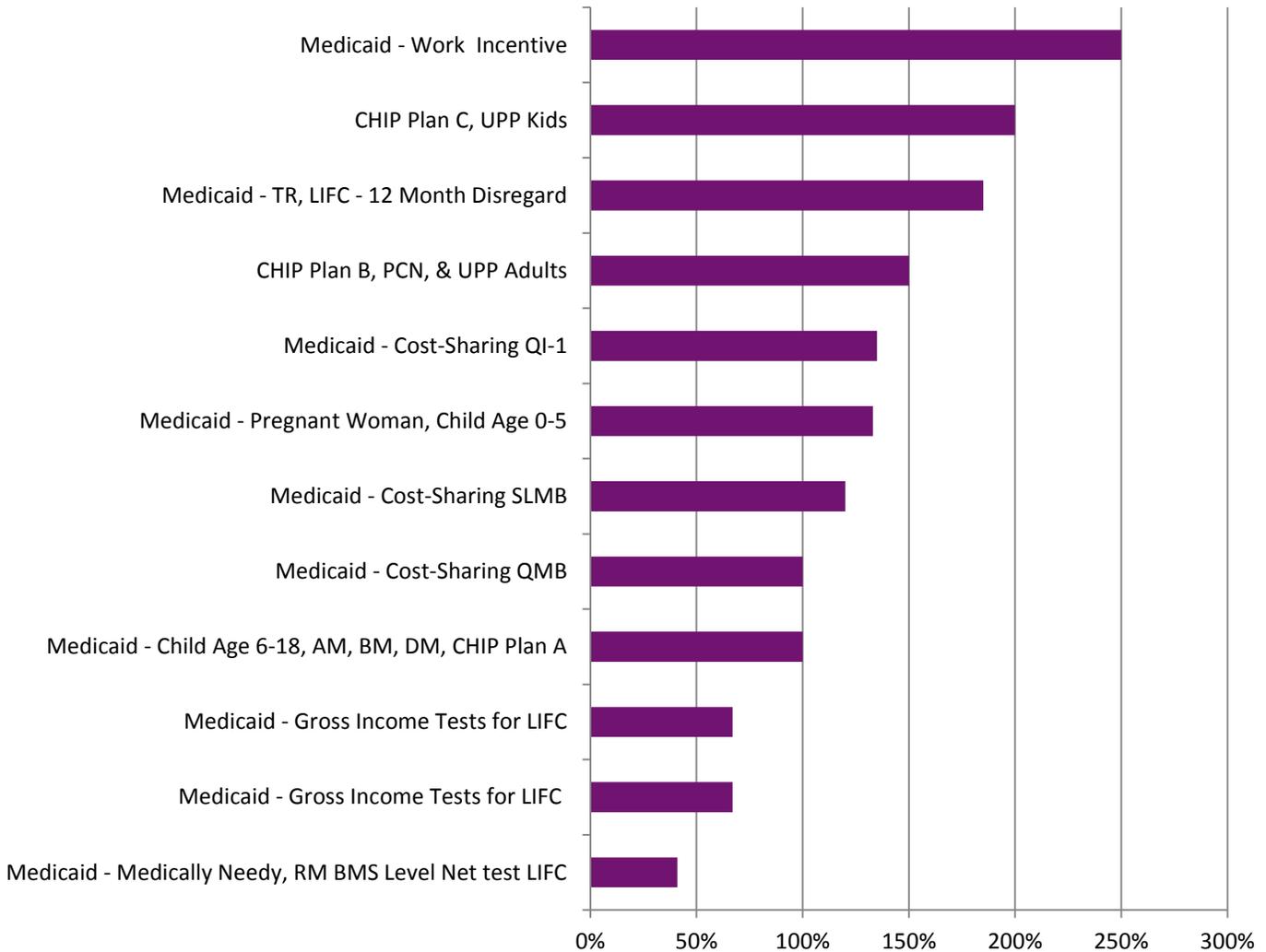


FIGURE A

Table B contains poverty level comparison between the United States, as a whole, and the state of Utah. The percent of Utah's population is lower than the nation's percentage for each level of poverty.

Table B		
Poverty Level	U.S.	Utah
Below 100% Poverty	15.1%	10.0%
101% - 125% of Poverty	19.8%	13.8%
126% - 135% of Poverty	21.6%	15.9%
136% - 150% of Poverty	24.6%	18.6%
150% - 185% of Poverty	31.3%	26.0%
186% - 200% of Poverty	33.9%	28.5%

Source: United States' Census Bureau found at http://www.census.gov/hhes/www/cpstables/032013/pov/POV46_001.htm

Appendix B: Glossary

TITLE XIX - MEDICAID	Title XIX of the Social Security Act requires states to establish Medicaid programs to provide medical assistance to low income individuals and families. Within broad federal rules, each state decides eligible coverage groups, eligibility criteria, covered services, payment levels, and administrative and operating procedures.
TITLE XXI – STATE CHILDREN’S HEALTH INSURANCE PROGRAM	The purpose of Title XXI is to provide funding to assist states in providing medical coverage to uninsured, low income children in an effective manner.
AID CATEGORIES	A designation under which a person may be eligible for medical assistance.
ARREARS	The amount of money owed to a state or to a Non-IV-A participant that was not paid when due.
CAPITATION	A reimbursement method where the contractor is paid a fixed amount (premium) per enrollee per month.
CATEGORY OF ASSISTANCE	A group of aid categories consisting of clients with similar Medicaid eligibility. Examples include the Elderly, Visually Impaired and People with Disabilities.
CATEGORY OF SERVICE	A group of services that are provided by a common provider. Examples include Inpatient Hospital, Outpatient Hospital and Physician Services.
CHIP	The Children’s Health Insurance Program is a state health insurance plan for children. Depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP.
CLAWBACK PAYMENTS	Federally required payments to the Medicare program that began in 2006 to cover the pharmacy needs of Medicare clients that were also eligible for Medicaid.
CMS	Centers for Medicare and Medicaid Services is a federal agency which administers Medicare, Medicaid, and the Children’s Health Insurance Program.
DOH	Refers to the Utah Department of Health.
DHS	Refers to the Utah Department of Human Services.
DSH	Disproportionate Share payments made by the Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid beneficiaries. The maximum amount of federal matching funds available annually to individual states for DSH payments is specified in the federal Medicaid statute.
DWS	Refers to the Utah Department of Workforce Services.
ELIGIBLE	An individual who is qualified to participate in the Utah State Medicaid or CHIP program but may or may not be enrolled.
ENROLLEE	An individual who is qualified to participate in Utah’s Medicaid or CHIP program and whose application has been approved but he or she may or may not be receiving services.
FMAP	Federal Medical Assistance Percentage is the percentage the federal government will match for state money spent on Medicaid.
MANAGED HEALTH CARE	A system of health care organizations that contract with Medicaid to provide medical and mental health services to Medicaid clients.

MEDICAID RESTRICTED ACCOUNT	The General Fund Restricted Account created to hold any general funds appropriated to the DOH for the state plan for medical assistance or for the Division of Medicaid and Health Financing that are not expended in the fiscal year for which the general funds are appropriated and which are not designated as non-lapsing. Unused state funds associated with the Medicaid program from DWS and DHS and any penalties imposed or collected under various statutes shall be deposited. See UCA 26-18-402 for more detail.
NURSING CARE FACILITIES ACCOUNT	Proceeds from the assessment imposed by Section UCA 26-35a-104 which are deposited in a restricted account to be used for the purpose of obtaining federal financial participation in the Medicaid program.
PCN	Primary Care Network is a health plan for adults administered by DOH. It covers services administered by a primary care provider. Applications are accepted only during open enrollment periods.
PARTICIPATING PROVIDER	A provider who submitted a bill to Utah's Medicaid program for payment during the fiscal year.
PRESUMPTIVE ELIGIBILITY	Provides limited and temporary coverage for pregnant women whose eligibility is determined by a qualified provider prior to an agency determination of Medicaid eligibility.
RECIPIENTS (CLIENTS)	The unduplicated number of enrollees who had paid claim activity during a specific time period. This count is unduplicated by category of service as well as in total.
SEED	State funds appropriated to agencies outside the Division of Medicaid and Health Financing that are transferred to the DOH in order to draw down the federal match for Medicaid activities that occur within those other agencies.
SPENDDOWN MONEY	Clients that have too much income to qualify for Medicaid can spenddown their income if they have qualifying medical expenses that bring their net income to Medicaid levels.
STATE FISCAL YEAR (SFY)	The State Fiscal Year is a 12-month calendar that begins July 1 and ends June 30 of the following calendar year.
TANF	The federal block grant program Temporary Assistance for Needy Families, which succeeds the Aid to Families with Dependent Children program. In Utah, this program is known as the Family Employment Program (FEP).
TPL	Refers to Third Party Liability. Individuals or entities who have financial liability for medical costs of Medicaid recipients.
TRENDS	A measure of the rate at which the data is changing. Trends are calculated by the least squares method based on the past twelve months of date up to and including the current month.
UNDUPLICATED COUNT	Recipients who are counted only once regardless of whether they used one or more categories of service or are covered by one or more categories of assistance.
UNITS OF SERVICE	A measure of the medical service rendered to a client. The unit of measure of a service unit will vary with the type of claim. For example, the service unit for an inpatient hospital claim is days of stay, while the service unit for a dental claim is procedures.
WAIVER	The waiving of certain Medicaid statutory requirements which must be approved by CMS (see Appendix B).
WELFARE REFORM	New federal requirements as a result of the Personal Responsibility and Work Opportunities Reconciliation Act of 1996.

Appendix C: DMHF WAIVERS

Waiver programs currently in effect in the state of Utah:

WAIVER TYPE 1115

Primary Care Network (PCN)

PCN is a health plan offering services from primary care providers. The federal government requires that more parents be enrolled than adults without children. Since 2002, Waiver Type 1115 has enabled funding for Non-Traditional Medicaid (average 21,000 adults annually), PCN (19,000 adults), and Utah's Premium Partnership for Health Insurance (UPP) (over 200 adults and 500 children annually). Funding for adults is through Title XIX (Medicaid). Children are funded through Title XXI (CHIP).

WAIVER TYPE 1915B

Choice of Health Care Delivery Program & Hemophilia Disease Management Program

This program grants operating authority to allow Medicaid to require Traditional Medicaid clients living in Davis, Salt Lake, Utah, and Weber counties to select a health plan that provides services in accordance with the program's waiver. In addition, this is the operating authority to allow Medicaid to contract with a Utah licensed pharmacy for the provision of anti-hemolytic factors to Utah's Medicaid clients with hemophilia.

Prepaid Mental Health Plan

This waiver allows Medicaid to mandatorily enroll most Title XIX recipients in 27 counties in this plan. Contracted mental health centers provide services covered under the waiver on an at-risk capitation basis.

WAIVER TYPE 1915C

Technology Dependent, Medically Fragile

This program offers the choice of home and community-based alternatives for technology dependent, medically fragile individuals with complex medical conditions, who would otherwise require placement in a Medicaid enrolled nursing facility to obtain needed services (the costs of which would be borne by Medicaid). The waiver operates statewide, and serves a maximum of 120 recipients at any point in time.

This program permits the State to furnish an array of home and community-based services (in addition to Medicaid State Plan services) necessary to assist technology dependent individuals with complex medical needs to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by the Division of Medicaid and Health Financing and the Division of Family Health and Prevention. The Division of Medicaid and Health Financing provides the State matching funds for this program.

Community Supports Waiver

This program serves over 4,400 individuals with intellectual disabilities in home and community-based setting as an alternative to institutional care in an Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID).

This program's primary focus is to provide services to children and adults with intellectual disabilities. Services are provided in an individual's own home, or for those with more complex needs, in a residential

setting. This program seeks to prevent or delay the need for services provided in an intermediate care facility for people with mental retardation (ICF/MR). The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

Aging Waiver

This program serves nearly 600 individuals over the age of 65 in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to elderly individuals in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Aging and Adult Services, provides for the day-to-day operation and the state funding of this program.

Acquired Brain Injury Waiver

This program serves approximately 100 individuals with acquired brain injuries in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to adults who have sustained acquired brain injuries. Services are provided in an individual's own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

Physical Disabilities Waiver

This program serves approximately 120 individuals with physical disabilities in home and community-based settings as an alternative to institutional care in a nursing facility.

This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. The Department of Human Services, Division of Services for People with Disabilities, provides for the day-to-day operation and the state funding of this program.

New Choices Waiver

This program is able to serve up to 1,400 people who were nursing facility residents or licensed assisted living facility residents immediately prior to enrolling in the waiver. The program provides services to these individuals in home and community-based settings as an alternative to institutional care in a nursing facility. Operation and administration of this waiver is completed by the Department of Health, Division of Medicaid and Health Financing.

The purpose of this waiver is to assist individuals to receive long term care services in a community-based setting rather than in a nursing facility.

2013

Utah Annual Report of **Medicaid & CHIP**



UTAH DEPARTMENT OF
HEALTH
MEDICAID

A Bridge to Wellness for Utah's Vulnerable

