

2010

Utah Statistical Report of Medicaid & CHIP

ANNUAL REPORT

STATE FISCAL YEAR 2010
July 2009 - June 2010



UTAH DEPARTMENT OF
HEALTH

Utah Statistical Report of Medicaid & CHIP

State Fiscal Year 2010

David N. Sundwall, M.D.

Executive Director
Utah Department of Health

Michael Hales, Director

Division of Medicaid and Health Financing
Deputy Director
Utah Department of Health

Tracy Luoma, Director

Bureau of Financial Services

Prepared By:

Bureau of Financial Services
Division of Medicaid and Health Financing
Utah Department of Health
Box 143104
Salt Lake City, UT 84114-3104

This report can be viewed at www.health.utah.gov/medicaid



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

David N. Sundwall, M.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 30, 2010

Dear Fellow Utahn:

It is my privilege to present to you the 2010 Annual Medicaid and CHIP Report of the Utah Department of Health. This report includes activities from July 2009 to June 2010.

During the year, more than 360,000 Utahns received services financed by the Utah Medicaid program. Among those who depend on Medicaid to meet their health care needs are low-income pregnant women and children, as well as elderly and individuals with disabilities.

Rising health care costs and the increased number of uninsured individuals and families are affecting both public and private health care financing. Our agency continues to seek new and innovative approaches to address the challenge of improving services while reducing costs. Efforts such as the Preferred Drug List, New Choices Waiver, a premium assistance program, emergency room utilization assessments and prior approval of certain procedures and prescriptions have all contributed to cost avoidance and savings to the State.

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



288 North 1460 West • Salt Lake City, Utah
Mailing Address: P.O. Box 144102 • Salt Lake City, Utah 84114-4102
Telephone (801) 538-7075 • Facsimile (801) 538-6860 • www.health.utah.gov

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Division of Medicaid and Health Financing

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

The administration of Medicaid and the Children's Health Insurance Program (CHIP) is accomplished through the Director's Office and six bureaus. The Director's Office administers and coordinates the program responsibilities delegated to develop, to maintain and to administer the Medicaid program in compliance with Title XIX and the CHIP program in compliance with Title XXI of the Social Security Act, the laws of the State of Utah, and the appropriate budget. Contract development and monitoring, staff training and development, and inventory control are coordinated from the Director's office. 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 quality control systems, including monitoring of the Medicaid, CHIP, Utah's Premium Partnership for Health Insurance (UPP), and the Primary Care Network (PCN) service programs, providers, and all third-party liability (TPL) activity. The bureau also performs budget forecasting and preparation, appropriation requests, legislative presentations, monitoring of medical assistance programs, and administration expenditures and federal reporting.

Bureau of Managed Health Care - The objectives of this bureau include the following: provide Medicaid and CHIP clients with a choice of health care delivery programs in order to enable them to use medical assistance program benefits properly; monitor the performance of the capitated prepaid mental health program under both Medicaid and CHIP; and operate the early periodic screening, diagnosis, and treatment (EPSDT) program that provides well-child health care.

Bureau of Long-Term Care - 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 authorization of Medicaid services.

Bureau of Medicaid Operations - The 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 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, and the Preferred Drug List as well as maintaining the State Plan.

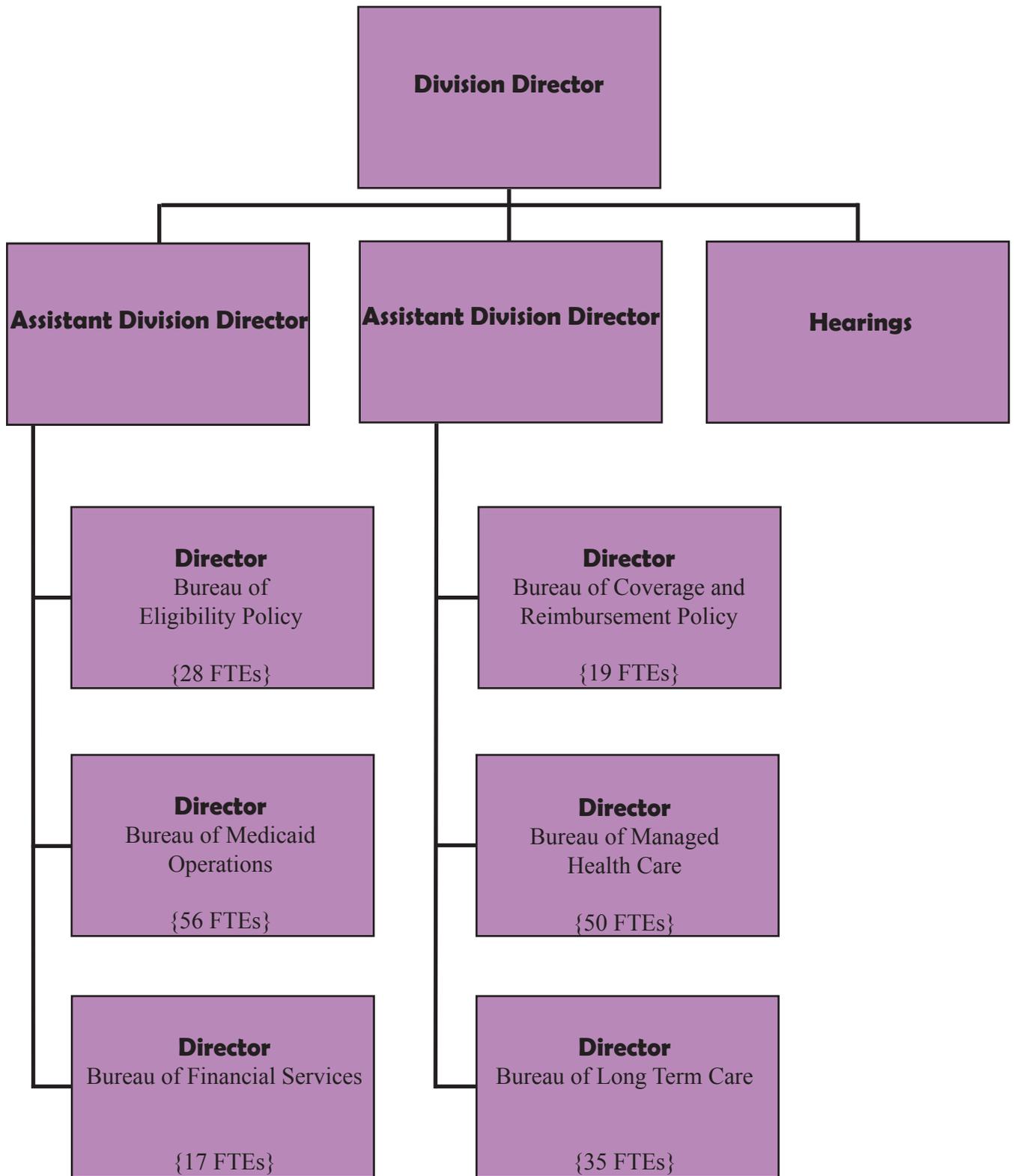
Bureau of Eligibility Policy - The bureau performs several functions related to Medicaid and CHIP program eligibility. This includes: interpreting federal or state regulations and writing medical eligibility policy; providing timely disability decisions based on Social Security Disability criteria; monitoring the accuracy and timeliness of the Medicaid program by reviewing eligibility determinations under guidance from Centers for Medicare and Medicaid Services; purchasing private health insurance plans for Medicaid recipients who are high risk, which saves Medicaid program dollars and monitoring for program accuracy.

Questions concerning any aspect of the Utah Statistical Report of Medicaid and CHIP 2010 can be answered by contacting the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Financial Services, at (801) 538-6145.

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.

Division of Medicaid and Health Financing Organizational Chart



Highlights of State Fiscal Year 2010

- The Division answered 326,724 calls from providers and/or clients by Medicaid customer service representatives.
- The Division processed over 7 million claims.
- The Division received 845,045 calls through Access Now, an automated eligibility line for providers to verify client enrollment in Medicaid.
- PCN, a limited-benefit Medicaid program, was open for enrollment in May, successfully enrolling an additional 2,498 uninsured adults.
- The Division streamlined efficiencies by merging seven bureaus into six bureaus.
- The Division awarded a contract for an additional claims auditing tool, which was implemented on December 20, 2010.
- The Division created a payment system process in the Medicaid Managed Care System (MMCS), which eliminates the previous manual process and is seen as a clear improvement. This process is used for the administrative payment of physical evaluations authorized by the Medical Review Board.
- The Division participated in a week long Kaizen exercise with the Department of Workforce Services (DWS), which helped to develop improved processes between the two departments.
- The Division discontinued the printing of more than four boxes of remittance advices per week by switching providers to an electronic remittance process.
- The Division submitted and gained Centers for Medicare and Medicaid Services (CMS) approval for the 5010 Advanced Planning Document (APD), the ICD-10 Implementation Advanced Planning Document (IAPD), and the APD and Request for Proposal (RFP) for a new Pharmacy Point of Sale system.
- The Division was directly involved in the full implementation of the eREP eligibility system. This involvement continues to be an on-going commitment by Division staff.
- The Division has been studying, researching, and planning the implementation of the Patient Protection and Affordable Care Act (PPACA).
- Medicaid Eligibility Quality Control (MEQC) created an Oracle database for review findings, which automates reports and sends findings to DWS.
- The Division worked with the Disability Medicaid Developer (DMD) team at DWS to improve and make more efficient the gathering of medical evidence, which is compiled into medical evidence packets for the Medical Review Board examiners.
- The Division created a new, automatic Buyout Program referral process to increase the program's utility.
- The Bureau of Long-Term Care renewed three HCBS Waivers for another five year period:
 - Waiver for Individuals Aged 65 and Older (Aging Waiver)
 - Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions (Community Supports Waiver)
 - New Choices Waiver
 - The New Choices Waiver is specifically intended to move Medicaid recipients from nursing facility care into home and community based care. This renewal waiver increased the number of people that can be served from 1,000 to 1,200.
 - Personnel resources were realigned within the Bureau to create a quality assurance specialist for this waiver.

- The Division added four new drug classes to the Preferred Drug List (PDL). These drug class additions, combined with savings from existing PDL classes, generated PDL savings totaling more than \$15 million in state and federal funds.
- The Division operated an Emergency Department (ED) diversion program to redirect clients seeking primary care needs in the ED of the State's hospitals. Findings revealed that a client's decision making is influenced by the intervention demonstrated by a 55 percent reduction in repeat non-emergent ED visits for participants.
- The Division engaged in payment reform efforts looking to change the underlying incentives in the health care system that currently exist for providers to provide excessive health care services. The Division is working closely with the Governor's Office and the Legislature to implement future proposals.

Medicaid Finance

The Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF), through state and federal resources, provides funding for medical services to needy individuals and families throughout the state. DMHF administers the Medicaid program through Title XIX of the Social Security Act.

MEANS OF FINANCE - Medicaid was established by Title XIX of the Social Security Act in 1965 and is a means-tested, open-ended entitlement public assistance program. Utah began its Medicaid program for acute and long-term care in 1966. UDOH 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 is funded by a share from both federal and state funds. This share is based on the Federal Medical Assistance Percentages (FMAP), which are updated every Federal Fiscal Year (FFY). The Federal Fiscal Year runs from October 1 to September 30. National FMAP ranges from 50 percent to 83 percent of program cost based on each states' latest three year average per capita income. The FMAP is modified to match the State Fiscal Year (SFY) which runs from July 1 to June 30 of the next calendar year (see Table 1). Below is a ten year historical list of FMAP for SFY's running from 2003 to 2012.

Federal Medicaid Assistance Percentages (FMAP) SFY 2003 – SFY 2010

SFY	Federal Percentage	State Percentage
2003	70.93%	29.07%
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%

Table 1

Utah Medicaid generally 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 the table above.

MEDICAID REVENUES AND EXPENDITURES - DMHF’s revenues include different fund sources that are used to match Medicaid or used for special programs in the Division. The revenue consists of General Fund, Federal Funds, Dedicated Credits, Restricted Revenues, and Transfers. Transfers include Medicaid match from other State Departments, referred to as “seeded funds” and a transfer of ARRA (American Recovery and Reinvestment Act of 2009) to the Department of Human Services. Figure 3 shows a breakout of the different types of revenue and the amount of each revenue in 2010.

Expenditures for Medicaid correspond to the enrollment numbers which are effected by economic, demographic, and age-mix factors. Understanding these factors is a key to projecting future costs for the Medicaid program.

Medicaid expenditures have seen an overall increase from \$1.72 billion in 2009 to \$1.78 billion in 2010, an increase of 3.5 percent (see Figure 1). However, this increase in expenditures is due to a substantial increase in the average monthly enrollees (11.9 percent) as opposed to the average monthly expenditures. In SFY 2010 the average expenditure per member per month (PMPM) was \$610 compared to \$659 in SFY 2009, a decrease of 7.4 percent.

Figure 1 illustrates the total Medicaid expenditure trend for the past five years, excluding administrative costs and Office of the Attorney General (AG) expenditures.

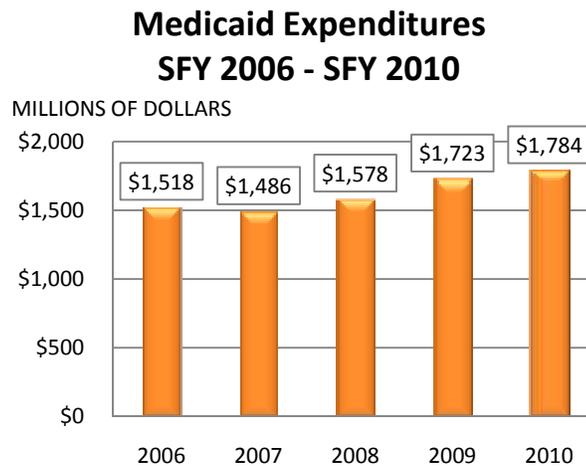


Figure 1

Expenditures incurred by clients through the Medicaid program are paid directly to licensed providers of medical care. 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.

Most of the Division’s expenditures are pass-through charges (98 percent). The other major charge is current expense which accounts for almost 2.5 percent of the total expenditures (see Figure 4).

Division of Medicaid and Health Financing Total Revenue Sources SFY 2010



Figure 2

Division of Medicaid and Health Financing Expenditures SFY 2010

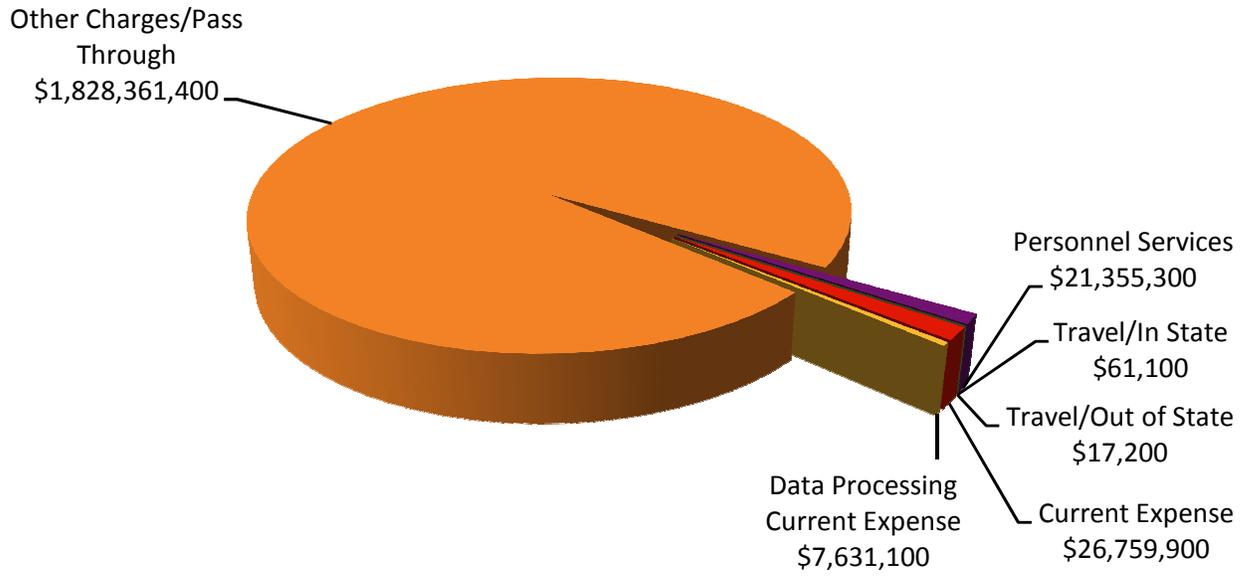


Figure 3

UTILIZATION - The State of Utah and the federal government do not limit the number of eligible people who can enroll in the established categories of eligibility for Medicaid.

The number of unduplicated Medicaid clients receiving at least one or more services during SFY 2010 was 360,226 compared to 338,130 during SFY 2009, an increase of 6.5 percent. Clients may receive services in more than one category of service during a specific time period.

The average cost per service in SFY 2010 ranged from \$22,000 for Mental Youth Center Inpatient Hospital Services to \$15 for Group Pre/Postnatal Education Services. The total number of claims in SFY 2010 was 5,864,257.

The number of unduplicated Medicaid clients receiving at least one or more services during a specified state fiscal year period over the past five years is shown in Figure 2.

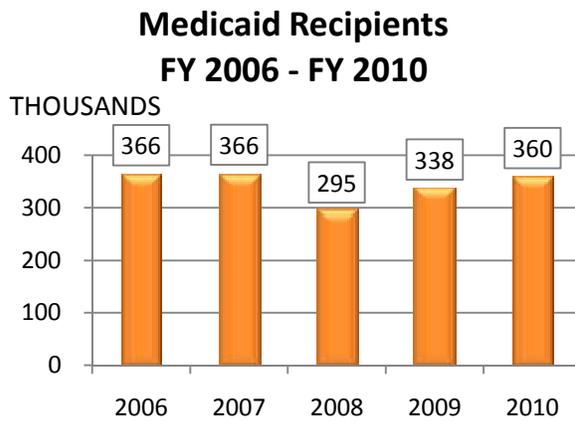


Figure 4

Medicaid Consolidated Report

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

Programs and services for Medicaid are delivered by UDOH, the Department of Human Services (DHS), the Department of Workforce Services (DWS), and a myriad of contracted providers including University of Utah Hospitals, local health organizations, not-for-profit and for-profit entities. The Office of the Attorney General also receives Medicaid funding to investigate and prosecute Medicaid fraud and abuse.

This consolidated report section shows how Medicaid appropriations are being spent for administration and services by the following departments: UDOH, DHS, DWS, University of Utah, and the Attorney General. In addition, UDOH passes funding through to local government and other providers. The Governor's Office of Planning and Budget reviewed expenditure data from these five state agencies.

Figure 5 shows Medicaid funding by funding source. Federal funds comprise the largest share at 67 percent of total funding. UDOH has also identified in the Consolidated Report, the category of service expenditures for SFY 2010, as well as the portion of the General Fund which is seeded to other state agencies and local governments.

Figure 6 shows all Medicaid expenditures for SFY 2010. Program expenditures totaled \$1,885,648,300. Expenditures for mandatory services comprised the largest portion of total expenditures (46 percent), followed by optional services (26 percent). Specific detail is shown for both service expenditures and administrative expenditures. Administrative expenses accounted for \$101.7 million, or six percent of the total Medicaid-related expenditures.

Table 3 shows Medicaid funding by source and type of service. In SFY 2010 federal funds provided the largest share of funds for both mandatory and optional services, totaling \$1.4 billion. General Funds provided \$279.8 million.

Table 4 shows Medicaid expenditures by type of service. Inpatient hospital services incurred the largest share of mandatory services (\$283,321,300), while Pharmacy incurred the largest portion of optional services (\$170,059,100).

Consolidated Funds SFY 2010

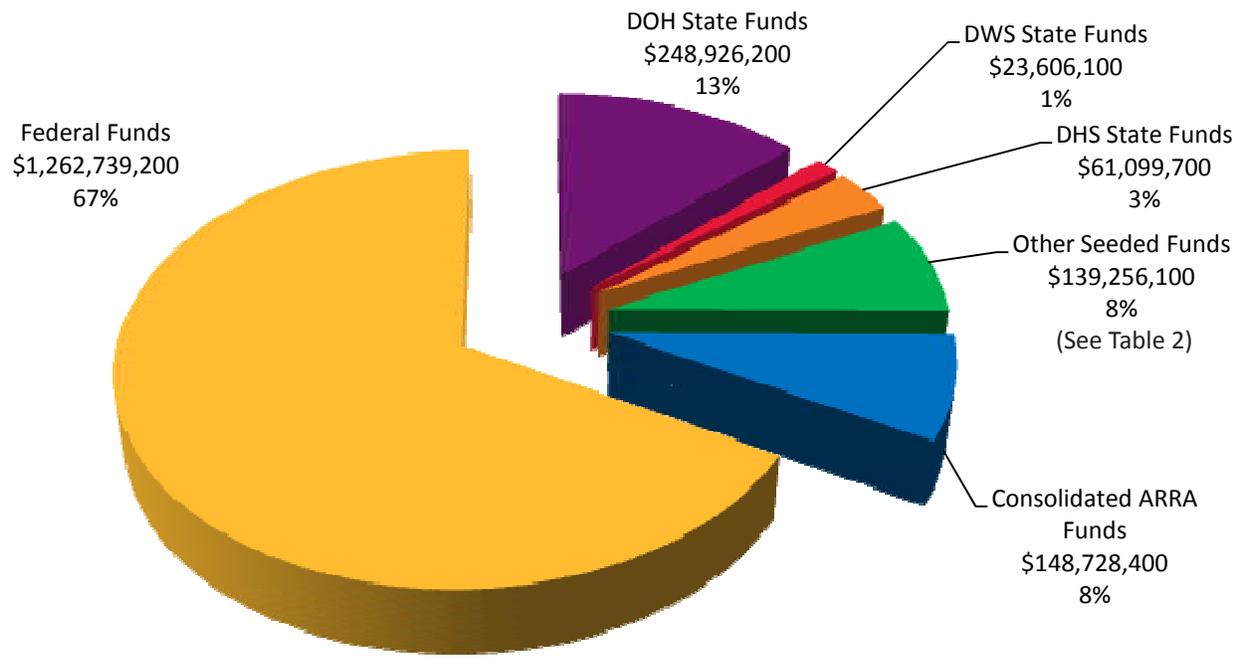


Figure 5

Other Seeded Funds	
Capitated Mental Health	\$20,250,900
Fee-For-Service Mental Health	\$352,600
Substance Abuse	\$1,767,600
Local Health Departments	\$4,288,800
School Districts	\$5,725,200
Div. of Community & Family Health	\$3,779,100
Hospital Assessment	\$7,552,200
Health & Dental Clinics	\$2,770,500
Pharmacy Rebates	\$63,918,900
Physician Enhancement	\$12,157,000
Indirect Medical Education (IME)	\$3,724,000
Graduate Medical Education (GME)	\$6,060,300
Disproportionate Share Hospital	\$6,890,900
Other	\$18,100
Total	\$139,256,100

Table 2

Consolidated Medicaid Revenues SFY 2010

Mandatory	LHB	LHC	LHD	LHE	LHF	LHG	Total
General Fund	\$44,035,100	\$1,969,200	\$39,579,500	\$16,684,800	\$22,297,300	\$28,386,200	\$152,952,100
Federal Funds	\$223,072,800	\$127,134,400	\$185,851,800	\$75,775,500	\$96,767,000	\$65,776,800	\$774,378,300
Dedicated Credits	\$7,552,200	\$0	\$0	\$428,800	\$0	\$1,737,800	\$9,718,800
Restricted Revenue	\$8,320,500	\$16,236,000	\$0	\$0	\$0	\$0	\$24,556,500
Transfers	\$125,100	\$7,400	\$558,200	\$127,100	\$182,500	\$3,006,500	\$4,006,800
Beginning Balance	\$20,123,500	(\$3,340,900)	(\$1,854,000)	(\$1,380,900)	(\$3,341,600)	(\$2,883,900)	\$7,322,200
Closing Balance	(\$19,464,800)	\$15,903,600	\$10,087,900	\$3,088,400	\$3,592,100	(\$8,343,900)	\$4,863,300
Lapsing Balance	(\$443,100)	(\$712,500)	\$0	\$0	\$0	\$0	(\$1,155,600)
	\$283,321,300	\$157,197,200	\$234,223,400	\$94,723,700	\$119,497,300	\$87,679,500	\$976,642,400

Optional	LJA	LJB	LJC	LJD	LJE	LJF	LJG	LJH	Total
General Fund	\$36,645,600	\$1,028,200	(\$7,167,000)	\$10,291,100	\$6,729,100	\$2,049,000	\$681,700	(\$11,177,200)	\$39,080,500
Federal Funds	\$72,264,400	\$126,255,200	\$133,679,200	\$24,702,500	\$25,330,300	\$67,612,600	\$1,561,000	\$131,128,700	\$582,533,900
Dedicated Credits	\$63,918,900	\$0	\$18,660,300	\$0	\$0	\$0	\$0	\$8,574,500	\$91,153,700
Restricted Revenue	\$76,000	\$0	\$0	\$0	\$0	\$1,654,300	\$0	\$0	\$1,730,300
Transfers	\$146,300	\$28,958,800	\$8,653,500	\$0	\$28,900	\$10,442,400	\$3,800	\$29,530,800	\$77,764,500
Beginning Balance	\$7,134,800	\$4,025,000	\$2,229,500	(\$2,069,100)	(\$3,176,200)	(\$921,200)	(\$187,900)	(\$6,050,200)	\$984,700
Closing Balance	(\$10,126,900)	(\$2,526,600)	\$5,893,000	\$3,349,200	\$2,488,900	\$3,618,000	\$23,100	\$11,394,500	\$14,113,200
Lapsing Balance	\$0	\$0	\$0	\$0	\$0	(\$124,000)	\$0	\$0	(\$124,000)
	\$170,059,100	\$157,740,600	\$161,948,500	\$36,273,700	\$31,401,000	\$84,331,100	\$2,081,700	\$163,401,100	\$807,236,800

Services	Admin *	Total	
General Fund	\$192,032,600	\$3,617,700	\$195,650,200
Federal Funds	\$1,356,912,200	\$54,555,400	\$1,411,467,600
Dedicated Credits	\$100,872,500	\$2,242,900	\$103,115,400
Restricted Revenue	\$26,286,800	\$350,000	\$26,636,800
Transfers	\$81,771,300	\$39,090,300	\$120,861,600
Beginning Balance	\$8,306,900	\$493,500	\$8,800,400
Closing Balance	\$18,976,500	\$492,200	\$19,468,700
Lapsing Balance	(\$1,279,600)	\$0	(\$1,279,600)
	\$1,783,879,200	\$100,841,900	\$1,884,721,200

• Administrative Revenues include the Office of the Attorney General revenues and do not include revenues from non-Medicaid Federal grants.

Consolidated Medicaid Expenditures SFY 2010

Mandatory	DOH	DHS	U of U	DWS	AG	Total
Inpatient Hospital	\$242,315,000	\$0	\$41,006,300	\$0	\$0	\$283,321,300
Nursing Home	\$157,197,200	\$0	\$0	\$0	\$0	\$157,197,200
Contracted Health Plan Services	\$201,111,200	\$0	\$33,112,200	\$0	\$0	\$234,223,400
Physician Services	\$69,308,500	\$0	\$25,415,200	\$0	\$0	\$94,723,700
Outpatient Hospital	\$111,527,100	\$0	\$7,970,200	\$0	\$0	\$119,497,300
Other Mandatory Services	\$87,537,100	\$0	\$142,400	\$0	\$0	\$87,679,500
Subtotal	\$868,996,100	\$0	\$107,646,300	\$0	\$0	\$976,642,400

Optional	DOH	DHS	U of U	DWS	AG	Total
Pharmacy	\$170,059,100	\$0	\$0	\$0	\$0	\$170,059,100
Home & Community Based Waivers	\$59,800	\$157,680,800	\$0	\$0	\$0	\$157,740,600
Mental Health Services	\$105,649,900	\$56,298,600	\$0	\$0	\$0	\$161,948,500
Buy In / Out	\$36,273,700	\$0	\$0	\$0	\$0	\$36,273,700
Dental Services	\$31,401,000	\$0	\$0	\$0	\$0	\$31,401,000
Intermediate Care Facilities	\$31,531,000	\$52,800,100	\$0	\$0	\$0	\$84,331,100
Vision Care	\$2,031,000	\$0	\$50,700	\$0	\$0	\$2,081,700
Other Optional Services	\$114,276,800	\$798,900	\$0	\$0	\$0	\$163,401,100
Disproportionate Share Hospital	\$0	\$0	\$20,443,300	\$0	\$0	\$0
Graduate Medical Education	\$0	\$0	\$15,358,400	\$0	\$0	\$0
Indirect Medical Education	\$0	\$0	\$12,523,700	\$0	\$0	\$0
Subtotal	\$491,282,300	\$267,578,400	\$48,376,100	\$0	\$0	\$807,236,800

Administrative	DOH	DHS	U of U	DWS	AG	Total
	\$34,578,500	\$17,589,200	\$0	\$47,212,200	\$1,462,100	\$100,842,000
Total Expenditures	\$1,394,856,900	\$285,167,600	\$156,022,400	\$47,212,200	\$1,462,100	\$1,884,721,200

- Note that for this report Home & Community Based Waivers does not include New Choice Waiver and Technology Waiver. New Choice Waiver is included in Other Optional Services. The Technology Waiver spans many service categories including Mandatory Services.

Consolidated Medicaid Expenditures SFY 2010

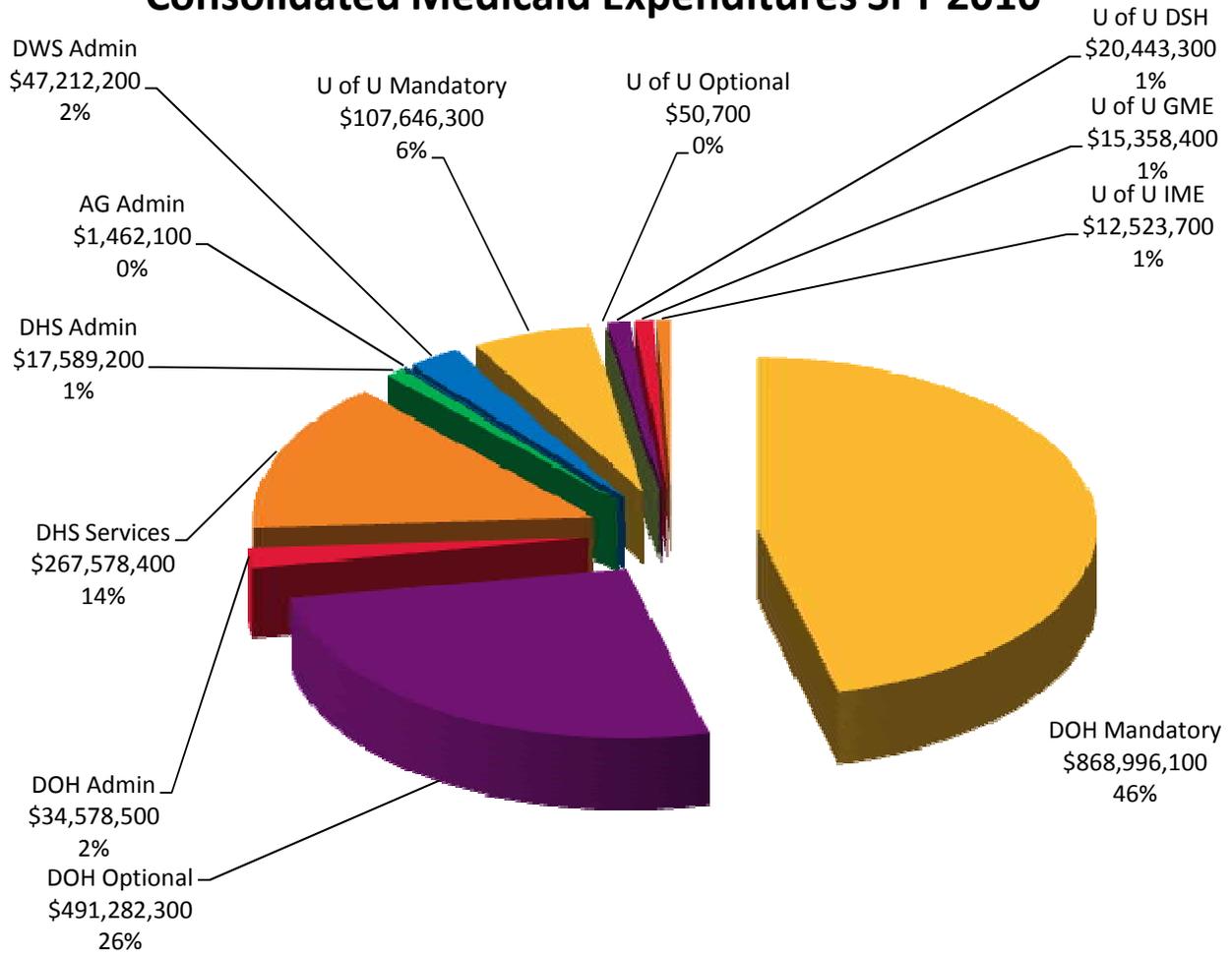


Figure 6

Utah Department of Health Division of Medicaid and Health Financing

The Utah Department of Health (UDOH) 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.

See the Division of Medicaid and Health Financing (DMHF) Overview on page 2 of this report for a breakdown of the bureau responsibilities within the UDOH/DMHF. Table 5 shows Medicaid expenditures by mandatory and optional services, and by administrative costs. Mandatory Medicaid services comprised the largest share of Medicaid services expenditures (64 percent) compared to optional services, which comprised 36 percent. Administrative expenditures were \$35 million, or 2.5 percent of total Medicaid expenditures. This amount does not include eligibility determination, which is done by DWS. Please note that HCBS Waivers in Table 5 do not include the New Choices Waiver or Technology Waiver (see note for Table 4).

In SFY 2010 UDOH/DMHF total budget was about \$2.2 billion. Total Medicaid expenditures were \$1.4 billion, or about 65 percent of the total budget. Table 5 shows SFY 2010 UDOH/DMHF Medicaid Expenditures.

Utah Department of Health / Division of Medicaid and Health Financing		
Services Expenditures - Actual		
<i>Mandatory</i>		<i>Percent of Total</i>
Inpatient Hospital	\$ 242,315,000	18%
Nursing Home	\$ 157,197,200	12%
Managed Care	\$ 201,111,200	15%
Physician Services	\$ 69,308,500	5%
Outpatient Hospital	\$ 111,527,100	8%
Other Mandatory	\$ 87,537,100	6%
TOTAL Mandatory	\$ 868,996,100	64%
<i>Optional</i>		
Pharmacy	\$ 170,059,100	13%
HCB Waivers	\$ 59,800	<1%
Capitated HM	\$ 105,649,900	8%
Buy In/Out	\$ 36,273,700	3%
Dental Services	\$ 31,401,000	2%
ICF/MR	\$ 31,531,000	2%
Vision Care	\$ 2,031,000	<1%
Other Optional	\$ 114,276,800	8%
TOTAL Optional	\$ 491,282,300	36%
Total Services Expenditures UDOH/DMHF	\$ 1,360,278,400	100%
Administrative Expenditures - Actual		
<i>Responsibilities:</i>		
<i>Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, client plan selection.</i>		
Personnel Services	\$ 16,255,300	46%
Travel - In State	\$ 32,000	<1%
Travel - Out of State	\$ 16,000	<1%
Current Expense	\$ 5,948,600	17%
Contractual	\$ 5,109,200	14%
DTS	\$ 7,976,700	23%
Total Administrative Expenditures UDOH/DMHF	\$ 35,337,800	100%
TOTAL	\$ 1,395,616,200	
TOTAL UDOH/DMHF Budget	\$2,152,577,000	
Medicaid, as a % of overall budget		65%

Table 5

Department of Human Services

The Department of Human Services (DHS) was created in 1990 under UCA 62A-1-102 to provide 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 aged.

Table 6 shows Medicaid expenditures by DHS by category of service and funding source as well as administrative costs. The largest portion of services funds was expended on people with disabilities - over \$153 million in federal funds and \$36 million from the General Fund - and accounts for over 70 percent of total DHS services expenditures. Administrative costs were \$17.6 million, or 6.2 percent of total Medicaid expenditures by DHS. Personnel expense was the largest component of expenditures at \$11.2 million.

In SFY 2010 DHS total budget was \$676 million, of which \$285 million was expended on Medicaid, or about 43 percent of the total DHS budget.

Table 6 illustrates the DHS Medicaid Expenditures for SFY 2010.

Department of Human Services							
Services Expenditures - Actual	Federal Funds		State Funds		TOTAL		Percent of Total
Child & Family Services	\$	30,013,700	\$	7,594,100	\$	37,607,800	14%
Juvenile Justice System	\$	15,143,700	\$	3,547,100	\$	18,690,800	7%
Substance Abuse & Mental Health	\$	15,129,200	\$	3,504,600	\$	18,633,800	7%
People with Disabilities	\$	153,002,100	\$	36,166,800	\$	189,168,900	71%
Aging & Adult Services	\$	2,560,100	\$	917,000	\$	3,477,100	1%
Total Services Expenditures DHS	\$	215,848,800	\$	51,729,600	\$	267,578,400	100%
<i>Expenditures include amounts paid directly by UDOH to providers who serve DHS clients.</i>							
Administrative Expenditures - Actual							
Personnel Services	\$	5,631,400	\$	5,631,400	\$	11,262,800	64%
Travel - In State	\$	32,150	\$	32,150	\$	64,300	<1%
Travel - Out of State	\$	250	\$	250	\$	500	<1%
Current Expense	\$	456,600	\$	1,607,600	\$	2,064,200	12%
DTS	\$	928,450	\$	928,450	\$	1,856,900	11%
Pass-through	\$	346,350	\$	346,350	\$	692,700	4%
Indirect Costs	\$	823,900	\$	823,900	\$	1,647,800	9%
Total Admin Expenditures DHS	\$	8,219,100	\$	9,370,100	\$	17,589,200	100%
TOTAL	\$	224,067,900	\$	61,099,700	\$	285,167,600	
TOTAL DHS Budget		\$676,920,600					
Medicaid, as a % of overall budget							42%

Table 6

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

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES - The mission for the Division 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 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 provides leadership and advocacy pertaining to issues that impact older Utahns, and serves elderly and disabled adults needing protection from abuse, neglect, or exploitation. The Division offers choices for independence by facilitating the availability of a community-based independent living in both urban and rural areas of the state. The Division 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 establishes sound fiscal practices, which provide useful information, and maintains reliable program and fiscal controls.

OFFICE OF PUBLIC GUARDIAN - The Office 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 is available. The office conducts intake and assessment for court petition process.

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 in the department.

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 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 the Division of Juvenile Justice Services include:

- Administration
- Early Intervention Services
- Community Programs
- Correctional Facilities
- Rural Programs
- Youth Parole Authority, the JJS equivalent to the Board of Pardons and Parole

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 in time sample. On a quarterly basis, eligibility workers in the Department record the time they spent on fourteen public assistance programs. Total costs are allocated to the various programs based on the percent of time derived from the sample.

Table 7 shows Medicaid administrative expenditures by DWS by cost type and funding source. Administrative costs totaled \$47.2 million, or 3 percent of the DWS total budget of \$1.6 billion.

Table 7 shows the DWS Medicaid Expenditures for SFY 2010.

Department of Workforce Services							
Administrative Expenditures - Actual	Federal Funds		State Funds		TOTAL		Percent of Total
Direct Costs	\$	1,369,900	\$	1,369,900	\$	2,739,800	6%
Allocated Costs	\$	22,236,200	\$	22,236,200	\$	44,472,400	94%
Total Admin Expenditures DWS	\$	23,606,100	\$	23,606,100	\$	47,212,200	100%

Does not include year-end closing entries made by DWS.

TOTAL DWS Budget	\$1,583,937,500
Medicaid, as a % of overall budget	3%

Table 7

Divisions and budget areas within DWS are as follows:

ELIGIBILITY SERVICES DIVISION - The 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. The entire eligibility component of these programs was transferred from UDOH to DWS in SFY 2008. Prior to that, DWS conducted about 40 percent of all eligibility determinations. General administration and oversight of the programs are still conducted within UDOH.

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 the programs. Actual payments to providers are made by UDOH.

MEDICAL PROGRAMS PERFORMANCE MEASURES - Program performance is measured by several mechanisms. Federal regulation requires that a decision be made on a medical application within 45 days following the date of application and 90 days for Disability 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 Food Stamps.

Approximately 28 percent of DWS time is related to the Medicaid program. As shown in Table 8, only six percent of the costs are direct, while 94 percent are allocated based on the random moment time study.

Office of the Attorney General

The Criminal Prosecution Program consists of five divisions of which two, criminal justice and investigations are responsible for investigation and prosecution of Medicaid fraud within the State. Table 8 shows Medicaid administrative expenditures by category and funding source. Of the \$1.5 million in total expenditures, over \$1 million (74 percent) is spent on personnel services. Total Medicaid expenditures comprise three percent of the Office of the Attorney General's budget.

Currently the Attorney General's office has ten full-time positions assigned to the Medicaid Fraud Unit. During SFY 2010 there were 113 new investigations opened and nearly \$30 million collected as a result of the efforts of this unit.

Table 8 shows the Office of the Attorney General Medicaid Expenditures for SFY 2010.

Attorney General						
Administrative Expenditures - Actual	Federal Funds		State Funds		TOTAL	Percent of Total
Personnel Services	\$	807,400	\$	269,200	\$ 1,076,600	74%
Travel	\$	3,700	\$	1,200	\$ 4,900	<1%
Supplies	\$	7,200	\$	2,400	\$ 9,600	1%
Contractual	\$	67,000	\$	22,300	\$ 89,300	6%
Other	\$	21,700	\$	7,200	\$ 28,900	2%
Indirect Costs	\$	189,600	\$	63,200	\$ 252,800	17%
Total	\$	1,096,600	\$	365,500	\$ 1,462,100	100%
TOTAL AG Budget		\$49,595,000				
Medicaid, as a % of overall budget		3%				

Table 8

University of Utah Medical Center

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

INPATIENT DISPROPORTIONATE SHARE HOSPITAL - These funds come from finite federal allocation to states and are used to pay “safety net” 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.

INPATIENT 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 mainly matched by the University and are subject to the calculated Upper Payment Limit (UPL) authorized by CMS.

INPATIENT INDIRECT MEDICAL EDUCATION (IME) - These funds help offset some of the clinical care costs of residency programs that serve Medicaid clients. All of the IME funds are matched by the University and are subject to the calculated UPL as authorized by CMS. Like GME funds, these funds cannot be used for academic programs.

Table 9 shows where the University of Utah expends Medicaid funds in SFY 2010. Expenditures for mandatory services comprise 69 percent of all University Hospital Medicaid expenditures, while optional services comprise the remaining 31 percent. Of mandatory services, the single largest expenditure is \$41 million for inpatient services or 26 percent of all Medicaid expenditures. In total, the \$156 million expended on Medicaid represents 18 percent of the University of Utah Hospital’s total SFY 2010 budget. This table does not include \$54,489,100 that is expended by ‘Healthy U’ contracted provider program to other Utah health care systems.

Table 9 illustrates the University of Utah Hospital Medicaid Expenditures for SFY 2010.

University of Utah (Hospital & Clinics)			
Service Expenditures - Actual			
Mandatory		TOTAL	Percent of Total
Inpatient Services	\$	41,006,300	26%
Contracted Health Plan Services	\$	33,112,200	21%
Physician Services	\$	25,415,200	16%
Outpatient Hospital	\$	7,970,200	5%
Other Mandatory Services	\$	142,400	<1%
TOTAL Mandatory	\$	107,646,300	69%
Optional			
Vision Care	\$	50,700	<1%
Disproportionate Share Hospital (Seeded by the U)	\$	20,443,300	13%
Graduate Medical Education (Realigned in FY2011 to a U-UPL calc.)	\$	15,358,400	10%
Indirect Medical Education (Eliminated in FY2011 to a U-UPL calc.)	\$	12,523,700	8%
TOTAL Optional	\$	48,376,100	31%
Total Services Expenditure	\$	156,022,400	100%
TOTAL University of Utah Budget (Hospital & Clinics)		\$876,000,000	
Medicaid, as a % of overall budget			18%

Table 9

Offsets to Medicaid Expenditures

In SFY 2010 a total of \$1.9 billion (state and federal resources) was expended for Medicaid in the State of Utah. Every effort is made by the various State agencies that receive Medicaid funding to offset these expenditures and thereby decrease the total resources allocated to Medicaid. In SFY 2010 a total of \$344,758,900 was used to offset Medicaid expenditures. These offsets are described below and detailed in Table 10.

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. Total co-payments collected in SFY 2010 amounted to \$6,130,500.

Third Party Liability - Services a Medicaid client receives can sometimes be billed to a third party provider such as Medicare. The Office of Recovery Services (ORS) also collects monies from these third parties. In SFY 2010, \$236,579,400 was collected or charged from/to third parties.

Pharmacy Rebates - Pharmacy retailers offer volume discount rebates to UDOH. In SFY 2010 UDOH received \$63,918,900 in pharmacy rebates.

Spendedown Income - If a potential Medicaid client exceeds the eligibility threshold, they have the option to spenddown (or pay part of) their income in order to become eligible for Medicaid. In SFY 2010, Medicaid clients spent down \$5,256,400.

Primary Care Network (PCN) Premiums - Adults must pay an annual premium, up to \$50, to be eligible for this program. In SFY 2010 a total of \$440,000 was collected.

Estate Recoveries - ORS has the responsibility to collect monies from estates when a Medicaid recipient over the age of 55 dies and a revocable trust existed. In SFY 2010, ORS recovered \$2,666,700 from estates.

Criminal and Civil Recoveries From the Attorney General Medicaid Fraud Unit - The Medicaid Fraud Unit in the Attorney General's Office collects criminal and civil penalties as a result of fraud and abuse that they investigate and prosecute. In addition, the Attorney General receives global settlements from class action lawsuits. In SFY 2010 a total of \$29,767,000 was collected from these three sources.

Expenditure Offsets - FY 2010 Actual							
Category of Services	Co-Payment	Third Party Liability	Rebates	ORS Spenddown Recovery	Premiums	Criminal/Civil Recoveries	TOTAL
Inpatient Hospital Services, General	\$ 594,000	\$ 77,793,000	\$ -	\$ -	\$ -	\$ -	\$ 78,387,000
Inpatient Hospital Services, Mental	\$ -	\$ (14,400)	\$ -	\$ -	\$ -	\$ -	\$ (14,400)
Outpatient Hospital Services, General	\$ 254,600	\$ 31,011,900	\$ -	\$ -	\$ -	\$ -	\$ 31,266,500
Nursing Facility II (NF II)	\$ -	\$ 5,000	\$ -	\$ -	\$ -	\$ -	\$ 5,000
Nursing Facility III (NF III)	\$ -	\$ 34,000	\$ -	\$ -	\$ -	\$ -	\$ 34,000
Nursing Facility I (NF I)	\$ -	\$ 19,823,000	\$ -	\$ -	\$ -	\$ -	\$ 19,823,000
Home Health Services	\$ -	\$ 5,576,900	\$ -	\$ -	\$ -	\$ -	\$ 5,576,900
Personal Care	\$ -	\$ 100	\$ -	\$ -	\$ -	\$ -	\$ 100
Substance Abuse Treatment Services	\$ -	\$ 25,400	\$ -	\$ -	\$ -	\$ -	\$ 25,400
Independent Lab and/or X-ray Services	\$ 1,900	\$ 550,500	\$ -	\$ -	\$ -	\$ -	\$ 552,400
Ambulatory Surgical Services	\$ 2,400	\$ 1,113,000	\$ -	\$ -	\$ -	\$ -	\$ 1,115,400
Contracted Mental Health Services	\$ -	\$ 7,600	\$ -	\$ -	\$ -	\$ -	\$ 7,600
Mental Health Services	\$ -	\$ 1,530,000	\$ -	\$ -	\$ -	\$ -	\$ 1,530,000
Rural Health Clinic Services	\$ -	\$ 283,600	\$ -	\$ -	\$ -	\$ -	\$ 283,600
ESRD Kidney Dialysis Services	\$ -	\$ 7,654,700	\$ -	\$ -	\$ -	\$ -	\$ 7,654,700
Pharmacy	\$ 4,460,800	\$ 4,298,600	\$ 63,918,900	\$ -	\$ -	\$ -	\$ 72,678,300
Medical Supply Services	\$ 3,000	\$ 6,947,100	\$ -	\$ -	\$ -	\$ -	\$ 6,950,100
Occupational Therapy	\$ 1,000	\$ 76,000	\$ -	\$ -	\$ -	\$ -	\$ 77,000
Medical Transportation	\$ -	\$ 5,041,200	\$ -	\$ -	\$ -	\$ -	\$ 5,041,200
Specialized Nursing Services	\$ -	\$ 559,500	\$ -	\$ -	\$ -	\$ -	\$ 559,500
Well-Child Care (EPSDT) Services	\$ -	\$ 859,400	\$ -	\$ -	\$ -	\$ -	\$ 859,400
Physician Services	\$ 494,500	\$ 31,959,600	\$ -	\$ -	\$ -	\$ -	\$ 32,454,100
Federally Qualified Health Centers	\$ 7,800	\$ 126,300	\$ -	\$ -	\$ -	\$ -	\$ 134,100
Dental Services	\$ 173,500	\$ 3,008,500	\$ -	\$ -	\$ -	\$ -	\$ 3,182,000
Pediatric/Family Nurse Practitioners	\$ 22,400	\$ 315,400	\$ -	\$ -	\$ -	\$ -	\$ 337,800
Psychologist Services	\$ -	\$ 248,300	\$ -	\$ -	\$ -	\$ -	\$ 248,300
Physical Therapy Services	\$ 12,500	\$ 871,300	\$ -	\$ -	\$ -	\$ -	\$ 883,800
Speech and Hearing Services	\$ -	\$ 54,900	\$ -	\$ -	\$ -	\$ -	\$ 54,900
Podiatry Services	\$ 7,500	\$ 675,800	\$ -	\$ -	\$ -	\$ -	\$ 683,300
Vision Care Services	\$ 12,100	\$ 310,100	\$ -	\$ -	\$ -	\$ -	\$ 322,200
Optical Supply Services	\$ -	\$ 60,300	\$ -	\$ -	\$ -	\$ -	\$ 60,300
Osteopathic Services	\$ 82,300	\$ 1,861,200	\$ -	\$ -	\$ -	\$ -	\$ 1,943,500
QMB-Only Services	\$ -	\$ 2,666,000	\$ -	\$ -	\$ -	\$ -	\$ 2,666,000
Chiropractic Services	\$ 200	\$ 57,100	\$ -	\$ -	\$ -	\$ -	\$ 57,300
Group Pre/Postnatal Education	\$ -	\$ 500	\$ -	\$ -	\$ -	\$ -	\$ 500
Nutritional Assessment Counseling	\$ -	\$ 200	\$ -	\$ -	\$ -	\$ -	\$ 200
New Choices Waiver Services	\$ -	\$ 600	\$ -	\$ -	\$ -	\$ -	\$ 600
Primary Care Network Premiums	\$ -	\$ -	\$ -	\$ -	\$ 440,000	\$ -	\$ 440,000
Recoveries from Attorney General	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 29,767,000	\$ 29,767,000
Estate Recoveries	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,666,700	\$ 2,666,700
Spenddown Collections	\$ -	\$ -	\$ -	\$ 5,256,400	\$ -	\$ -	\$ 5,256,400
ORS Collections	\$ -	\$ 31,187,200	\$ -	\$ -	\$ -	\$ -	\$ 31,187,200
TOTAL	\$ 6,130,500	\$ 236,579,400	\$ 63,918,900	\$ 5,256,400	\$ 440,000	\$ 32,433,700	\$ 344,758,900

Table 10

Medicaid Enrollment

The enrollment process eligibility determinations for the Medicaid program are made primarily by DWS, with a limited number done by DHS. Eligibility requirements for Medicaid are based on Title XIX of the Social Security Act. There are over 30 types of Medicaid classifications, each with varying eligibility requirements. Eligibility always considers household income. Most programs limit the assets that an individual or a family may have in order to qualify. The total number of enrollees for the Medicaid program was 481,402 in SFY 2010 and compared with 338,925 in SFY 2009—an increase of 42 percent. All Medicaid costs are federally matched. Eligible clients are divided by category of assistance. Figure 7 below illustrates the major categories and their percentage of the total. The majority of eligible clients is made up of children. In 2010 approximately 57 percent of the Medicaid recipients were children.

Children - Individuals under age 19

Adults in families, which include their children

Pregnant women

Individuals with a disability - Individuals who have been determined disabled by Social Security

Aged individuals - Individuals age 65 of age or older

Blind individuals - Individuals of any age who meet Social Security’s criteria for statutory blindness

Women with breast or cervical cancer

Medicare Cost-Sharing Programs for those who receive Medicare

Primary Care Network (PCN) - Low-income individuals who do not meet criteria for any of the above listed groups, ages 19-64

Figure 7 illustrates SFY 2010 eligible clients by category of assistance.

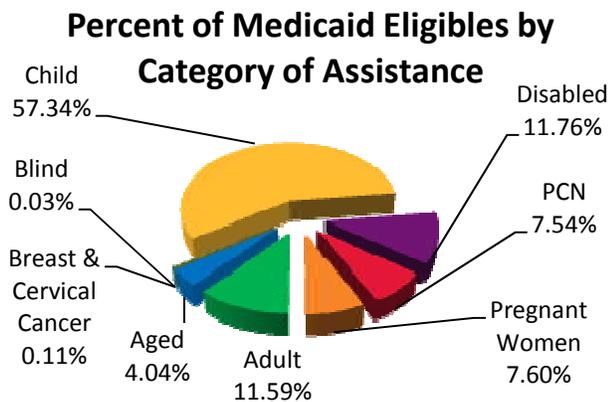


Figure 7

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

- Age
- Pregnancy
- Category of Assistance
- Other

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
- Other

As shown in Figure 7, although children make up 57 percent of the Medicaid recipients, they only account for 28 percent of the total Medicaid expenditures. Individuals with disabilities account for 42 percent of the total Medicaid expenditures (see Figure 8).

Figure 8 illustrates total SFY 2010 Medicaid expenditures by category of assistance.

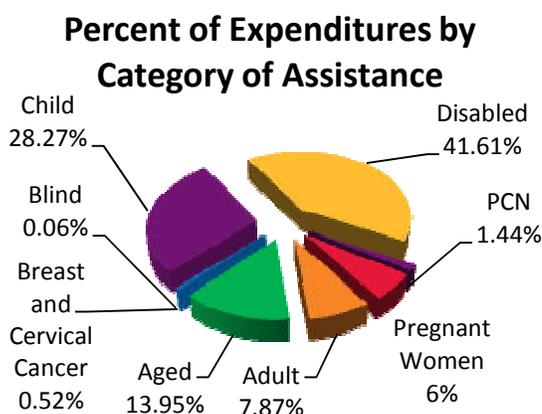


Figure 8

Income and asset tests are primary factors in determining eligibility. The Medicaid program must 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.

ENROLLMENT STATISTICS - A Medicaid eligible is a person who may fit the established eligibility criteria of the program, whether or not the person applied for Medicaid.

A Medicaid enrollee is a person fitting the established eligibility criteria of the program, who has applied for, and been approved by the Medicaid program to receive services, regardless of whether he or she received any service and/or any claims have been filed on his/her behalf.

An accurate method of estimating caseload is to calculate the average number of individuals enrolled per month, or the average member months. Figure 9 shows the number of member months in thousands over the past five state fiscal years. Average member months increased from 217,974 in SFY 2009 to 243,819 in SFY 2010. This is an increase of 11.9 percent.

Figure 9 illustrates the number of member months over the past five years.



Figure 9

A Medicaid recipient is an enrollee with at least one processed claim during the time period involved, in this case during SFY 2010 (July 1, 2009 to June 30, 2010), whether or not he or she was enrolled on the date the claim was paid, but was enrolled at the time the service for the claim was provided. For example, there may be a processed claim during this particular period for services that were provided in a prior period for an individual and his or her eligibility ended before this state fiscal year.

Medicaid Services

Medical services covered by the Medicaid program can be classified into six major service groups:

Hospital Care - Inpatient and outpatient hospital services.

Managed Care Organizations (MCOs) - Health plan-based services that provide a full range of inpatient and ambulatory medical services to enrolled Medicaid clients and reimbursed based on a monthly capitation rate or another federally approved methodology.

Pharmacy - Prescription drug products.

Long-Term Care - Services provided to individuals who are either elderly or have a disability. Services can be provided in either an institutional or community-based setting.

Physicians - All physician-delivered services.

Other Care - Includes a wide range of medical services, such as vision care, home health care, rural health clinics, and pre-natal care.

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

MANAGED CARE ORGANIZATIONS - There were 137,216 average monthly clients enrolled in Managed Health Care (MHC) in SFY 2010. MHC in Utah operates under federal 1915(b) freedom of choice waiver authority. The waiver allows the State to require Medicaid clients living in urban counties to select a health plan as their primary provider of care. MHC has decreased the unnecessary use of many health care services. A voluntary MHC program was expanded to rural communities in SFY 1988. Of clients under MHC, three percent live in rural areas and 97 percent live in urban areas. Of the clients who were eligible for MHC in FY 2010, 93 percent in the four urban counties were enrolled and 61 percent in the rural areas were enrolled either with a health plan or primary care provider.

Figure 10 illustrates the MHC eligible-client distribution for the past five state fiscal years. Figure 11 shows the total MHC care expenditures for the same five state fiscal years.

Techniques used to manage health care include the following: prior authorizations, case management, post-payment reviews, the Lock-In program, the selection of a primary care physician and the MCO option mentioned above.

Care Delivered Through Health Plans - Managed Care includes services provided to recipients through contracts between the DMHF and health plans. DMHF contracted with three health plans in SFY 2010. The health plans provided comprehensive health care for 137,216 average monthly enrollees in SFY 2010, compared with 121,634 SFY 2009.

Figure 10 illustrates the managed health care eligible-client distribution for the past five fiscal years. These figures do not include clients receiving services in long-term care programs.

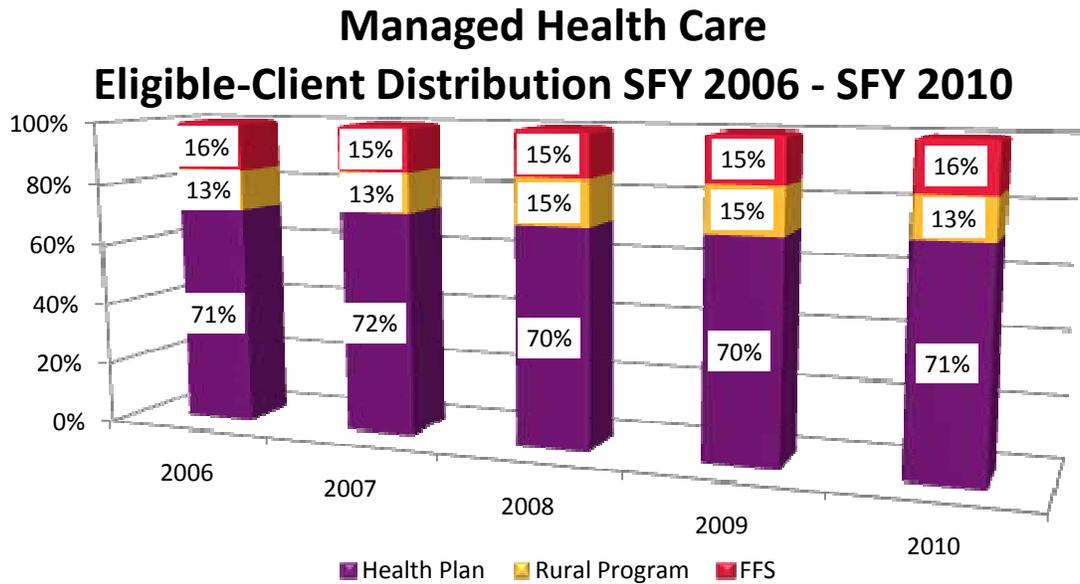


Figure 10

Figure 11 denotes total managed care expenditures for the past five fiscal years in millions of dollars.

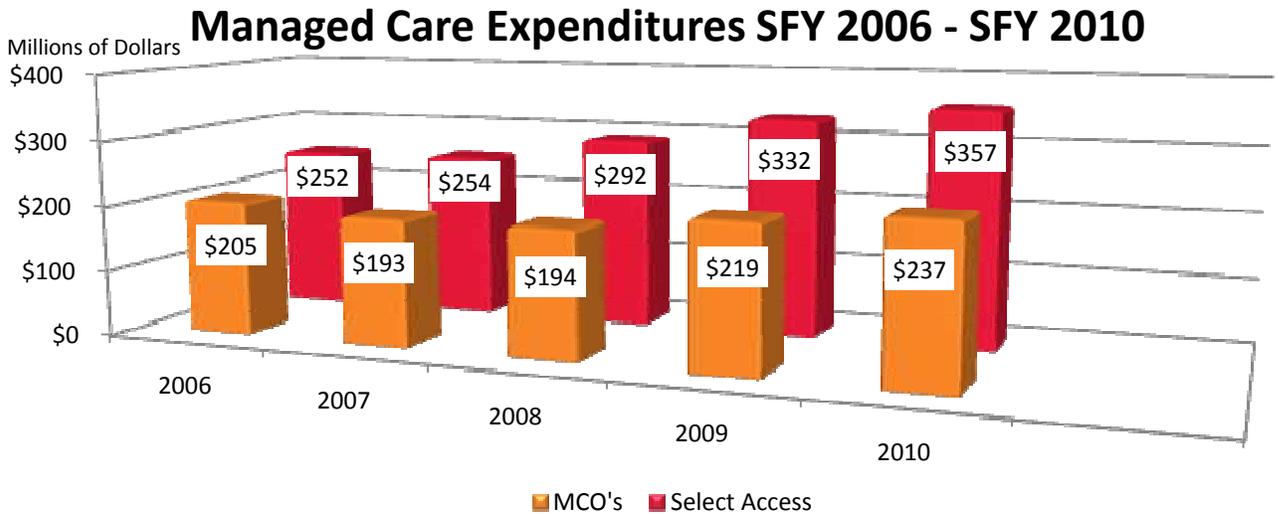


Figure 11

PHARMACY - Utah Medicaid provides coverage for nearly all available prescription drugs approved by the Food and Drug Administration (FDA).

To manage the costs of prescription drugs, Utah Medicaid 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.

Utah Medicaid also employs a Preferred Drug List (PDL) program with prior authorization. This program looks to determine the most efficacious drugs in each therapeutic class and then designate those drugs as preferred agents for use. The manufacturers of these products usually provide a secondary rebate to Medicaid.

LONG-TERM CARE - Long-term care (LTC) is a variety of services that help meet the needs of people with a chronic illness or disability. LTC services can be provided in home and community-based (HCBS) settings or nursing facilities. LTC accounted for 24 percent of the total Medicaid expenditures for SFY 2010.

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 (mental retardation). 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. Figure 12 shows the total expenditures in millions of dollars for the past five state fiscal years for nursing home services.

Figure 12 illustrates total nursing home expenditures for SFY 2006 – SFY 2010.

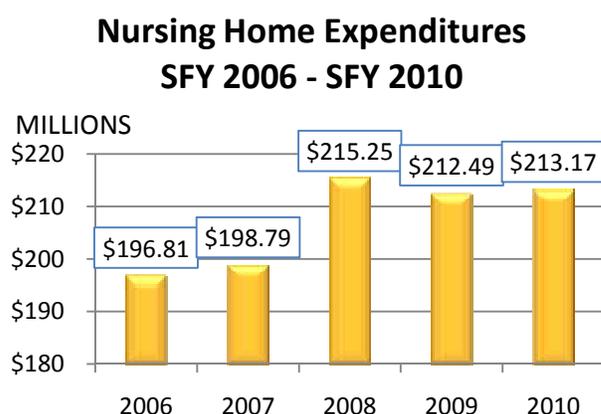


Figure 12

Home and Community-Based Services (HCBS) - Figure 13 illustrates total home and community based waiver expenditures for SFY 2006 through SFY 2010.

These programs provide LTC services in home and community-based settings as an alternative to nursing home services. The day-to-day administration and state funding of four of the HCBS waivers is provided by DHS. Utah currently has six HCBS waivers: Waiver for Individuals Aged 65 and Older, Waiver for Individuals with Acquired Brain Injuries, Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, and the Waiver for Individuals with Physical Disabilities. The two remaining waivers are managed and funded through UDOH: New Choices Waiver and Technology Dependent Waiver. UDOH, as the Medicaid agency retains final administrative oversight for all HCBS waivers.

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, the Division of Aging and Adult Services oversees this program.

Waiver for Individuals with Acquired Brain Injuries - This program's primary focus is to provide services to adults who have suffered 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, provides for the day-to-day operation and 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 mental retardation (ICF/MR). DHS, Division of Services for People with Disabilities, provides for the day-to-day operation and 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, provides for the day-to-day operation and the state funding of this program.

New Choices Waiver - The purpose of this waiver is to assist individuals who are currently residing in nursing homes to have the option to move back into a community-based setting and receive their LTC services in that setting rather than in a nursing home.

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 to live at home and avoid institutionalization. Responsibility for the day-to-day administration and operation of this waiver is shared by the Medicaid agency and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). The Medicaid agency provides the State matching funds for this program.

Figure 13 illustrates total home and community based waiver expenditures for SFY 2006 – 2010.

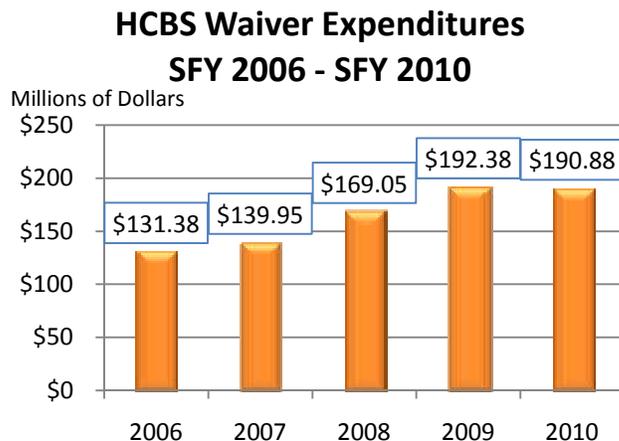


Figure 13

Determination of Need - Prior to receiving a Medicaid payment, the Agency assures that each person receiving long-term care services, whether in nursing homes or HCBS waiver programs, has had an assessment performed and has been determined to require the level-of-care provided in the long-term care program for which they are applying. Individuals are then reassessed on an annual or other routinely scheduled basis to assure the need for LTC services continues to exist.

Figure 14 shows the average monthly recipients who received services in HCBS waivers or received Nursing Home Services in SFY 2010.

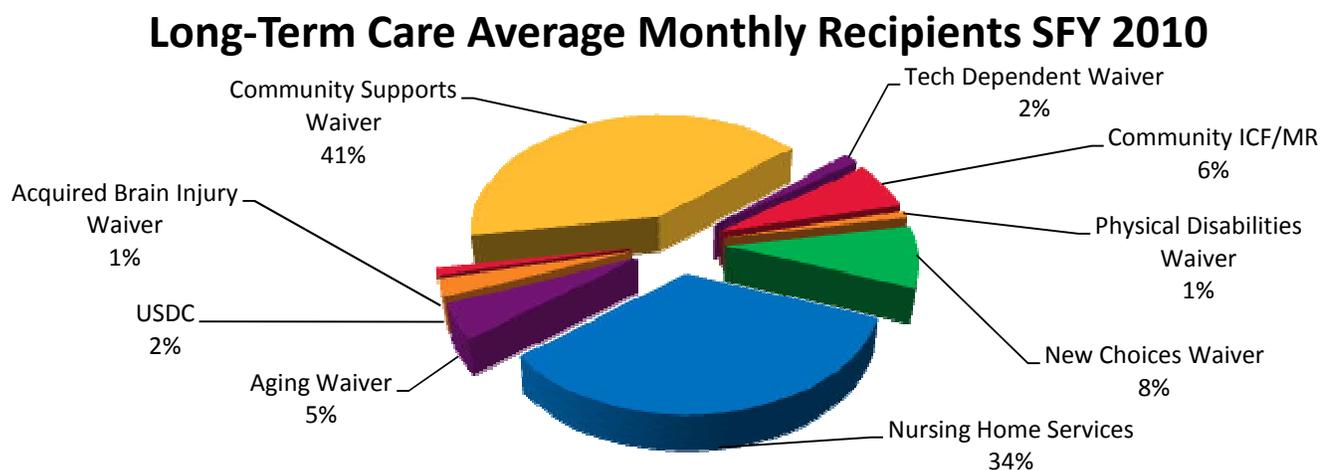


Figure 14

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.

PROVIDERS - Medical services in Medicaid are provided by any willing provider who bills Medicaid directly. In SFY 2010 there were 1,602 fee-for-service (FFS) providers that directly billed Medicaid.

Table 11 provides a unique count of providers by category of service.

Number of Participating FFS Providers by Category of Service

Category of Service	SFY 2010
Inpatient Hospital	188
Outpatient Hospital	367
Long-Term Care Facilities	122
Home Health Services	160
Personal Care Services	47
Substance Abuse Treatment Services	35
Independent Lab and/or X-Ray Services	89
Ambulatory Surgical Services	46
Contracted Mental Health Services	185
Mental Health Services	11
Rural Health Clinics	17
Kidney Dialysis	42
Pharmacy	592
Medical Supplies	541
Occupational Therapy	52
Medical Transportation	122
Specialized Nursing & Pediatrics	290
Well Child Care	643
Physician Services	3,443
Federally Qualified Health Centers	25
Dental	715
Psychologist Services	84
Physical Therapy	242
Speech and Hearing Services	96
Podiatrist	118
Vision Care	264
Optical Supplies	11
Osteopathic Services	337
QMB Services	162
Home & Community Based Waiver Services	610
Chiropractic Services	209
Targeted Case Management	13
Perinatal / Postnatal Care	25
Skills Development	32
Early Intervention	17
Buy-Out	1,602
Total	11,554

Table 11

Recipients by County SFY 2010 (MAP)

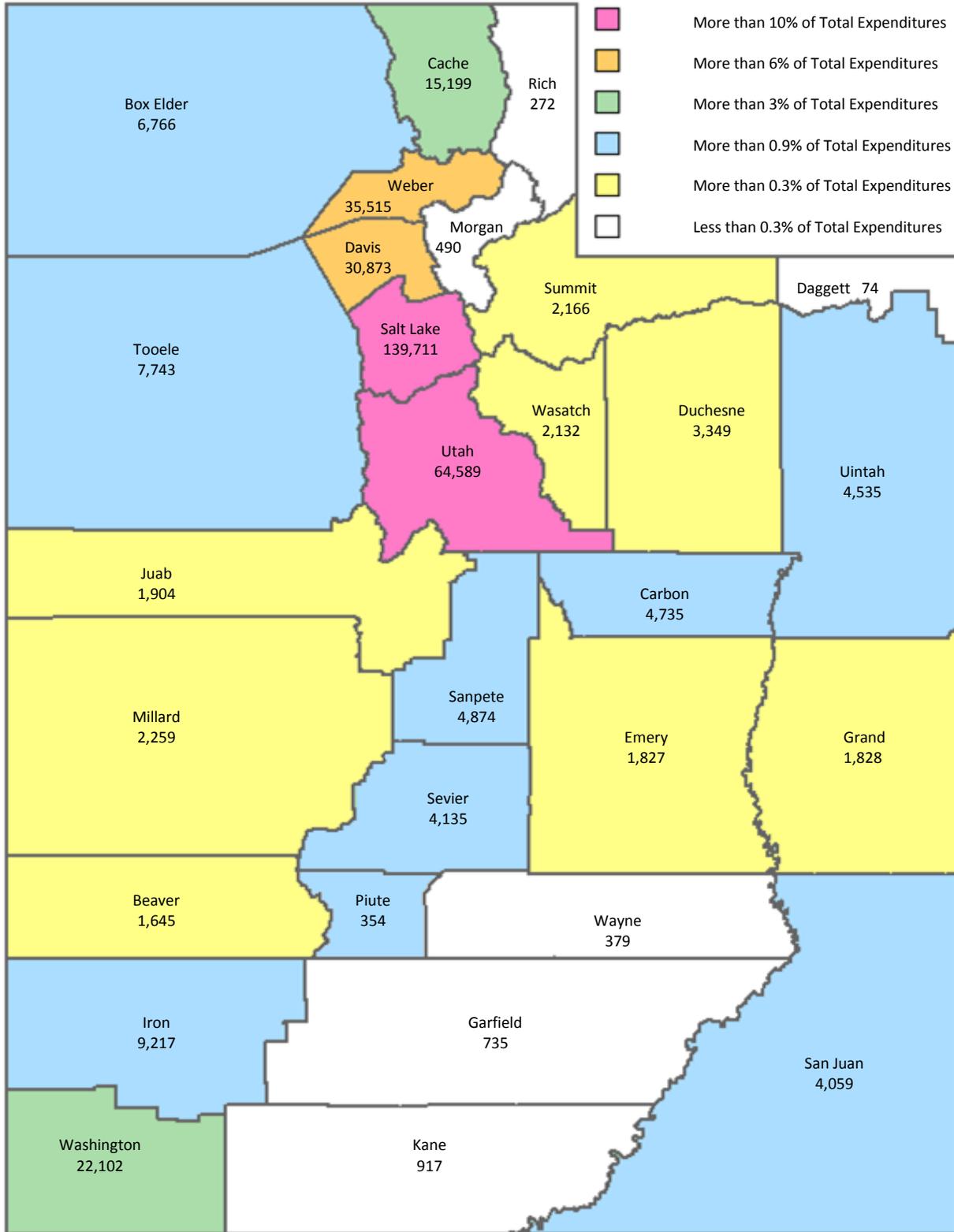


Table 12

Medicaid Expenditures by County and Service Group SFY 2010 *

	Hospital Care	Managed Care	Pharmacy Services	Long-Term Care	Physician Services	Other Services	Grand Total
Beaver	\$2,903,556	\$504	\$385,546	\$996,267	\$340,480	\$1,251,806	\$5,878,159
Box Elder	\$9,086,420	\$636,297	\$2,900,916	\$3,368,565	\$2,473,704	\$10,175,240	\$28,641,142
Cache	\$19,233,961	\$304,607	\$5,860,455	\$5,099,047	\$6,491,693	\$21,927,794	\$58,917,557
Carbon	\$7,736,734	\$665	\$2,427,477	\$2,392,357	\$1,615,411	\$8,176,313	\$22,348,957
Daggett	\$107,457	\$0	\$30,129	\$28,364	\$20,112	\$40,176	\$226,238
Davis	\$20,373,562	\$30,103,021	\$14,768,255	\$18,116,449	\$4,655,834	\$43,526,586	\$131,543,707
Duchesne	\$4,670,893	\$1,423	\$1,625,391	\$2,088,711	\$1,207,243	\$4,390,464	\$13,984,125
Emery	\$2,512,752	\$0	\$887,969	\$1,012,666	\$487,297	\$2,400,941	\$7,301,625
Garfield	\$1,553,635	\$38,730	\$340,490	\$868,558	\$158,975	\$724,572	\$3,684,960
Grand	\$2,991,219	\$94,139	\$618,934	\$373,677	\$412,828	\$1,819,503	\$6,310,300
Iron	\$9,282,440	\$4,070,159	\$3,745,700	\$2,860,385	\$2,637,716	\$13,731,550	\$36,327,950
Juab	\$3,532,646	\$30,609	\$837,351	\$1,746,042	\$554,322	\$3,488,398	\$10,189,368
Kane	\$1,961,018	\$117,148	\$274,039	\$637,835	\$222,903	\$688,427	\$3,901,370
Millard	\$3,324,146	\$22,981	\$933,498	\$1,505,169	\$762,635	\$2,002,007	\$8,550,436
Morgan	\$265,201	\$201,957	\$180,779	\$1,734	\$84,674	\$509,264	\$1,243,609
Out of State	\$166,297	\$0	\$38,432	\$0	\$61,585	\$510,715	\$777,029
Piute	\$410,152	\$148	\$181,639	\$14,857	\$70,292	\$788,199	\$1,465,287
Rich	\$249,320	\$11,842	\$80,260	\$54,886	\$73,243	\$316,036	\$785,587
Salt Lake	\$192,663,424	\$139,235,574	\$61,007,305	\$69,843,732	\$53,065,459	\$202,595,303	\$718,410,797
San Juan	\$5,807,763	\$19,225	\$2,753,664	\$2,585,560	\$3,335,464	\$4,648,586	\$19,150,262
Sanpete	\$7,550,809	\$297	\$2,303,602	\$1,632,983	\$1,746,708	\$8,055,455	\$21,289,854
Sevier	\$6,140,198	\$25,096	\$2,119,916	\$1,741,071	\$1,489,576	\$4,976,913	\$16,492,770
Summit	\$2,763,403	\$242,606	\$443,558	\$68,125	\$626,347	\$2,063,313	\$6,207,352
Tooele	\$12,405,895	\$3,305,099	\$3,846,519	\$2,241,055	\$2,412,256	\$7,615,288	\$31,826,112
Uintah	\$8,648,123	\$0	\$1,880,385	\$2,357,106	\$1,831,109	\$6,110,013	\$20,826,736
Utah	\$69,054,375	\$23,235,610	\$25,328,953	\$58,987,767	\$17,727,458	\$94,960,158	\$289,294,321
Wasatch	\$2,343,041	\$893	\$523,945	\$938,704	\$584,475	\$2,200,359	\$6,591,417
Washington	\$19,637,367	\$7,491,318	\$6,697,294	\$9,630,431	\$6,476,350	\$26,322,212	\$76,254,972
Wayne	\$681,254	\$5,188	\$88,672	\$10,208	\$138,805	\$307,753	\$1,231,880
Weber	\$34,483,729	\$27,488,183	\$15,252,907	\$21,967,814	\$8,110,580	\$45,616,316	\$152,919,529
Grand Total	\$452,540,790	\$236,683,319	\$158,363,980	\$213,170,125	\$119,875,534	\$521,939,660	\$1,702,573,408

* Note that figures do not include approximately \$81,306,000 of expense transaction that cannot be broken out by county.

Medicaid Recipients by County and Service Group SFY 2010

	Hospital Care	Managed Care	Pharmacy Services	Long-Term Care	Physician Services	Other Services	Total (Unduplicated)
Beaver	669	3	719	38	694	1,152	3,275
Box Elder	2,874	264	4,071	112	4,607	6,543	18,471
Cache	7,263	207	9,177	161	10,805	14,883	42,496
Carbon	2,415	2	2,816	94	3,193	4,595	13,115
Daggett	36	0	39	1	46	70	192
Davis	6,484	16,256	17,717	425	11,159	30,114	82,155
Duchesne	1,792	2	1,858	62	2,316	3,225	9,255
Emery	725	0	1,035	41	988	1,746	4,535
Garfield	357	35	400	29	433	685	1,939
Grand	838	31	928	14	1,074	1,729	4,614
Iron	3,696	2,386	5,662	99	5,368	8,787	25,998
Juab	895	19	1,042	49	1,265	1,856	5,126
Kane	419	88	477	18	531	864	2,397
Millard	1,204	13	1,324	51	1,590	2,141	6,323
Morgan	131	99	268	4	261	475	1,238
Out of State	45	0	66	0	573	538	1,222
Piute	183	1	237	2	243	326	992
Rich	98	8	156	2	133	266	663
Salt Lake	37,170	69,988	76,955	2,222	57,232	134,873	378,440
San Juan	1,223	14	2,308	92	3,049	3,737	10,423
Sanpete	2,372	3	2,894	55	3,306	4,650	13,280
Sevier	2,285	23	2,593	59	2,845	3,974	11,779
Summit	897	111	1,103	6	1,338	2,075	5,530
Tooele	3,102	1,376	4,699	77	4,617	7,468	21,339
Uintah	2,355	0	2,519	74	3,058	4,383	12,389
Utah	21,639	13,715	36,716	1,095	37,092	62,735	172,992
Wasatch	1,006	2	1,144	38	1,461	1,982	5,633
Washington	8,447	5,102	12,678	342	12,461	21,302	60,332
Wayne	139	1	213	1	174	361	889
Weber	10,679	13,411	20,738	698	16,404	34,659	96,589
Total (Unduplicated)	121,438	123,160	212,552	5,961	188,316	362,194	1,013,621

Table 14

CHIP Finance

UDOH manages the Children's Health Insurance Program (CHIP) through DMHF, the same division that manages Utah's Medicaid program. All eligibility actions are handled through DWS. CHIP is a state-sponsored, health insurance plan for uninsured children whose parents' income is less than 200 percent of the federal poverty level (FPL). In 2010, this limit is equal to \$44,100 in annual income for a family of four.

Since being signed into law in 1998, CHIP has covered more than 212,000 Utah children, making it possible for them to get preventive care to stay healthy and medical services when they get sick or injured.

In accordance with Section 26-40-106, Utah Code Annotated, CHIP benefits were actuarially equivalent during fiscal year 2010 to benefits received by enrollees in Select Health's Small Business Account plan, the commercial plan with the largest enrollment in the state. In SFY 2010 CHIP contracted with two HMO plans to provide medical services, Molina and the Public Employee's Health Plan (PEHP). All dental services were provided through PEHP's dental plan.

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 2010, 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 is \$14.3 million (\$10.3 million in Tobacco Settlement Restricted Fund, \$2.0 million in General Fund and an expected \$2.0 million in carryover 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 in carryover from SFY 2009.

CHIP EXPENDITURES - For SFY 2010, CHIP spent \$69.0 million on health plan premiums and \$7.6 million on administration (see Table 15). The majority of the administrative costs are for eligibility determinations made by DWS. With an average monthly enrollment of 42,006 in SFY 2010, the average cost per child was \$1,812 per year, or \$151 per month.

Table 15 shows CHIP expenditures in SFY 2010.

CHIP		
Service Expenditures - Actual	TOTAL	Percent of Total
Capitated Managed Health Care		
PEHP	\$36,708,100	48%
Molina	\$21,278,600	28%
Immunization Services	\$477,100	1%
Dental Services	\$9,933,700	13%
Other Services	\$361,800	0%
Total CHIP Services	\$68,759,300	89%
UPP Services	\$599,600	1%
Total Service Expenditures	\$69,358,900	90%
Administrative Expenditures		
DOH	\$3,086,000	4%
DWS	\$4,556,700	6%
Total Administrative Expenditures	\$7,642,700	10%
TOTAL	\$77,001,600	100%

Table 15

MAJOR BUDGET CATEGORIES -

Medical - CHIP contracts with two different managed care organizations. One provider is a full risk provider offering a comprehensive medical coverage plan with CHIP funds paying the cost of a monthly capitated rate. The other provider has a non-risk contract, but administers an identical comprehensive medical coverage plan with CHIP funds paying a monthly capitated rate. Any savings or losses incurred in addition to the monthly capitated rate are passed back to the State as a return of premium (in the case of a savings) or an additional premium cost (in the case of a loss).

Dental - CHIP utilizes one provider to manage the dental program. This provider is a non-risk provider with CHIP funds paying a monthly capitated rate for dental coverage. As with the non-risk provider for medical, the State carries the risk or full cost for providing this benefit.

UPP - Utah's Premium Partnership for Health Insurance (UPP) is an effort to offer families a rebate 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 Enrollment

ELIGIBILITY REQUIREMENTS AND THE ENROLLMENT PROCESS - As required by House Bill 326 (2008), CHIP does not close enrollment and continuously accepts new applications. Applications for CHIP and UPP can be submitted through the mail, in-person, and online. A simplified renewal form and process has been implemented to reduce unnecessary barriers for the families being served.

Basic eligibility criteria:

1. Gross family income cannot be higher than 200 percent FPL (200 percent FPL for a family of four is \$44,100).
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.

CHIP children are enrolled in the program for a twelve-month period.

CHIP contracted with two health plans in SFY 2010 to provide medical service for enrollees:

1. Molina
2. PEHP

CHIP contracted with the PEHP's dental plan in SFY 2010 to provide dental services for all enrollees.

ENROLLMENT STATISTICS - Of the current enrollees, the ethnicity, race, age and income breakdowns are as follows:

Ethnicity (as of August 2010)	
Hispanic	10,465
Non-Hispanic	29,995
Race (as of August 2010)	
White	37,159
Multiple Races	1,673
Asian	648
Native American/Alaska Native	488
Black	472
Native Hawaiian/Pacific Islander	413
Age (as of August 2010)	
Less than 10	20,837
10 to 19	20,016

Income (as of August 2010)	
Less than 100% FPL	17,286
101% to 150% FPL	14,958
151% to 200% FPL	8,615

Sixty-nine percent of CHIP children are residents of Davis, Salt Lake, Weber, and Utah counties. Thirty-one percent are residents of other counties.

Figure 15 shows enrollment since CHIP was re-opened in July 2007.

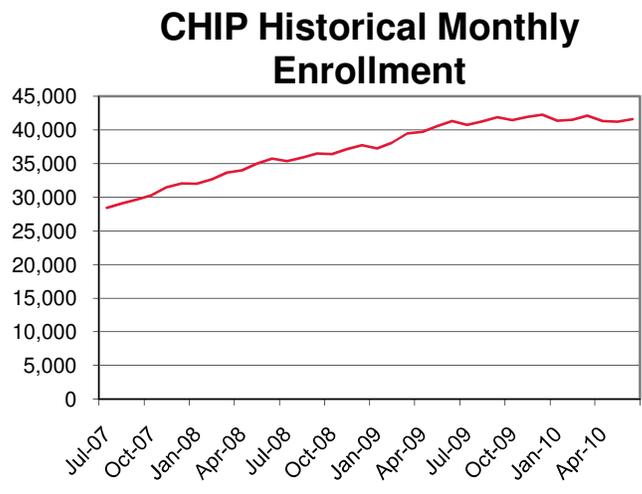


Figure 15

CHIP Services

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 (12-month waiting period)

UPP Services

In an effort to create private health insurance opportunities for individuals that qualify for CHIP, UDOH 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 monthly 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. If the family does not purchase dental coverage for their children through their work, the children can be enrolled in CHIP dental coverage, which was provided through PEHP in SFY 2010. Those rebates are currently \$120 per child per month for medical coverage and an additional \$20 per child per month for dental coverage.

In August 2010, there were 393 children enrolled in UPP. Of the 393 enrollees, 321 received both the medical and dental subsidy and 72 received the medical subsidy and enrolled in the CHIP dental plan. In December 2009, UPP was given approval by the CMS to help low-income individuals and families pay for their COBRA coverage. Now families either COBRA eligible or 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, UDOH continues to push 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. UDOH also included this amendment request in a waiver renewal request submitted in February 2010. UDOH continues discussions with the federal government and is asking for approval of the amendment by December 2010. If the amendment is approved by that date, UDOH hopes to offer this rebate option to families in the summer of 2011.

On March 24, 2010, President Obama 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. UDOH 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.

APPENDIX A: 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 Aged, Blind and Disabled.
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.
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 UDOH 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 nonlapsing. 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 UDOH. 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 Utah Department of Health 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	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.
UDOH	Refers to the Utah Department of Health.
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 B: Utah Medicaid Waivers

Waiver programs currently in effect in the State of Utah:

Waiver Type 1115

Primary Care Network (PCN)

PCN is a health plan for adults 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 Nontraditional 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

(i) 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.

(ii) 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

(i) 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 Medicaid agency and the Division of Family Health and Prevention (also under the umbrella of the Single State Medicaid Agency). The Medicaid agency provides the State matching funds for this program.

(ii) 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 Mental Retardation (ICF/MR). The Operating Agency is DHS, Division of Services for People with Disabilities.

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.

(iii) 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. The Operating Agency is DHS, Division of Aging and Adult Services.

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, provides for the day-to-day operation and the state funding of this program.

(iv) 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. The Operating Agency is DHS, Division of Services for People with Disabilities.

This program's primary focus is to provide services to adults who have suffered 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.

(v) 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. The Operating Agency is DHS, Division of Services for People with 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, provides for the day-to-day operation and the state funding of this program.

(vi) New Choices Waiver

This program serves approximately 800 people who were nursing 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. The Operating Agency is the State Medicaid Agency.

The purpose of this waiver is to assist individuals who are currently residing in nursing homes to have the option to move back into a community-based setting and receive their long-term care services in that setting rather than in a nursing home.

APPENDIX C: Comparison of Adult Medicaid Programs

A provider can refuse to see you, if you do not pay your co-pay.

Benefit	Traditional Medicaid (usually 18 years or older)	Non-Traditional Medicaid (usually 18 years or older)	Primary Care Network (PCN) (19 years or older)
Out of Pocket Maximum	Pharmacy: \$15 per month Inpatient: \$220 per year Physician & Outpatient: \$100 per year	\$500 per calendar year per person	\$1,000 per calendar year/ per person (up to \$50 enrollment fee not included)
Dental	Not covered	Not covered	10% co-pay (limited benefits)
Emergency Room	\$0 co-pay (\$6 co-pay for non-emergent use of the ER)	\$0 co-pay (\$6 co-pay for non-emergent use of the ER)	\$30 co-pay (see PCN Member Guide for limitations)
Family Planning	Office visit: \$0 co-pay Pharmacy: \$0 co-pay (see current OTC list)	Office visit: \$0 co-pay Pharmacy: \$0 co-pay (see current OTC list) <i>Implants & patches are not covered</i>	Office visit: \$5 co-pay Pharmacy: \$5 co-pay for generic & OTC (see current OTC list) <i>Implants & sterilization are not covered</i>
Inpatient Hospital	\$220 co-pay yearly for non-emergent stays	\$220 co-pay for each non-emergent stay	Not covered
Lab	\$0 co-pay	\$0 co-pay	5% co-pay of allowed amount if over \$50
Medical Equipment & Supplies	\$0 co-pay	\$0 co-pay	10% co-pay for covered services
Mental Health	\$0 co-pay at prepaid Mental Health Center	\$0 co-pay (30 annual inpatient, 30 annual outpatient visits maximum)	Not covered
Occupational & Physical Therapy	\$0 co-pay	\$3 co-pay (limited 10 visits per year total)	Not covered
Office Visit & Outpatient	\$3 co-pay	\$3 co-pay (\$0 co-pay for preventative care or immunizations)	Outpatient: Not covered Office visit: \$5 co-pay (pregnancy related services not covered)
Pharmacy	*\$3 co-pay per prescription (limited to \$15 per month) <i>Review process for more than 7 prescriptions per month</i> Limited over-the-counter drug coverage	\$3 co-pay per prescription <i>Review process for more than 7 prescriptions per month</i> Limited over-the-counter drug coverage	Generic - \$5 co-pay Brand Name - 25% co-pay (limited to 4 prescriptions per month)
Transportation	\$0 co-pay	\$0 co-pay (limited to emergency transportation)	\$0 co-pay (limited to emergency transportation)
Vision	Optometrist - \$0 co-pay for annual eye exam Ophthalmologist - \$3 co-pay for annual eye exam <i>Glasses are not covered</i>	Annual coverage limited to \$30 for a medically necessary eye exam <i>Glasses are not covered</i>	\$5 co-pay for annual exam <i>Glasses are not covered</i>
X-ray	\$0 co-pay	\$0 co-pay	5% co-pay of allowed amount over \$100

- American Indians, pregnant women and children are excluded from co-pays. In addition to Traditional Medicaid benefits, pregnant women and children will receive dental, vision and chiropractic benefits.

- Other insurance or Medicare may affect co-pay and co-insurance.

This chart may change at any time without notice. Updated July 2009.

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