2015 Utah Annual Report of Medicaid & CHIP

STATE FISCAL YEAR 2015
July 2014 - June 2015

Utah Annual Report of
Medicaid & CHIP

State Fiscal Year 2015

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State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

Joseph K. Miner, 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 18, 2015

Dear Fellow Utahn:

It is my privilege to present to you the 2015 Medicaid and CHIP Annual Report of the Utah Department of Health (UDOH). This report includes the Division of Medicaid and Health Financing (Division) activities from July 2014 to June 2015. It provides an overview of the continual efforts by committed state employees and stakeholders to ensure that Utah's most vulnerable populations maintain the focus of the program.

Throughout the past year, Medicaid continued to explore opportunities and initiatives to improve health care for members, while honoring its obligation to be good stewards of the funds provided by the taxpayer. Some of those activities included:

- The implementation of Release 2, as part of a multi-year project to replace the current Medicaid Management Information System (MMIS). Release 2 added the HealthBeat dashboard, which tracks progress toward health program goals and operational performance to access and monitor meaningful data.
- Medicaid's Accountable Care Organization (ACO) delivery model which has effectively improved health outcomes, increased access to health care and even reduced costs. Now more than 86 percent of Medicaid members receive services through an ACO and it is estimated that the ACOs produced $11 million of General Fund savings in the past two years.
- Working closely with the Governor's Office and legislative leadership to develop a Medicaid expansion plan that closes the health insurance coverage gap for low-income adults while encompassing Utah's priorities and maintaining federal approval.

I remain optimistic about Medicaid's role in the health care system in Utah. It plays a vital and essential part of the infrastructure. It meets the medical and behavioral health care needs for thousands of low-income families, individuals who are elderly or who have disabling conditions. By covering the needs of our fellow-citizens, Medicaid serves a greater purpose in helping individuals avoid becoming medically frail, avoid filing for medical bankruptcy and reducing intergenerational poverty. UDOH and the Division look forward to the continued cooperation with the Governor's Office, the Utah State Legislature, the Medicaid provider community, and the citizens.

Sincerely,

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

UTAH DEPARTMENT OF HEALTH

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2015 Division Highlights

HEALTH CARE REFORM

- Negotiated with the Centers for Medicare and Medicaid Services (CMS) to develop a plan that fit Utah's priorities, closed the health insurance coverage gap and would be approved by CMS.
- Collaborated with the Governor's Office to develop and release the Governor's detailed Healthy Utah plan.
- Participated in town hall meetings statewide to inform the public, media and legislators about Healthy Utah.
- Worked with the legislature to provide data and policy guidance with regard to proposed alternative Medicaid expansion proposals.

PROVIDER REIMBURSEMENT INFORMATION SYSTEM FOR MEDICAID (PRISM)

- Implemented Release 2, as part of a multi-year project to replace the current Medicaid Management Information System (MMIS). Release 2 added the HealthBeat dashboard, which tracks progress toward health program goals and operational performance. The HealthBeat dashboard is an internal tool used by staff to access and monitor meaningful data.

WAIVERS

- Submitted renewal requests to CMS for the following waivers to be effective July 1, 2015:

  Aging Waiver: This waiver is designed to provide services statewide to help older adults remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program. This program provided services to 617 individuals in FY 2015.

  New Choices Waiver: This waiver program is designed to serve people who have been residing long term in a nursing facility, assisted living facility, small health care facility or other Utah licensed medical facility that is not an institution for mental disease (IMD). The program provides supportive services to enable individuals to live in their own homes or in other community-based settings. This program served 1,829 individuals in FY 2015.

  Community Supports Waiver: This waiver is designed to provide services statewide to help persons with intellectual disabilities or persons with conditions related to intellectual disabilities remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program. This program provided services to 4,874 Medicaid members in FY2015.
- Submitted a new waiver request to CMS to provide services to children with medically complex conditions.
- Continued the Autism Waiver Program, which served approximately 300 children in FY2015. The program had one open enrollment during FY2015, in which 25 new children were enrolled. Using standardized evaluation tools, outcomes were extremely positive in both verbal and behavioral trajectories for the enrolled participants receiving Applied Behavior Analysis therapy.

CUSTOMER SERVICE

- Answered more than 267,806 calls from Medicaid clients and providers by Medicaid customer service representatives.
- Processed 6,491,817 million claims.
- Received 475,345 calls through AccessNow, an automated eligibility line for providers to verify if their patients are enrolled in Medicaid.
- Enrolled 6,422 new providers (full enrollment) and enrolled 910 providers with limited enrollment.
- Provided program and plan education to 120,855 Medicaid recipients and 12,425 CHIP recipients.
- Received 87,591 calls in the Health Program Representative Unit.
- Provided training to 1,250 Medicaid providers and staff in the annual statewide provider training.
- Participated in two successful implementations for the Governors SUCCESS Framework.

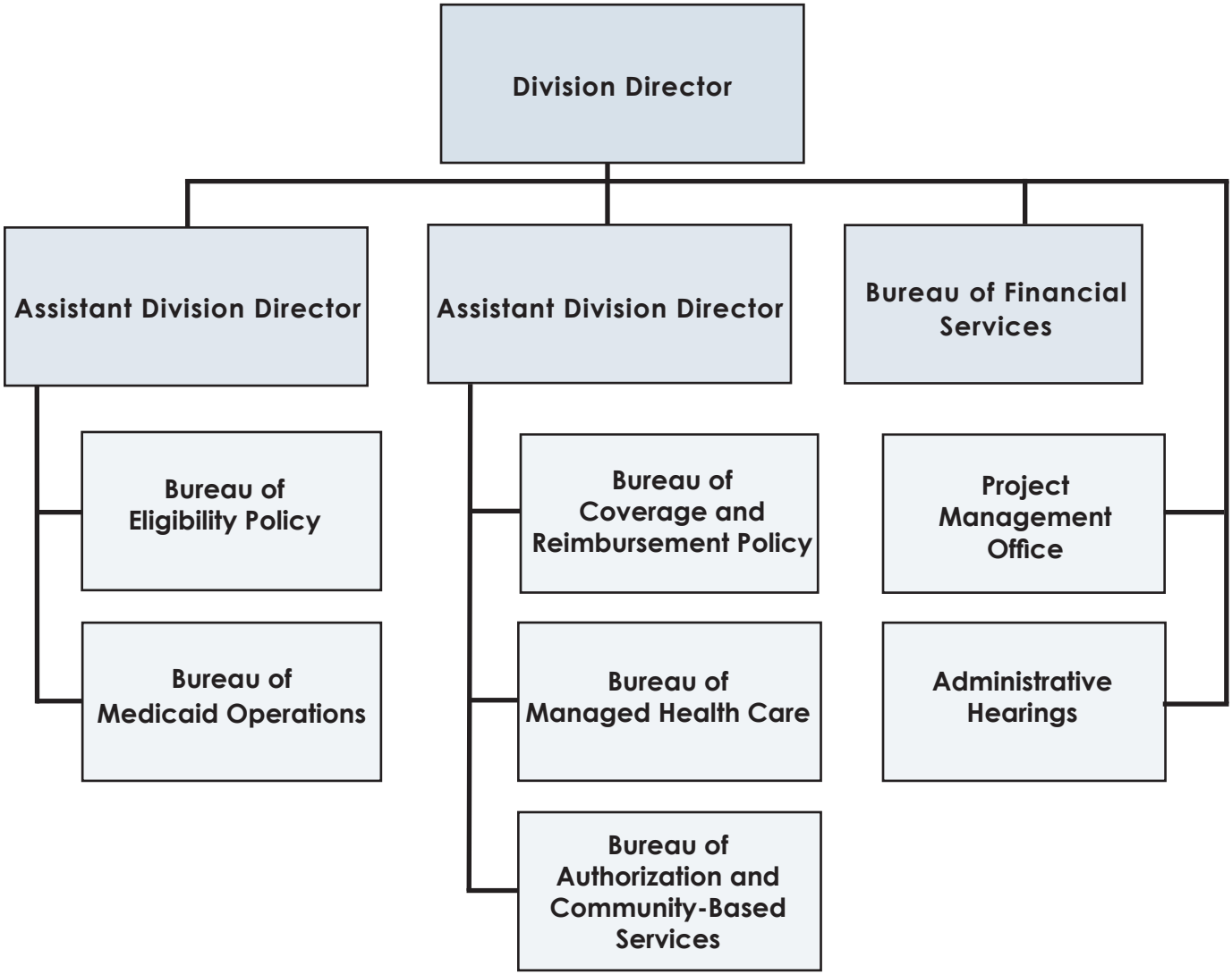
SERVICE DELIVERY AND PAYMENT

- Added 27 new classes to the Preferred Drug List (PDL), now totaling 121 classes on the PDL. These drug class additions, combined with savings from existing PDL classes are expected to generate annualized PDL savings of approximately $48.2 million in total funds ($14.1 million in General Funds).
- Migrated 837, 820, 834, 835, 999 and 277CA Electronic Data Interchange (EDI) Transactions to Oracle Translator to enable Strategic National Implementation Process (SNIP) validation for HIPAA Transactions.
- Continued implementing the ACA rules including Federal Criminal Background Checks and sanctioning databases for Medicaid providers.
- Reviewed over 40,000 codes necessary to successfully transition from ICD-9 to ICD-10.
- Submitted 21 State Plan Amendments and 54 State Administrative Rules.
- Revised program coverage and payment rules related to the 340B drug discount program.
- Continued enhanced reimbursement in accordance with 42 CFR 447.405, up to the Medicare allowed, to qualifying physicians for certain Evaluation and Management, and vaccine codes.
- Automated the Electronic Funds Transfer/Electronic Remittance Advice from a manual process. Providers now submit financial information through a secure portal, creating a more timely process with less errors, in which providers can make their own changes.
- Began reimbursing Medicaid providers for physician and nurse practitioner services delivered via telemedicine to Medicaid members. Telemedicine is two-way, real-time interactive communication between the patient and the provider at the distant site, typically using audio and video equipment.
- Launched the Utah Pharmacy Provider Portal interface, allowing all registered Medicaid prescribers to submit and manage prior authorizations (PA). The portal is designed to improve patient care through more efficient and accurate health care, as prescribers can be access the portal on any device that can run a web browser, including iPads and tablets, smartphones or Blackberry devices.

Mission Statement

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

Organizational Chart



Division Overview

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

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

BUREAU OF FINANCIAL SERVICES

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

BUREAU OF MANAGED HEALTH CARE

The primary responsibility of this bureau is to administer all managed care federal waivers and contracts for both Medicaid and CHIP. In addition, the bureau is responsible for staff that provide education and assistance to Medicaid and CHIP members regarding selection of managed care plans and appropriate use of Medicaid and CHIP benefits. In addition, this bureau monitors the performance and quality of services provided by managed care organizations on behalf of Medicaid and CHIP. Managed care includes physical, mental, and dental health services. In addition, the bureau is responsible for the early periodic screening, diagnosis, and treatment (EPSDT) program that provides well-child health care, the Medicaid restriction program, and the School Based Skills Development program.

BUREAU OF AUTHORIZATION AND COMMUNITY-BASED SERVICES

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

BUREAU OF MEDICAID OPERATIONS

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

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY

The general responsibilities of this bureau include benefit policy formulation, interpretation, and implementation planning. This responsibility encompasses the scope of service and reimbursement policy for Utah's Medicaid program. The bureau also maintains the State Plan and oversees the pharmacy program, which includes the Drug Utilization Review Board and the Preferred Drug List.

BUREAU OF ELIGIBILITY POLICY

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

Division Expenditures

Figure 1 shows a breakdown of DMHF state fiscal year (SFY) 2015 expenditures. Medicaid mandatory and optional services comprise 91.3 percent of total expenditures, Medicaid administrative services account for 5 percent and CHIP administration and services for 4 percent.

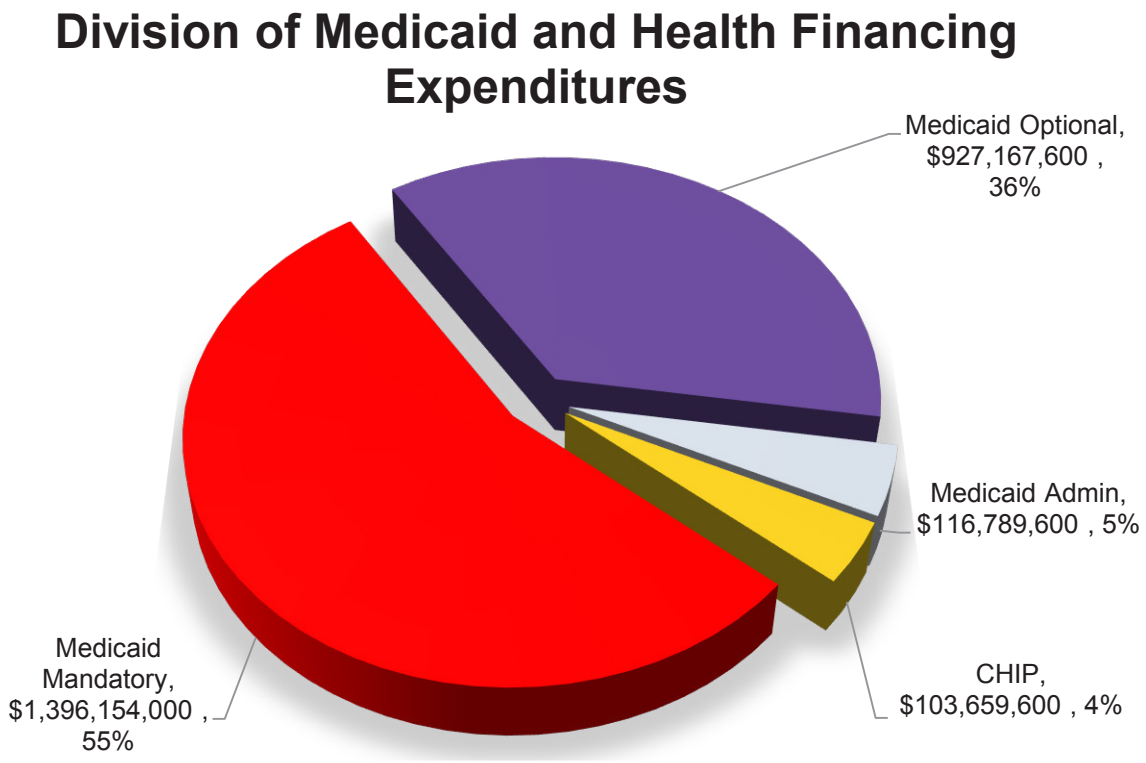


FIGURE 1

Table 1 breaks down the categories in Figure 1 by expenditure types. Approximately 98 percent of the DMHF expenditures are for pass-through charges. Personnel services account for one percent of total expenditures. Table 1 provides a break out of these expenditures for state fiscal years (SFY) 2011 to 2015.

TABLE 1: Division of Medicaid and Health Financing Expenditures SFY 2011 SFY 2015						
Category	**Expenditure Type**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**
Medicaid Admin.	Capital Expenditure	$0	$0	$32,000	$0	$0
	Current Expense	$4,202,400	$6,132,600	$4,824,900	$4,586,000	$4,719,500
	Data Processing Capital Expenditure	$834,700	$309,600	$1,086,500	$0	$0
	Data Processing Current Expense	$7,483,400	$7,799,800	$8,737,900	$10,374,700	$13,106,000
	Other Charges/Pass Through	$77,942,700	$67,488,000	$68,543,700	$81,495,400	$81,511,000
	Personnel Services	$13,814,300	$14,268,100	$15,034,000	$16,357,100	$17,378,000
	Travel/In State	$20,500	$23,700	$24,100	$21,300	$15,300
	Travel/Out of State	$21,600	$28,900	$30,400	$39,500	$59,800
Admin Total		**$ 104,319,600**	**$ 96,050,700**	**$ 98,313,500**	**$ 112,874,000**	**$ 116,789,600**
Medicaid Mandatory	Capital Expenditure	$0	$72,000	$22,400	$86,100	$0
	Current Expense	$2,137,900	$3,154,800	$3,179,000	$4,243,800	$4,380,200
	Data Processing Current Expense	$63,200	$2,420,700	$9,550,000	$15,130,800	$8,990,300
	Other Charges/Pass Through	$1,020,253,000	$1,048,141,200	$1,156,619,400	$1,339,260,400	$1,375,055,600
	Personnel Services	$5,018,300	$4,273,600	$4,059,000	$7,592,800	$7,666,600
	Travel/In State	$21,200	$30,600	$26,900	$33,000	$36,700
	Travel/Out of State	$6,200	$1,500	$8,100	$15,900	$24,600
	Trust & Agency Disbursements	$0	$87,300	($3,700)	$0	$0
Mandatory Total		**$1,027,499,800**	**$1,058,181,700**	**$1,173,461,100**	**$1,366,362,800**	**$1,396,154,000**
Medicaid Optional	Current Expense	$3,400,400	$1,678,900	$2,088,900	$123,000	$234,100
	Data Processing Current Expense	$2,000	$20,400	$2,200	$12,600	$14,000
	Other Charges/Pass Through	$837,575,700	$911,658,600	$923,030,000	$897,075,700	$926,542,500
	Personnel Services	$392,700	$119,600	$308,000	$307,400	$377,000
	Travel/In State	$0	$0	$1,700	$0	$0
	Travel/Out of State	$2,000	$17,200	$19,400	$0	$0
Optional Total		**$ 841,372,800**	**$ 913,494,700**	**$ 925,450,200**	**$ 897,518,700**	**$ 927,167,600**
Medicaid Total		**$1,973,192,200**	**$2,067,727,100**	**$2,197,224,800**	**$2,376,755,500**	**$2,440,111,200**
CHIP	Current Expense	$253,200	$982,800	$333,000	$199,500	$237,300
	Data Processing Capital Expenditure	$21,400	$2,200	$26,900	$0	$0
	Data Processing Current Expense	$18,300	$43,400	$25,600	$10,400	$5,600
	Other Charges/Pass Through	$70,120,400	$71,328,500	$71,330,100	$72,829,600	$102,788,100
	Personnel Services	$924,500	$1,139,200	$996,200	$684,200	$623,200
	Travel/In State	$4,200	$2,700	$2,500	$1,500	$600
	Travel/Out of State	$16,100	$11,800	$7,500	$400	$4,800
CHIP Total		**$ 71,358,100**	**$ 73,510,600**	**$ 72,721,800**	**$ 73,725,600**	**$ 103,659,600**
Total Expenditures		**$2,044,550,300**	**$2,141,237,700**	**$2,269,946,600**	**$2,450,481,100**	**$2,543,770,800**

Medicaid Management Information System (MMIS) expenditures are included in the "Medicaid Mandatory" category for fiscal years 2012 and 2013 to be consistent with fiscal years 2014 and 2015.

MEDICAID FINANCE

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

Means of Finance

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

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

Medicaid is funded by a share of both federal and state funds. This percentage of federal versus state funding is based on the Federal Medical Assistance Percentages (FMAP), which are updated every Federal Fiscal Year (FFY). The FFY runs from October 1 to September 30. The FMAP for each state ranges from 50 percent to 73.4 percent of program cost. The funding formula is based on each state's latest three year average per capita income. Table 2 is an eleven year historical list of Utah FMAP running from 2005 to 2015, modified to match the state fiscal year (SFY), which runs from July 1 on one year to June 30 of the following year.

TABLE 2: Federal Medicaid Assistance Percentages (FMAP) for Utah SFY 2005 SFY 2015

SFY	Federal Percentage	State Percentage
2005	72.04%	27.96%
2006	71.11%	28.89%
2007	70.30%	29.70%
2008	71.26%	28.74%
2009	70.94%	29.06%
2010	71.44%	28.56%
2011	71.27%	28.73%
2012	71.03%	28.97%
2013	69.96%	30.04%
2014	70.16%	29.84%
2015	**70.50%**	**29.50%**

DMHF receives approximately 65 percent of its program funding from federal match and 35 percent from the State General Fund, transfers and provider assessments. During fiscal years 2009 – 2011, the federal government provided a temporary increase to the FMAP as specified in the American Recovery and Reinvestment Act (ARRA). Those increases are not specified in Table 2. Medicaid administrative costs are generally matched at 50 percent by federal funds.

Figure 2 is a breakout of Medicaid program expenditures. The largest component, "Other Charges/ Pass Through," is largely comprised of payments to providers of Medicaid services. Specifically, pass-through charges are incurred for the provision of physical health, behavioral health, dental health and long-term care services provided through contracted entities and administrative services provided by other state agencies.

Medicaid Expenditures

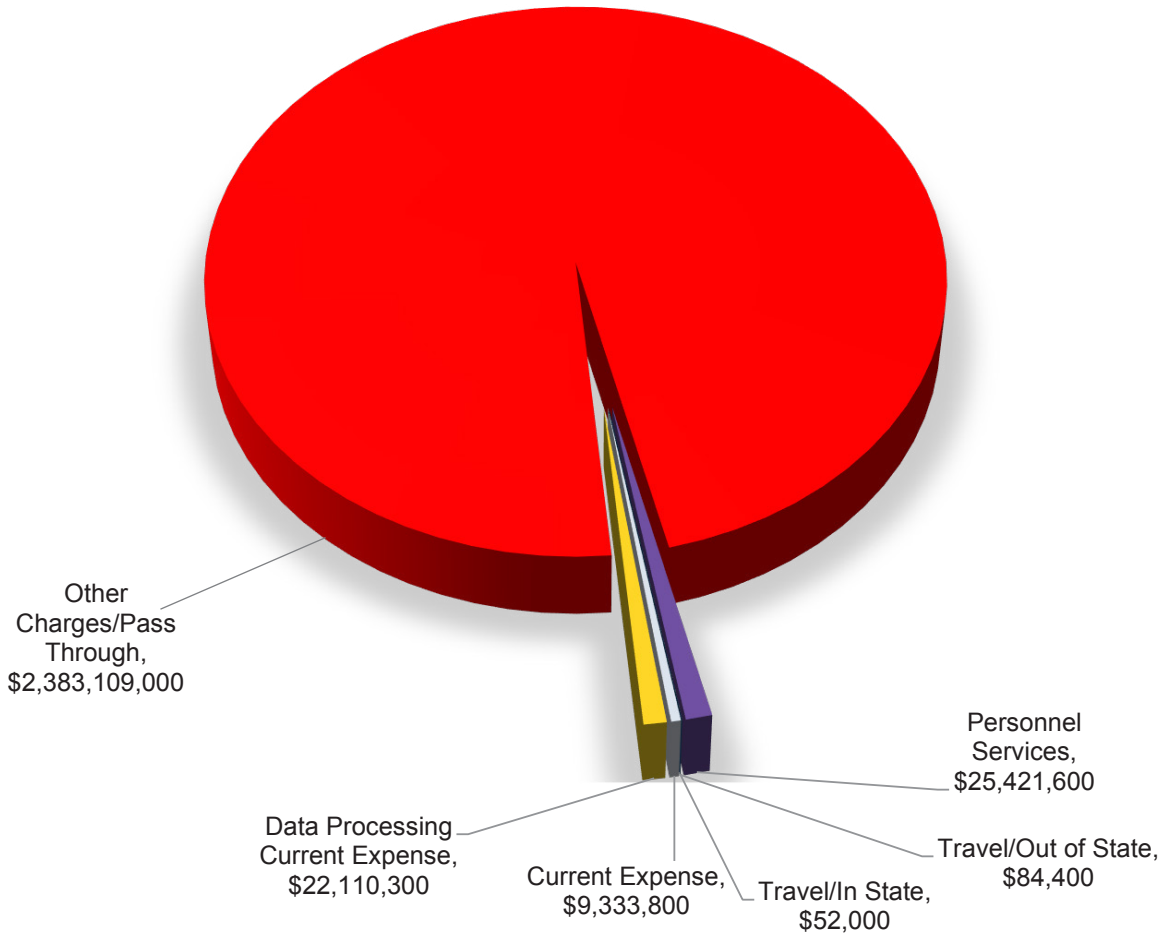


FIGURE 2

DMHF's revenues come from various fund sources, namely the State General Fund, Dedicated Credits, Restricted Revenues, Transfers and the associated Federal Funds. Transfers and most Dedicated Credits are funds from other state agencies, local county agencies, or school districts and are often referred to as "seeded funds", which are used to draw down federal matching funds based on the FMAP. Figure 3 shows a breakout of revenue types, sources and amounts in 2015.

Medicaid Program Total Revenue Sources

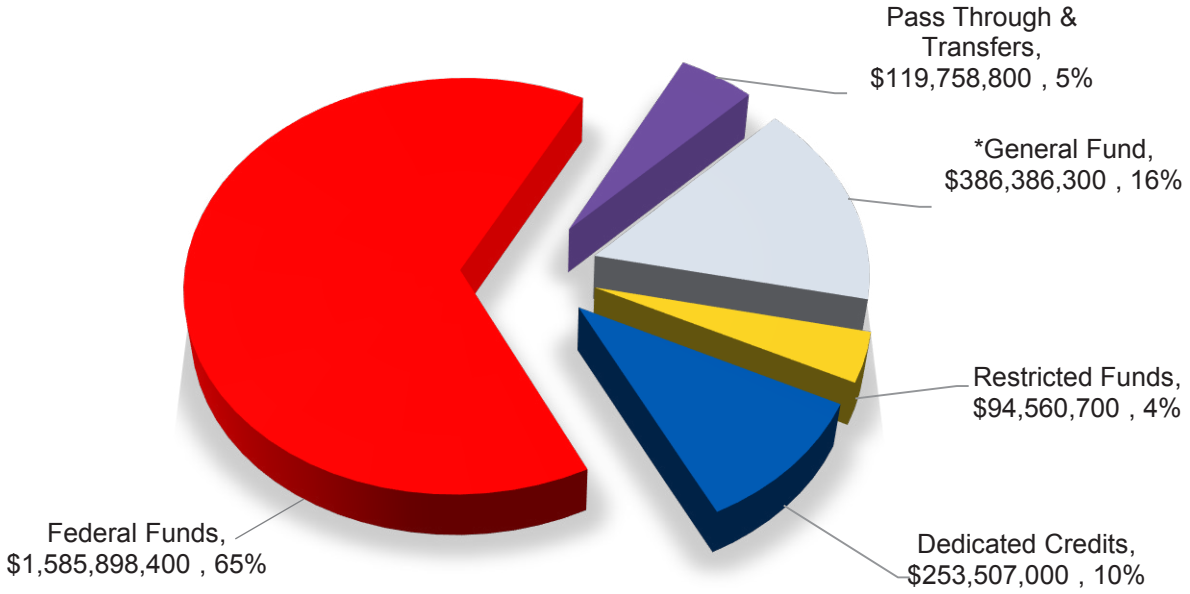


FIGURE 3

**General Fund includes appropriated General Fund, the SFY 2015 beginning balance, lapsing and non-lapsing funds.*

Offsets to Medicaid Expenditures

Medicaid expenditures are decreased by means of the following offsets.

CO-PAYMENTS

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

THIRD-PARTY LIABILITY

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

PHARMACY REBATES

DOH negotiates supplemental rebates with manufacturers for increased offsets.

SPENDDOWN INCOME

If a potential Medicaid member's income exceeds the eligibility threshold, the individual has the option to spenddown (or pay part of) his/her income in order to become eligible for Medicaid.

OTHER COLLECTIONS

The Attorney General's Office and the Utah Office of Inspector General are actively involved in recovering overpayments.

Table 3 reports the Medicaid offsets received in SFY 2015, classified by service category and other sources.

TABLE 3: Expenditure Offsets - SFY 2015						
Category Of Service and Other Sources	Co-Payment	Third Party	Rebates	Spenddown and Other Collections	Premiums	Total
Pharmacy	$2,060,600	$5,549,600	$136,205,400	$0	$0	$143,815,600
Inpatient Hospital Services, General	$438,400	$58,681,100	$0	$0	$0	$59,119,500
Outpatient Hospital Services, General	$158,200	$23,936,400	$0	$0	$0	$24,094,600
Physician Services	$245,200	$18,780,600	$0	$0	$0	$19,025,800
Nursing Facility I (NF I)	$0	$17,684,000	$0	$0	$0	$17,684,000
ESRD Kidney Dialysis Services	$1,100	$5,670,200	$0	$0	$0	$5,671,300
Medical Transportation	$0	$5,199,000	$0	$0	$0	$5,199,000
Home Health Services	$0	$4,728,200	$0	$0	$0	$4,728,200
QMB-Only Services	$0	$4,615,000	$0	$0	$0	$4,615,000
Medical Supply Services	$0	$4,165,600	$0	$0	$0	$4,165,600
Osteopathic Services	$61,200	$2,000,800	$0	$0	$0	$2,062,000
Mental Health Services	$0	$1,495,800	$0	$0	$0	$1,495,800
Podiatry Services	$4,200	$620,900	$0	$0	$0	$625,100
Ambulatory Surgical Services	$1,600	$544,400	$0	$0	$0	$546,000
Pediatric/Family Nurse Pract	$16,200	$477,700	$0	$0	$0	$493,900
Specialized Nursing Services	$0	$492,300	$0	$0	$0	$492,300
Independent Lab and/or X-Ray Services	$800	$452,600	$0	$0	$0	$453,400
Psychologist Services	$0	$431,600	$0	$0	$0	$431,600
Physical Therapy Services	$100	$400,800	$0	$0	$0	$400,900
Dental Services	$100	$385,400	$0	$0	$0	$385,500
Substance Abuse Treatment Services	$0	$314,000	$0	$0	$0	$314,000
Rural Health Clinic Services	$0	$256,200	$0	$0	$0	$256,200
Vision Care Services	$600	$194,700	$0	$0	$0	$195,300
Federally Qualified Health Centers	$0	$192,600	$0	$0	$0	$192,600
Well Child Care (EPSDT) Services	$0	$97,700	$0	$0	$0	$97,700
USTS IMR-1 Services	$0	$53,400	$0	$0	$0	$53,400
Occupational Therapy	$0	$46,100	$0	$0	$0	$46,100
Contracted Mental Health Services	$0	$36,400	$0	$0	$0	$36,400
Speech and Hearing Services	$0	$36,200	$0	$0	$0	$36,200
Inpatient Hospital Services, Mental	$0	$29,800	$0	$0	$0	$29,800
Autism Waiver	$0	$26,800	$0	$0	$0	$26,800
Nursing Facility III (NF III)	$0	$25,200	$0	$0	$0	$25,200
Optical Supply Services	$0	$15,800	$0	$0	$0	$15,800
Chiropractic Services	$300	$4,300	$0	$0	$0	$4,600
ORS Collections	$0	$14,603,200	$0	$19,371,000	$0	$33,974,200
Attorney General/MFCU	$0	$0	$0	$5,402,500	$0	$5,402,500
Recovery Audit Contracts (RAC)	$0	$0	$0	$6,572,200	$0	$6,572,200
Office of Inspector General (OIG)	$0	$75,000	$0	$1,334,000	$0	$1,409,000
Primary Care Network Premiums	$0	$0	$0	$0	$500	$500
TOTAL	**$2,988,600**	**$172,319,400**	**$136,205,400**	**$32,679,700**	**$500**	**$344,193,600**

Medicaid Consolidated Report of Expenditures and Revenues

All Medicaid funds are administered by the Utah Department of Health (DOH). As per federal requirements, all funding for Medicaid must flow through DOH and be governed by a memorandum of understanding for all functions performed by other entities including other state agencies local governments, for profit entities, and not-for-profit entities.

As the Medicaid Single State Agency, DOH is ultimately responsible and accountable for all aspects of Medicaid. DOH is required to exercise administrative discretion on the administration and supervision of the Medicaid State Plan, issue policies, rules, and regulations relating to Medicaid program matters.

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

This consolidated report section shows Medicaid funding and the related service expenditures in the following state agencies: DOH, DHS, DWS, U of U, the Office of Attorney General, and the Office of Inspector General. The Governor's Office of Management and Budget reviews expenditure data from these six state agencies. In addition, DOH passes funding through to local government and other providers.

Figure 4 illustrates Medicaid funding sources. Table 4 details the composition of "Other Revenue Sources" shown in Figure 4.

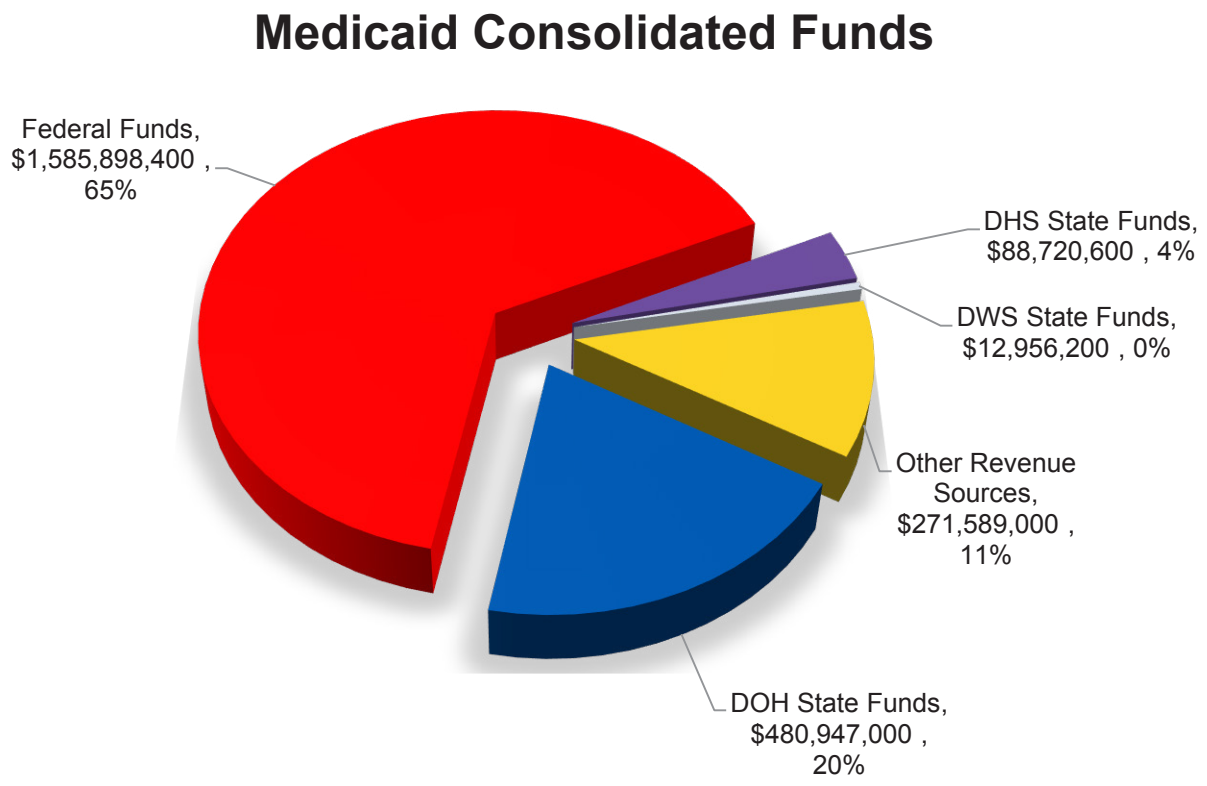


FIGURE 4

Table 4 details the composition of the "Other Revenue Sources" in Figure.

TABLE 4: Other Revenue Sources	
Pharmacy Rebates	$136,205,400
Mental Health Services	$37,214,600
Inpatient UPL Payments	$26,690,900
School Districts	$13,932,500
Physician Enhancement	$10,970,100
MFCU/OIG	$6,482,500
Disproportionate Share Hospital	$6,394,000
Outpatient Hospital UPL	$6,112,000
Nursing Facility NSGO UPL	$5,504,100
Healthy U Health Plan	$5,128,000
Family & Health Preparedness	$3,192,500
Health & Dental Clinics	$2,987,700
Substance Abuse	$3,668,000
DHS (Non-Medicaid)	$1,898,300
CHIP Allocation	$1,819,600
Refugee Relocation	$1,197,700
Local Health Departments	$772,000
Early Intervention	$375,500
Inmate Billing	$474,700
Center for Health Data	$202,100
Disease Control and Prevention	$183,300
Other	$183,000
PCN Enrollment Fees	$500
Total	**$271,589,000**

Table 5 specifies Medicaid funding at the appropriated line item level. Starting in FY 2015, Medicaid Management Information System (MMIS) replacement funding (LHL) is placed under the mandatory line item.

Table 6 details Medicaid mandatory, optional and administrative expenditures by the state agency. Expenditures for the MMIS replacement (PRISM) project are included in DOH mandatory expenditures.

TABLE 5: Consolidated Medicaid Revenues

Mandatory	LHB Inpatient Hospital	LHC Nursing Home	LHD Managed HealthCare	LHE Physician Services	LHF Outpatient Hospital	LHG Other Mandatory Services	LHH Crossover Services	LHJ Medical Supplies	LHK Primary Care Case Management	LHL Medicaid MIS Replacement	Total
General Fund	$19,756,200	$29,963,800	$177,125,800	$16,210,100	$17,953,800	$18,193,600	$4,251,900	$3,053,600	$0	$2,004,300	$288,513,100
Federal Funds	$95,554,300	$132,031,000	$598,530,100	$45,424,300	$45,756,500	$36,910,000	$8,223,000	$7,723,100	$0	$11,300,100	$981,452,400
Dedicated Credits	$0	$5,180,300	$31,930,800	$778,300	$222,900	$1,776,100	$0	$0	$0	$0	$39,888,400
Restricted Revenue	$20,765,900	$21,341,800	$48,500,000	$0	$0	$0	$0	$0	$0	$0	$90,607,700
Pass Through	$376,100	$0	$0	$0	$0	$0	$0	$0	$0	$0	$376,100
Transfers	$5,604,100	$19,800	$0	$327,800	$177,100	$1,396,100	$0	$20,300	$0	$0	$7,545,200
Beginning Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,500,000	$1,500,000
Non-Lapsing Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	($3,500,000)	($3,500,000)
Lapsing Balance	($1,610,400)	($1,214,300)	($9,148,100)	$1,400,000	$1,028,600	($894,600)	($1,757,300)	$176,800	$0	$1,790,400	($10,228,900)
	$140,446,200	$187,322,400	$846,938,600	$64,140,500	$65,138,900	$57,381,200	$10,717,600	$10,973,800	$0	$13,094,800	$1,396,154,000

Optional	LJA Pharmacy	LJB Home & Community Based Waivers	LJC Capitated Mental Health Services	LJD Buy In/Out	LJE Dental Services	LJF Intermediate Care Facilities for Mental Health	LJG Vision Care	LJH Other Optional Services	LJK Non Service Expenses	LJL Hospice	LJM, & LJN DSH & Clawback	Total
General Fund	$3,016,800	$259,500	$4,032,000	$18,189,900	$13,490,100	$8,210,200	$496,600	$21,836,200	$100	$4,322,600	$31,984,900	$105,838,900
Federal Funds	($23,534,300)	$141,194,200	$115,618,900	$27,100,500	$37,551,500	$59,394,000	$1,243,500	$82,453,500	$60,833,700	$10,331,900	$17,218,200	$529,405,600
Dedicated Credits	$134,882,200	$0	$35,880,900	$0	$0	$0	$0	$12,759,500	$14,887,600	$0	$6,141,800	$204,552,000
Restricted Revenue	$0	$0	$0	$0	$0	$3,262,300	$0	$0	$0	$0	$0	$3,262,300
Pass Through	$9,300	$57,931,500	$6,302,400	$0	$0	$14,683,300	$0	$5,144,600	$0	$0	$0	$84,071,100
Transfers	$200,800	$0	$51,800	$0	$8,500	$0	$3,700	$36,800	$0	$500	$275,100	$577,200
Beginning Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Lapsing Balance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Lapsing Balance	($1,838,900)	$993,900	$3,930,000	$369,400	$2,284,800	($766,900)	$35,100	($7,950,900)	$2,869,500	($1,300)	($464,200)	($539,500)
	$112,735,900	$200,379,100	$165,816,000	$45,659,800	$53,334,900	$84,782,900	$1,778,900	$114,279,700	$78,590,900	$14,653,700	$55,155,800	$927,167,600

	Services	Admin	Total
General Fund	$394,352,000	$6,359,100	$400,711,100
Federal Funds	$1,510,858,000	$75,040,400	$1,585,898,400
Dedicated Credits	$244,440,400	$9,066,600	$253,507,000
Restricted Revenue	$93,870,000	$690,700	$94,560,700
Pass Through	$84,447,200	$0	$84,447,200
Transfers	$8,122,400	$27,189,200	$35,311,600
Beginning Balance	$1,500,000	$0	$1,500,000
Non-Lapsing Balance	($3,500,000)	($1,527,400)	($5,027,400)
Lapsing Balance	($10,768,400)	($29,000)	($10,797,400)
	$2,323,321,600	**$116,789,600**	**$2,440,111,200**

TABLE 6: Consolidated Medicaid Expenditures							
Mandatory	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
Inpatient Hospital	$111,818,800	$0	$28,627,400	$0	$0	$0	$140,446,200
Nursing Home	$187,322,400	$0	$0	$0	$0	$0	$187,322,400
Contracted Health Plan Services	$686,413,600	$0	$160,525,000	$0	$0	$0	$846,938,600
Physician Services	$61,797,400	$0	$2,343,100	$0	$0	$0	$64,140,500
Outpatient Hospital	$52,687,400	$0	$12,451,500	$0	$0	$0	$65,138,900
Other Mandatory Services	$48,581,500	$0	$8,799,700	$0	$0	$0	$57,381,200
Crossovers	$10,717,600	$0	$0	$0	$0	$0	$10,717,600
Medical Supplies	$10,973,800	$0	$0	$0	$0	$0	$10,973,800
Medicaid MIS Replacement	$13,094,800	$0	$0	$0	$0	$0	$13,094,800
Subtotal	$1,183,407,300	$0	$212,746,700	$0	$0	$0	$1,396,154,000
Optional	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
Pharmacy	$112,735,900	$0	$0	$0	$0	$0	$112,735,900
Home & Community Based Waivers	$8,086,200	$192,292,900	$0	$0	$0	$0	$200,379,100
Mental Health Services	$165,816,000	$0	$0	$0	$0	$0	$165,816,000
Intermediate Care Facilities	$35,026,400	$49,756,500	$0	$0	$0	$0	$84,782,900
Other Optional Services	$114,270,900	$0	$8,800	$0	$0	$0	$114,279,700
Inpatient UPL Payments	$0	$0	$33,526,900	$0	$0	$0	$33,526,900
Buy In / Out	$45,659,800	$0	$0	$0	$0	$0	$45,659,800
Dental Services	$53,334,900	$0	$0	$0	$0	$0	$53,334,900
Disproportionate Share Hospital	$6,477,800	$934,600	$16,991,600	$0	$0	$0	$24,404,000
Clawback Payments	$0	$0	$30,751,800	$0	$0	$0	$30,751,800
Non-Service Expenditures	$19,571,300	$0	$0	$0	$0	$0	$19,571,300
Hospice Care Services	$14,653,700	$0	$0	$0	$0	$0	$14,653,700
UUMG Physician Enhancement	$0	$0	$19,267,900	$0	$0	$0	$19,267,900
Graduate Medical Education	$1,558,700	$0	$4,666,100	$0	$0	$0	$6,224,800
Vision Care	$1,707,600	$0	$71,300	$0	$0	$0	$1,778,900
Subtotal	$578,899,200	$242,984,000	$105,284,400	$0	$0	$0	$927,167,600
Administrative	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$48,603,500	**$17,992,700**	**$0**	**$46,952,200**	**$734,100**	**$2,507,100**	**$116,789,600**
Total Expenditures	**DOH**	**DHS**	**U of U**	**DWS**	**AG**	**OIG**	**Total**
	$1,810,910,000	**$260,976,700**	**$318,031,100**	**$46,952,200**	**$734,100**	**$2,507,100**	**$2,440,111,200**

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

UTAH DEPARTMENT OF HEALTH - DIVISION OF MEDICAID AND HEALTH FINANCING

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

Table 7 shows SFY 2015 Medicaid mandatory, optional and administrative expenditures managed within DOH.

TABLE 7: Utah Department of Health / Division of Medicaid and Health Financing

Service Expenditures			
Mandatory		***Total Exp***	***Percent of Total***
	Inpatient Hospital	$111,818,800	9.4%
	Nursing Home	$187,322,400	15.8%
	Contracted Health Plan Services	$686,413,600	58.0%
	Physician Services	$61,797,400	5.2%
	Outpatient Hospital	$52,687,400	4.5%
	Other Mandatory Services	$48,581,500	4.1%
	Crossovers	$10,717,600	< 1.0%
	Medical Supplies	$10,973,800	< 1.0%
	Medicaid MIS Replacement	$13,094,800	1.1%
	Total Mandatory	**$1,183,407,300**	**100.0%**
Optional		***Total Exp***	***Percent of Total***
	Pharmacy	$112,735,900	19.5%
	Home & Community Based Waivers	$8,086,200	1.4%
	Mental Health	$165,816,000	28.6%
	Buy In / Out	$45,659,800	7.9%
	Dental Services	$53,334,900	9.2%
	Intermediate Care Facilities	$35,026,400	6.1%
	Vision Care	$1,707,600	< 1.0%
	Other Optional Services	$114,270,900	19.7%
	Non-Service Expenditures	$19,571,300	3.4%
	Hospice Care Services	$14,653,700	2.5%
	DSH Expenditures	$6,477,800	1.1%
	Clawback Payments	$0	< 1.0%
	Graduate Medical Education	$1,558,700	< 1.0%
	Total Optional	**$578,899,200**	**100.0%**
Total Service Expenditures UDOH/DMHF		**$1,762,306,500**	**100.0%**
Administrative Expenditures			
Responsibilities:			
Claims payment, rate setting, cost settlement, contracting, prior authorization of services, waiver management, and client plan selection			
		Total Exp	***Percent of Total***
	Current Expense	$4,719,500	9.7%
	Data Processing Current Expense	$13,106,000	27.0%
	Other Charges/Pass Through	$13,324,900	27.4%
	Personnel Services	$17,378,000	35.8%
	Travel/In State	$15,300	< 1.0%
	Travel/Out of State	$59,800	< 1.0%
Total Admin Expenditures UDOH/DMHF		**$48,603,500**	**100.0%**
Total DOH Medicaid Expenditures		**$1,810,910,000**	**100.0%**
Total UDOH Budget		**$2,670,931,500**	
Medicaid as a % of Overall Budget		**67.8%**	

DEPARTMENT OF HUMAN SERVICES

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

Table 8 shows Medicaid expenditures made by DHS by category of service and funding source, as well as administrative costs for SFY 2015.

TABLE 8: Department of Human Services

Service Expenditures - Actual (Through DHS)	*Federal Funds*	*State Funds*	*Total*	*Percent of Total*
People with Disabilities (Includes Developmental Center)	$159,337,100	$66,610,200	$225,947,300	86.6%
Utah State Hospital	$12,013,100	$5,023,600	$17,036,700	6.5%
Total Service Expenditures DHS	**$171,350,200**	**$ 71,633,800**	**$242,984,000**	93.1%
Administrative Expenditures - Actual				
Total Administrative Expenditures DHS	**$9,489,100**	**$8,503,600**	**$17,992,700**	6.9%
TOTAL Expenditures (Through DHS)	**$180,839,300**	**$80,137,400**	**$260,976,700**	100.0%
Service Expenditures - Direct Billed to DOH (State participation from DHS to DOH)				
Child and Family Services		$5,020,400		
Juvenile Justice Services		$1,685,500		
Aging and Adult Services		$1,256,300		
Administrative Fee		$621,000		
Total State Funds for Direct Billed Expenditures		**$8,583,200**		
Total DHS Line Item Expenditures	**$728,041,600**			
Medicaid as a % of Expenditures	**36%**			

DHS Divisions are as follows:

Executive Director's Operations (EDO) - provides direction, guidance, and fiscal support. Services include licensing, review, and public guardian.

Division of Substance Abuse and Mental Health (DSAMH) - promotes prevention education, early intervention, residential treatment, and recovery support for individuals who suffer from substance abuse or mental illness. The Utah State Hospital (USH), an entity of DSAMH, provides care specializing in services for individuals with severe and persistent mental illness.

Division of Services for People with Disabilities (DSPD) - provides a wide range of in-home and out-of-home services for people with intellectual disabilities, physical disabilities, and acquired brain injuries. The Utah State Developmental Center (USDC), an entity of DSPD, provides facility based care and treatment for people with severe disabilities.

Office of Recovery Services (ORS) - provides child support collection services and third-party Medicaid recovery services.

Division of Child and Family Services (DCFS) - provides child welfare and domestic violence services in partnership with communities, including child abuse prevention, child protective services, in-home services, foster care, adoption, and domestic violence support, treatment, and shelter.

Division of Aging and Adult Services (DAAS) - promotes a wide variety of home and community-based services for elderly individuals to be protected from abuse, neglect, and exploitation, and to maintain their independence by living at home rather than residing in nursing facilities.

Division of Juvenile Justice Services (DJJS) - provides services to youth offenders with a comprehensive array of programs including intervention, home detention, secure detention, day reporting centers, case management, community alternatives, observation and assessment, long-term secure facilities, transition, rehabilitation, and youth 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 time sample. DWS eligibility workers are sampled and asked to record the time they spent on fourteen public assistance programs. Total costs are allocated on a quarterly basis to the various programs based on the percent of time derived from the sample.

Table 9 shows DWS Medicaid administrative expenditures in SFY 2015 by cost type and funding source.

TABLE 9: Department of Workforce Services

Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*	*Percent of Total*
Direct Costs	$33,996,000	$12,956,200	$46,952,200	100.0%
Total Admin Expenditures DWS	**$33,996,000**	**$12,956,200**	**$46,952,200**	**100.0%**

Total DWS Line Item Expenditures	**$932,138,600**
Medicaid as a % of Overall Budget	**5%**

Divisions and budget areas within DWS are as follows:

Eligibility Services Division - The Eligibility Services Division was created in 2009 to centralize the State's public assistance eligibility process using the state's eligibility system, eREP, and 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 citizenship, income level, Utah residency, assets, and the presence of dependents in the home. Generally, those who receive coverage must renew their coverage annually to confirm continued eligibility.

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

these programs to DWS. However, general administration and oversight of these programs remains within DOH.

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

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

OFFICE OF THE ATTORNEY GENERAL

The Division of Child and Family Support, Health Unit, within the Office of Attorney General also provides legal support to DOH, reviews Medicaid and CHIP contracts and policies, and represents Medicaid and CHIP in administrative and judicial proceeding. Table 10 shows the Office of the Attorney General Medicaid Expenditures for SFY 2015.

TABLE 10: Office of Attorney General

Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*
Total Administrative Expenditures AG	**$367,000**	**$367,100**	**$734,100**

OFFICE OF INSPECTOR GENERAL, FOR MEDICAID SERVICES

The Office of Inspector General (OIG) is an independent office of program evaluation and review located within the Department of Administrative Services. The purpose of this office is to ensure adequate internal controls are in place, effective policies and procedures are established and followed in the Medicaid program, and investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program.

Table 11 shows Medicaid administrative expenditures in SFY 2015. OIG expenditures are considered 100 percent Medicaid related.

TABLE 11: Office of Inspector General

Administrative Expenditures - Actual	*Federal Funds*	*State Funds*	*Total*
Total Administrative Expenditures OIG	**$1,366,500**	**$1,140,600**	**$2,507,100**

UNIVERSITY OF UTAH MEDICAL CENTER

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

Inpatient Disproportionate Share Hospital – These funds come from finite federal allocation to states and are used to pay hospitals that serve a disproportionate share of Medicaid and uninsured patients. The funds are intended to offset some of the hospital costs in serving these clients.

Direct Graduate Medical Education (GME) – These funds offset some of the costs of residency programs that serve Medicaid clients. The funds cannot be used for academic programs but are used to cover some of the patient care costs associated with the care provided by residents. These funds are subject to the calculated Upper Payment Limit (UPL) authorized by CMS. The non-federal share of GME is provided by DOH.

Inpatient Upper Payment Limit (UPL) – These funds reimburse the hospital up to the Medicare upper limit. The funds help offset some of the medical care costs. All of the UPL funds are matched by the University and are subject to the calculated UPL as authorized by CMS.

University of Utah Medical Group (UUMG) Supplemental Payments – These funds supplement the physician payments up to the average commercial rate. The non-federal share is provided by UUMG to be matched to the extent allowed by CMS.

Table 12 shows where the University of Utah expended Medicaid funds during SFY 2015.

TABLE 12: University of Utah Medical Center

Service Expenditures - Actual		
Mandatory	***Expenditures***	***Percent of Total***
Inpatient Services	$28,627,400	9.0%
Contracted Health Plan	$160,525,000	50.5%
Physician Services	$2,343,100	<1.0%
Outpatient Hospital	$12,451,500	3.9%
Other Mandatory Services	$8,799,700	2.8%
Total Mandatory	**$212,746,700**	**66.9%**
Optional	***Expenditures***	***Percent of Total***
Vision Care	$71,300	<1.0%
Disproportionate Share Hospital	$16,991,600	5.3%
Graduate Medical Education	$4,666,100	1.5%
Clawback Payments	$30,751,800	9.7%
Inpatient UPL Payments	$33,526,900	10.5%
UUMG Physician Enhancement	$19,267,900	6.1%
Other Optional Services	$8,800	<1.0%
Total Optional	**$105,284,400**	**33.1%**
Total Service Expenditures U of U	**$318,031,100**	**100%**

MEDICAID ENROLLMENT

The enrollment process and eligibility determinations for Medicaid are made primarily by the Department of Workforce Services (DWS), with a limited number completed by the Department of Human Services (DHS). Eligibility requirements for Medicaid are based on Title XIX of the Social Security Act. There are more than 30 types of Medicaid classifications, each with varying eligibility requirements. Household income is a primary consideration for eligibility. Eligibility for some programs is limited by the amount of assets an individual or a household possesses. The Affordable Care Act (ACA) has required that states raise the minimum income level to at least 133% of the federal poverty level (FPL), add an income disregard equal to five percentage points of the FPL, and remove the Medicaid asset test for children, effective January 1, 2014.

For this report, the Medicaid classifications are summarized in the following aid groups:

- Children (individuals under age 19)
- Parents (adults in families with dependent children)
- Pregnant women
- Individuals with disabilities (individuals determined disabled by the state or Social Security)
- Elderly individuals (individuals aged 65 or older)
- Visually impaired individuals (individuals of any age who meet Social Security's criteria for statutory blindness)
- Women with breast or cervical cancer
- Individuals who participate in a Medicare Cost-Sharing Program
- Primary Care Network (PCN) enrollees (low-income adults who do not meet criteria for any of the above listed groups)
- Medically needy (Spenddown program for individuals who meet all conditions to qualify, except their monthly income but agree to "spend down" their monthly income to the Medicaid income standard)

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

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

Each state sets an income limit within federal guidelines for Medicaid eligibility groups and determines what income counts toward that limit. Family size plays a part in the financial qualification for Medicaid. See Appendix A for the 2015 HHS Federal Poverty Levels (FPL).

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

Medicaid Benefits

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

- Age
- Pregnancy
- Category of Assistance

Differences in benefits include:

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

Enrollment Statistics

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

AVERAGE MEMBERS PER MONTH BY CATEGORY OF AID

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

Figure 5 shows the average members per month for all categories of assistance combined.

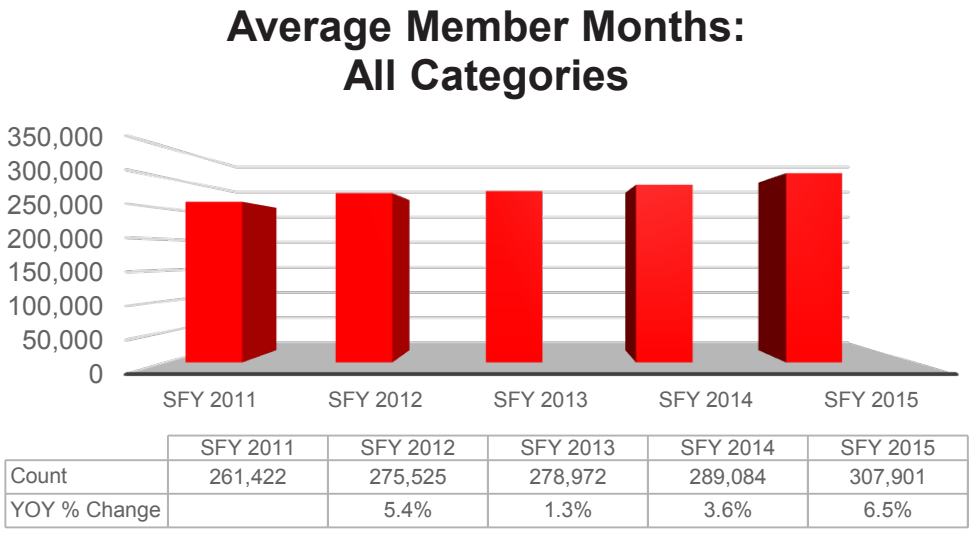
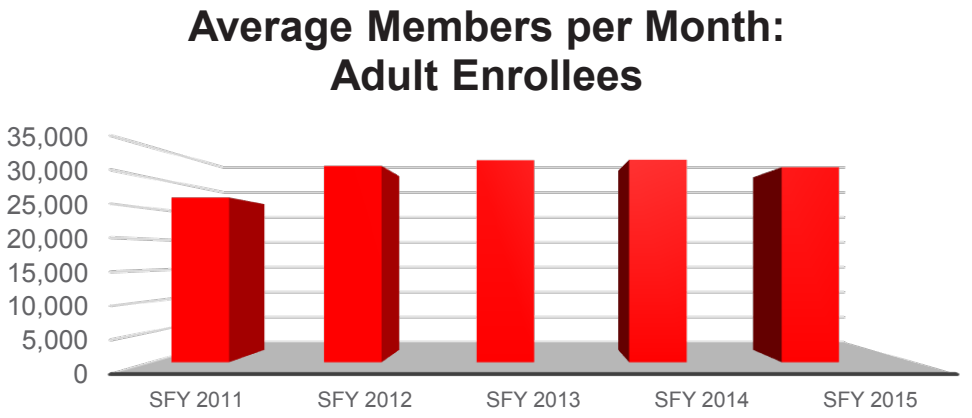


FIGURE 5

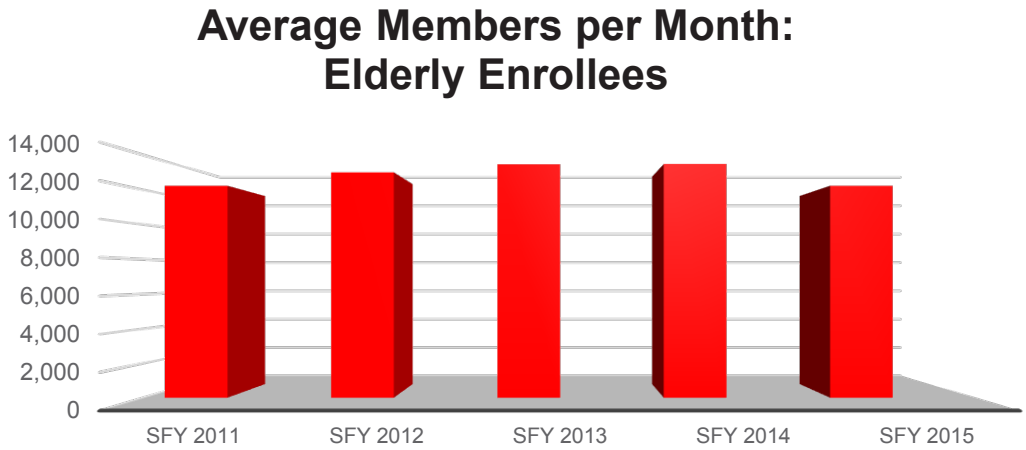
Figure 6 provides a look at average monthly adult members.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	26,852	32,023	32,950	33,018	31,799
YOY % Change		19.3%	2.9%	0.2%	-3.7%

FIGURE 6

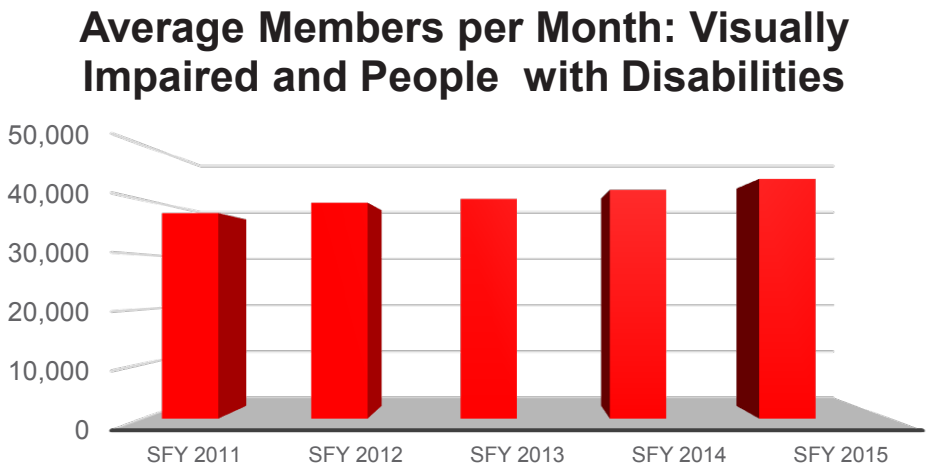
Figure 7 illustrates the average monthly enrollment for individuals aged 65 and older.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	12,243	13,017	13,479	13,497	12,242
YOY % Change		6.3%	3.5%	0.1%	-9.3%

FIGURE 7

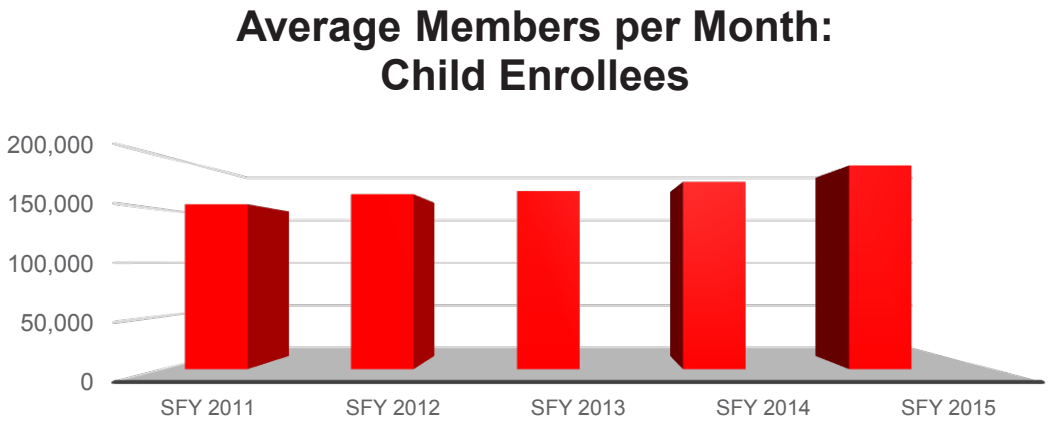
Figure 8 shows average monthly enrollment for the visually impaired and people with disabilities.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	37,607	39,497	40,190	41,861	43,850
YOY % Change		5.0%	1.8%	4.2%	4.8%

FIGURE 8

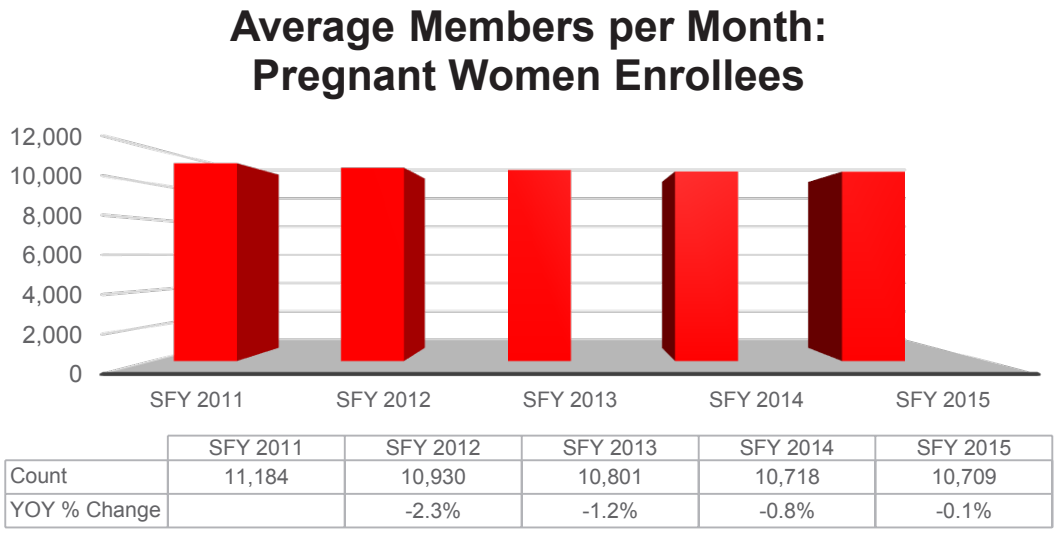
Figure 9 depicts the average members per month for Medicaid enrolled children.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	155,179	164,622	167,648	176,370	191,682
YOY % Change		6.1%	1.8%	5.2%	8.7%

FIGURE 9

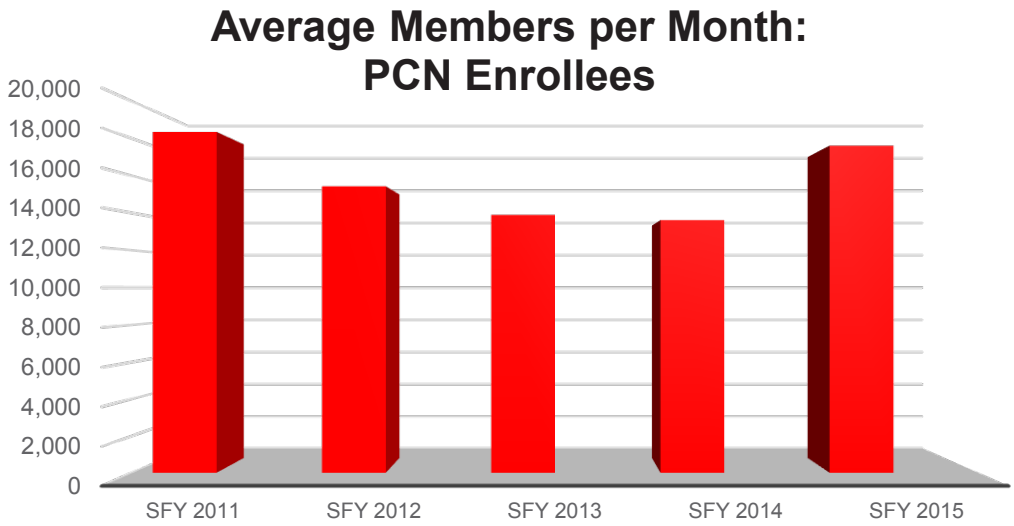
Figure 10 portrays the average monthly enrollment of pregnant women.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	11,184	10,930	10,801	10,718	10,709
YOY % Change		-2.3%	-1.2%	-0.8%	-0.1%

FIGURE 10

Figure 11 shows the average members per month for PCN. Unlike other categories of aid, the number of PCN member months is dependent on the number of open enrollment events.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
PCN	18,357	15,436	13,904	13,619	17,620
YOY % Change		-15.9%	-9.9%	-2.0%	29.4%

FIGURE 11

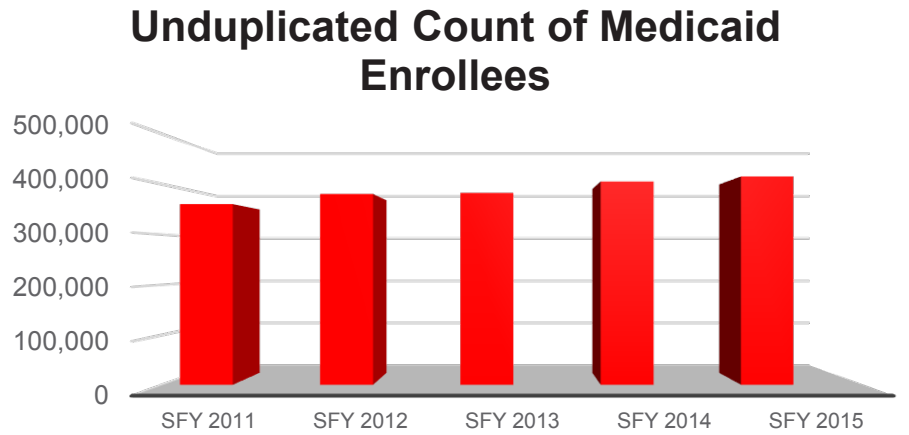
Table 13 provides a county-level look at the average monthly Medicaid enrollment as a percent of population.

TABLE 13: Average Monthly Enrollment as a Percent of County Population					
	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
BEAVER	12.0%	11.8%	12.1%	11.8%	13.0%
BOX ELDER	8.9%	9.4%	9.8%	10.2%	11.4%
CACHE	9.1%	9.3%	9.3%	9.7%	11.2%
CARBON	14.5%	14.7%	15.3%	15.9%	16.8%
DAGGETT	4.4%	4.0%	4.5%	4.7%	3.7%
DAVIS	6.8%	7.1%	7.1%	7.3%	8.0%
DUCHESNE	11.5%	11.9%	11.0%	10.4%	11.8%
EMERY	10.6%	11.0%	11.1%	11.6%	12.1%
GARFIELD	8.6%	8.2%	9.1%	9.0%	8.8%
GRAND	12.0%	12.1%	11.6%	12.5%	13.9%
IRON	14.1%	14.6%	14.3%	15.0%	17.0%
JUAB	11.3%	11.2%	11.1%	11.1%	12.2%
KANE	8.5%	9.0%	8.9%	8.5%	10.0%
MILLARD	12.4%	11.7%	11.7%	11.7%	13.4%
MORGAN	3.4%	3.7%	3.6%	3.8%	4.4%
PIUTE	15.1%	14.4%	13.0%	14.0%	16.0%
RICH	9.0%	8.2%	7.5%	7.5%	9.2%
SALT LAKE	9.7%	10.2%	10.2%	10.4%	11.3%
SAN JUAN	21.8%	23.5%	23.8%	24.4%	25.5%
SANPETE	11.7%	12.0%	11.8%	12.1%	13.5%
SEVIER	13.0%	13.4%	13.5%	14.1%	15.6%
SUMMIT	3.7%	3.8%	3.6%	3.7%	4.5%
TOOELE	9.1%	9.7%	10.0%	10.5%	11.4%
UINTAH	8.5%	8.7%	8.5%	8.8%	9.6%
UTAH	8.5%	8.7%	8.6%	8.7%	9.9%
WASATCH	6.0%	6.2%	6.3%	6.3%	6.9%
WASHINGTON	11.5%	12.2%	12.0%	12.3%	13.7%
WAYNE	8.8%	8.4%	7.9%	8.1%	11.1%
WEBER	10.7%	11.4%	11.5%	11.7%	12.8%
STATE OF UTAH	9.4%	9.8%	9.8%	10.0%	11.0%

UNDUPLICATED MEDICAID ENROLLMENT

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

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



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	360,775	380,959	383,309	405,897	415,843
YOY % Change		5.6%	0.6%	5.9%	2.5%

FIGURE 12

Table 14 breaks down the unduplicated enrollment count by race, age group and gender. Members are given the option to self-report their race. In the event race is not reported, members are place in the "other" category.

TABLE 14: Enrollment by Race, Age Group and Gender SFY 2011 - SFY 2015

Race	Age	Gender	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Asian	Age < 19	F	1,740	1,690	1,658	1,880	1,461
		M	1,913	1,834	1,784	1,983	1,580
	Age < 19 Total		3,653	3,524	3,442	3,863	3,041
	Age 19 - 64	F	1,801	1,888	2,000	1,931	1,697
		M	999	1,163	1,180	1,070	961
	Age 19 - 64 Total		2,800	3,051	3,180	3,001	2,658
	Age 65 or Older	F	747	761	778	759	776
		M	438	441	454	438	433
	Age 65 or Older Total		1,185	1,202	1,232	1,197	1,209
Asian Total			7,638	7,777	7,854	8,061	6,908
Black	Age < 19	F	3,170	3,079	3,019	3,055	2,578
		M	3,394	3,323	3,263	3,374	2,914
	Age < 19 Total		6,564	6,402	6,282	6,429	5,492
	Age 19 - 64	F	2,042	2,105	2,251	2,208	2,206
		M	1,207	1,310	1,412	1,377	1,371
	Age 19 - 64 Total		3,249	3,415	3,663	3,585	3,577

TABLE 14: Enrollment by Race, Age Group and Gender SFY 2011 SFY 2015 Continued							
Race	Age	Gender	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Black	Age 65 or Older	F	134	138	141	135	153
		M	84	93	105	101	120
	Age 65 or Older Total		218	231	246	236	273
Black Total			10,031	10,048	10,191	10,250	9,342
Native American	Age < 19	F	3,378	3,425	3,272	3,366	2,999
		M	3,530	3,524	3,387	3,492	3,148
	Age < 19 Total		6,909	6,949	6,659	6,858	6,858
	Age 19 - 64	F	790	958	974	996	994
		M	364	465	459	453	466
	Age 19 - 64 Total		1,154	1,423	1,433	1,449	1,460
	Age 65 or Older	F	405	418	414	392	435
		M	189	216	208	204	217
	Age 65 or Older Total		594	634	622	596	652
Native American Total			8,656	9,006	8,714	8,903	8,970
Pacific Islander	Age < 19	F	1,744	1,730	1,740	1,730	1,278
		M	1,891	1,866	1,876	1,892	1,408
	Age < 19 Total		3,635	3,596	3,616	3,622	2,686
	Age 19 - 64	F	886	852	943	896	771
		M	400	455	461	415	373
	Age 19 - 64 Total		1,286	1,307	1,404	1,311	1,144
	Age 65 or Older	F	91	92	91	84	87
		M	72	68	73	63	61
	Age 65 or Older Total		163	160	164	147	148
Pacific Islander Total			5,084	5,063	5,184	5,080	3,978
White	Age < 19	F	84,941	79,623	74,204	81,018	68,146
		M	89,529	84,152	78,439	84,333	71,792
	Age < 19 Total		174,470	163,775	152,646	165,351	139,938
	Age 19 - 64	F	74,817	76,024	76,699	74,623	73,002
		M	35,636	37,370	36,909	35,476	36,214
	Age 19 - 64 Total		110,453	113,394	113,609	110,099	109,216
	Age 65 or Older	F	8,724	8,800	8,808	8,243	8,843
		M	3,768	3,873	3,912	3,672	4,006
	Age 65 or Older Total		12,492	12,673	12,720	11,915	12,849
White Total			297,415	289,842	278,971	287,365	262,003
Other	Age < 19	F	10,792	20,857	26,881	33,328	48,339
		M	11,245	21,972	28,261	35,377	51,383
	Age < 19 Total		22,037	42,829	55,144	68,705	99,722
	Age 19 - 64	F	6,597	10,134	10,105	9,724	13,287
		M	2,236	4,244	4,698	5,084	7,747
	Age 19 - 64 Total		8,833	14,378	14,803	14,808	21,034
	Age 65 or Older	F	723	1,330	1,659	1,850	2,590
		M	358	686	791	875	1,296
	Age 65 or Older Total		1,081	2,016	2,450	2,725	3,886
Other Total			31,951	59,223	72,395	86,238	124,642
Grand Total			**360,775**	**380,959**	**383,309**	**405,897**	**415,843**

Figure 13 shows each of the categories of assistance as a percent of total, statewide unduplicated Medicaid enrollment for FY 2015.

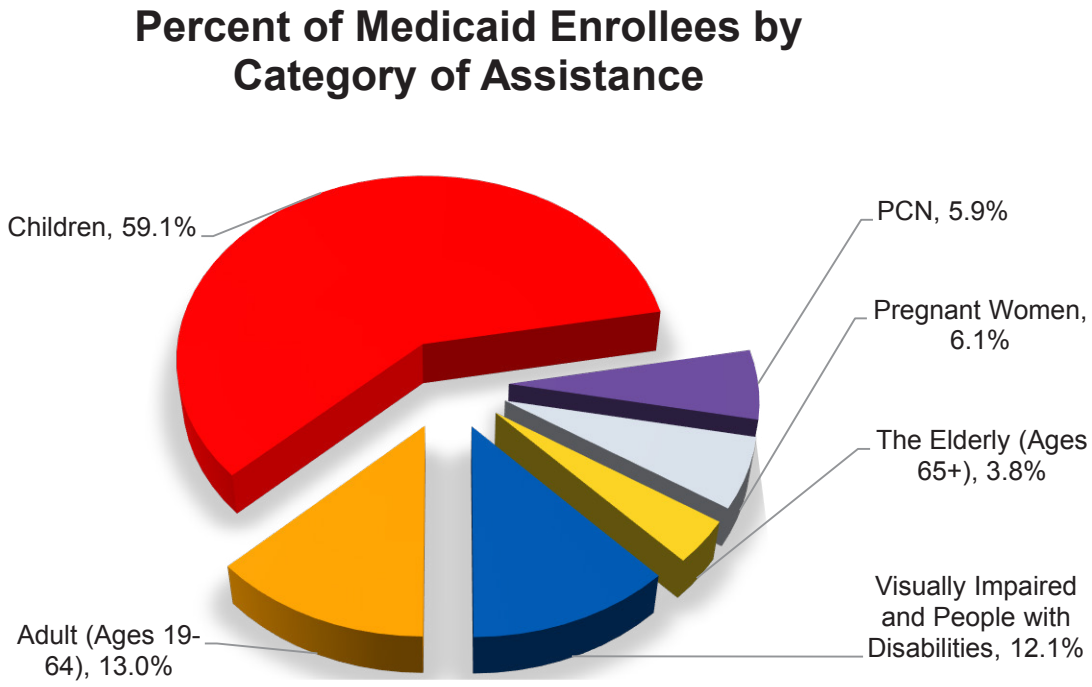


FIGURE 13

Table 15 presents the same information as Figure 13 from SFY 2011 to SFY 2015.

TABLE 15: Statewide Medicaid Enrollment Composition

Category of Assistance	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Adult (Ages 19-64)	12.7%	14.1%	14.4%	13.8%	13.0%
Children	57.3%	57.0%	56.7%	59.0%	59.1%
PCN	6.5%	6.1%	5.9%	5.0%	5.9%
Pregnant Women	7.6%	7.0%	6.9%	6.4%	6.1%
The Elderly (Ages 65+)	4.0%	4.1%	4.2%	4.0%	3.8%
Visually Impaired and People with Disabilities	11.9%	11.7%	11.9%	11.8%	12.1%
Statewide Total	100.0%	100.0%	100.0%	100.0%	100.0%

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

TABLE 16: Medicaid Enrollment Composition by County

County	Category of Assistance	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
BEAVER	Adult (Ages 19-64)	10.0%	11.4%	11.6%	10.7%	10.5%
	Children	52.3%	53.5%	50.3%	53.7%	56.5%
	PCN	12.9%	12.2%	13.1%	11.1%	9.2%
	Pregnant Women	8.8%	6.9%	6.3%	6.1%	5.5%
	The Elderly (Ages 65+)	5.8%	5.5%	6.7%	6.4%	6.0%
	Visually Impaired and People with Disabilities	10.2%	10.5%	12.1%	12.0%	12.3%
BOX ELDER	Adult (Ages 19-64)	12.0%	13.3%	14.2%	13.1%	12.9%
	Children	57.6%	57.3%	56.4%	58.9%	59.2%
	PCN	8.3%	7.4%	6.8%	5.3%	5.6%
	Pregnant Women	6.8%	6.5%	6.5%	6.6%	5.7%
	The Elderly (Ages 65+)	3.2%	3.3%	3.4%	3.1%	3.0%
	Visually Impaired and People with Disabilities	12.1%	12.1%	12.8%	13.0%	13.5%
CACHE	Adult (Ages 19-64)	12.3%	13.8%	14.4%	13.7%	13.2%
	Children	59.1%	58.9%	58.2%	61.1%	61.4%
	PCN	6.1%	5.4%	5.4%	4.5%	5.2%
	Pregnant Women	10.2%	9.8%	9.7%	8.9%	8.5%
	The Elderly (Ages 65+)	2.8%	2.7%	2.6%	2.4%	2.5%
	Visually Impaired and People with Disabilities	9.5%	9.5%	9.6%	9.4%	9.2%
CARBON	Adult (Ages 19-64)	14.9%	15.3%	15.9%	15.7%	14.9%
	Children	47.6%	48.6%	48.4%	49.8%	49.5%
	PCN	8.1%	7.3%	7.3%	7.1%	7.6%
	Pregnant Women	6.5%	6.3%	5.8%	4.9%	4.7%
	The Elderly (Ages 65+)	4.7%	4.5%	4.7%	4.6%	4.4%
	Visually Impaired and People with Disabilities	18.2%	18.1%	18.0%	17.8%	18.9%
DAGGETT	Adult (Ages 19-64)	17.6%	20.3%	13.0%	11.8%	12.9%
	Children	58.8%	54.4%	56.5%	56.5%	61.4%
	PCN	4.7%	11.4%	13.0%	8.2%	7.1%
	Pregnant Women	7.1%	2.5%	4.3%	4.7%	5.7%
	The Elderly (Ages 65+)	3.5%	2.5%	4.3%	4.7%	2.9%
	Visually Impaired and People with Disabilities	8.2%	8.9%	8.7%	14.1%	10.0%
DAVIS	Adult (Ages 19-64)	13.6%	15.1%	15.4%	14.9%	14.0%
	Children	58.0%	57.7%	57.1%	59.2%	59.6%
	PCN	6.5%	5.9%	5.9%	4.8%	5.7%
	Pregnant Women	7.2%	6.6%	6.5%	6.2%	6.0%
	The Elderly (Ages 65+)	3.0%	3.1%	3.4%	3.2%	2.8%
	Visually Impaired and People with Disabilities	11.7%	11.6%	11.8%	11.8%	12.0%
DUCHESNE	Adult (Ages 19-64)	12.8%	15.0%	13.8%	12.8%	14.2%
	Children	54.3%	53.9%	54.4%	57.0%	55.9%
	PCN	5.2%	4.9%	5.0%	4.3%	5.1%
	Pregnant Women	7.4%	6.8%	6.5%	5.9%	6.9%
	The Elderly (Ages 65+)	5.4%	4.7%	4.9%	4.9%	4.5%
	Visually Impaired and People with Disabilities	14.8%	14.7%	15.4%	15.1%	13.4%
EMERY	Adult (Ages 19-64)	11.7%	12.2%	13.0%	14.2%	13.5%
	Children	54.0%	55.7%	56.7%	58.2%	58.2%
	PCN	9.8%	7.8%	7.1%	5.9%	6.3%
	Pregnant Women	6.1%	6.1%	5.4%	4.1%	4.2%
	The Elderly (Ages 65+)	4.8%	4.7%	4.9%	4.2%	4.0%
	Visually Impaired and People with Disabilities	13.7%	13.5%	12.9%	13.2%	13.8%

TABLE 16: Medicaid Enrollment Composition by County Continued						
County	Category of Assistance	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
GARFIELD	Adult (Ages 19-64)	9.4%	10.9%	10.4%	9.6%	9.9%
	Children	46.5%	47.1%	48.7%	54.5%	56.9%
	PCN	17.1%	17.1%	14.9%	11.0%	8.3%
	Pregnant Women	6.4%	6.5%	7.8%	6.7%	5.9%
	The Elderly (Ages 65+)	8.3%	6.8%	6.1%	6.6%	6.5%
	Visually Impaired and People with Disabilities	12.3%	11.7%	12.1%	11.6%	12.5%
GRAND	Adult (Ages 19-64)	11.5%	12.7%	12.8%	12.8%	11.5%
	Children	48.7%	50.3%	49.2%	50.7%	52.7%
	PCN	13.6%	10.4%	9.3%	8.4%	8.1%
	Pregnant Women	7.0%	6.5%	7.7%	7.1%	6.7%
	The Elderly (Ages 65+)	4.9%	5.8%	6.6%	6.3%	5.9%
	Visually Impaired and People with Disabilities	14.4%	14.3%	14.4%	14.8%	15.0%
IRON	Adult (Ages 19-64)	12.9%	14.4%	14.8%	14.0%	13.6%
	Children	54.6%	54.4%	53.7%	56.7%	57.4%
	PCN	10.9%	10.0%	9.7%	8.2%	8.2%
	Pregnant Women	8.1%	7.7%	7.2%	6.8%	6.6%
	The Elderly (Ages 65+)	2.9%	2.9%	3.1%	3.0%	2.7%
	Visually Impaired and People with Disabilities	10.6%	10.6%	11.5%	11.3%	11.6%
JUAB	Adult (Ages 19-64)	11.9%	12.0%	13.3%	12.6%	10.4%
	Children	58.0%	59.1%	58.2%	59.3%	59.3%
	PCN	6.1%	5.6%	4.7%	4.4%	6.4%
	Pregnant Women	6.4%	5.6%	5.4%	5.7%	5.4%
	The Elderly (Ages 65+)	4.0%	4.2%	4.4%	4.2%	4.2%
	Visually Impaired and People with Disabilities	13.5%	13.5%	14.0%	13.8%	14.3%
KANE	Adult (Ages 19-64)	10.6%	13.8%	11.8%	12.2%	11.0%
	Children	50.0%	47.7%	48.3%	52.6%	56.4%
	PCN	11.6%	11.2%	11.6%	8.5%	7.7%
	Pregnant Women	7.9%	7.7%	7.4%	6.1%	6.5%
	The Elderly (Ages 65+)	7.0%	7.5%	7.5%	7.6%	5.7%
	Visually Impaired and People with Disabilities	13.0%	12.1%	13.5%	13.1%	12.7%
MILLARD	Adult (Ages 19-64)	9.7%	12.4%	12.6%	10.5%	11.1%
	Children	55.8%	57.2%	56.4%	60.0%	62.0%
	PCN	12.0%	10.7%	10.1%	9.0%	7.1%
	Pregnant Women	6.2%	5.1%	5.4%	4.9%	4.8%
	The Elderly (Ages 65+)	5.6%	4.9%	5.2%	5.2%	4.2%
	Visually Impaired and People with Disabilities	10.8%	9.8%	10.4%	10.4%	10.8%
MORGAN	Adult (Ages 19-64)	9.8%	12.0%	13.8%	12.3%	13.1%
	Children	56.7%	56.2%	54.4%	61.5%	63.0%
	PCN	11.5%	10.5%	9.6%	5.8%	5.0%
	Pregnant Women	8.7%	8.9%	8.6%	6.7%	7.3%
	The Elderly (Ages 65+)	2.5%	2.0%	3.0%	2.3%	2.0%
	Visually Impaired and People with Disabilities	10.8%	10.4%	10.6%	11.4%	9.7%
PIUTE	Adult (Ages 19-64)	11.0%	9.7%	10.2%	14.2%	14.5%
	Children	52.8%	53.0%	48.5%	52.7%	53.8%
	PCN	18.5%	18.2%	19.5%	14.0%	13.8%
	Pregnant Women	3.5%	2.2%	4.3%	5.7%	3.8%
	The Elderly (Ages 65+)	3.5%	4.1%	4.0%	2.6%	2.8%
	Visually Impaired and People with Disabilities	10.7%	12.9%	13.5%	10.8%	11.3%

TABLE 16: Medicaid Enrollment Composition by County Continued						
County	Category of Assistance	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
RICH	Adult (Ages 19-64)	13.2%	13.8%	14.7%	13.6%	12.9%
	Children	57.2%	59.1%	60.3%	60.3%	61.4%
	PCN	9.5%	6.7%	6.6%	5.8%	5.9%
	Pregnant Women	8.9%	6.7%	5.1%	6.1%	6.6%
	The Elderly (Ages 65+)	2.5%	2.3%	1.5%	2.0%	2.3%
	Visually Impaired and People with Disabilities	8.6%	11.4%	11.8%	12.2%	10.9%
SALT LAKE	Adult (Ages 19-64)	12.8%	14.1%	14.3%	13.6%	12.6%
	Children	56.5%	56.2%	56.0%	57.9%	57.8%
	PCN	5.6%	5.5%	5.3%	4.7%	5.9%
	Pregnant Women	7.2%	6.5%	6.4%	6.0%	5.6%
	The Elderly (Ages 65+)	4.9%	5.0%	5.2%	5.0%	4.8%
	Visually Impaired and People with Disabilities	13.0%	12.8%	12.9%	12.8%	13.4%
SAN JUAN	Adult (Ages 19-64)	13.9%	17.1%	16.6%	15.7%	14.3%
	Children	54.1%	51.7%	51.9%	53.7%	53.7%
	PCN	4.9%	5.9%	6.8%	6.6%	7.1%
	Pregnant Women	5.4%	5.2%	5.5%	5.1%	5.2%
	The Elderly (Ages 65+)	10.6%	9.8%	9.3%	8.9%	8.3%
	Visually Impaired and People with Disabilities	11.0%	10.3%	9.8%	9.9%	11.5%
SANPETE	Adult (Ages 19-64)	10.6%	11.5%	11.9%	11.8%	11.5%
	Children	57.5%	57.7%	57.8%	61.0%	61.3%
	PCN	10.5%	9.4%	9.1%	6.9%	6.8%
	Pregnant Women	6.5%	6.2%	6.1%	5.3%	5.0%
	The Elderly (Ages 65+)	4.0%	3.9%	3.9%	4.0%	3.7%
	Visually Impaired and People with Disabilities	11.0%	11.3%	11.2%	11.0%	11.8%
SEVIER	Adult (Ages 19-64)	12.6%	14.5%	15.5%	15.3%	14.0%
	Children	53.3%	53.0%	51.4%	53.8%	54.6%
	PCN	10.3%	10.2%	9.8%	8.3%	8.3%
	Pregnant Women	6.9%	5.6%	5.6%	5.7%	5.8%
	The Elderly (Ages 65+)	4.4%	4.7%	5.0%	4.3%	4.1%
	Visually Impaired and People with Disabilities	12.5%	12.0%	12.8%	12.6%	13.1%
SUMMIT	Adult (Ages 19-64)	9.4%	11.2%	10.4%	9.0%	9.1%
	Children	66.7%	65.7%	65.0%	67.9%	69.2%
	PCN	5.2%	5.1%	5.5%	4.5%	4.5%
	Pregnant Women	8.1%	7.0%	6.8%	6.2%	6.3%
	The Elderly (Ages 65+)	2.4%	2.7%	3.1%	3.5%	2.9%
	Visually Impaired and People with Disabilities	8.1%	8.2%	9.3%	8.9%	8.0%
TOOELE	Adult (Ages 19-64)	14.2%	15.2%	15.9%	16.1%	14.8%
	Children	57.0%	57.2%	56.5%	58.4%	59.4%
	PCN	6.3%	5.8%	5.6%	4.9%	6.0%
	Pregnant Women	6.8%	6.5%	6.3%	5.9%	5.4%
	The Elderly (Ages 65+)	3.3%	3.2%	3.1%	2.8%	2.4%
	Visually Impaired and People with Disabilities	12.3%	12.1%	12.6%	11.9%	11.9%
UINTAH	Adult (Ages 19-64)	14.2%	15.7%	15.2%	15.2%	15.0%
	Children	57.1%	57.7%	58.7%	59.5%	61.2%
	PCN	4.4%	3.9%	3.6%	3.3%	3.6%
	Pregnant Women	8.5%	7.5%	7.8%	7.3%	6.8%
	The Elderly (Ages 65+)	4.4%	4.2%	3.9%	3.8%	3.5%
	Visually Impaired and People with Disabilities	11.4%	11.1%	10.7%	10.8%	10.0%

TABLE 16: Medicaid Enrollment Composition by County Continued						
County	Category of Assistance	SFY2011	SFY2012	SFY2013	SFY2014	SFY2015
UTAH	Adult (Ages 19-64)	12.6%	13.9%	14.3%	13.6%	13.4%
	Children	60.1%	59.6%	59.3%	62.3%	62.3%
	PCN	6.2%	5.9%	5.5%	4.3%	5.1%
	Pregnant Women	9.1%	8.4%	8.4%	7.8%	7.1%
	The Elderly (Ages 65+)	2.5%	2.7%	2.8%	2.7%	2.6%
	Visually Impaired and People with Disabilities	9.5%	9.6%	9.7%	9.4%	9.5%
WASATCH	Adult (Ages 19-64)	10.6%	12.7%	12.8%	11.2%	10.4%
	Children	61.2%	61.4%	62.6%	65.7%	67.3%
	PCN	7.6%	6.6%	5.6%	4.8%	4.3%
	Pregnant Women	8.0%	7.2%	6.8%	7.0%	6.8%
	The Elderly (Ages 65+)	3.2%	2.9%	2.8%	3.0%	2.7%
	Visually Impaired and People with Disabilities	9.4%	9.3%	9.4%	8.5%	8.5%
WASHINGTON	Adult (Ages 19-64)	11.8%	13.6%	14.1%	13.3%	12.2%
	Children	60.5%	59.9%	59.8%	62.7%	62.7%
	PCN	7.8%	7.1%	6.8%	5.8%	6.6%
	Pregnant Women	7.7%	7.1%	6.7%	6.1%	5.9%
	The Elderly (Ages 65+)	3.8%	3.9%	3.9%	3.8%	3.7%
	Visually Impaired and People with Disabilities	8.4%	8.5%	8.6%	8.4%	8.9%
WAYNE	Adult (Ages 19-64)	11.9%	13.1%	12.1%	12.2%	12.4%
	Children	58.3%	58.5%	53.9%	55.2%	56.7%
	PCN	9.2%	10.3%	10.9%	9.0%	8.7%
	Pregnant Women	7.9%	4.6%	5.8%	6.5%	6.2%
	The Elderly (Ages 65+)	4.2%	4.1%	5.2%	6.3%	4.8%
	Visually Impaired and People with Disabilities	8.4%	9.3%	12.1%	10.9%	11.2%
WEBER	Adult (Ages 19-64)	12.9%	14.8%	14.9%	14.0%	13.0%
	Children	55.4%	55.1%	54.9%	56.1%	55.8%
	PCN	6.1%	5.5%	5.4%	5.2%	6.7%
	Pregnant Women	6.8%	6.1%	6.2%	6.0%	5.9%
	The Elderly (Ages 65+)	4.2%	4.2%	4.2%	4.0%	3.7%
	Visually Impaired and People with Disabilities	14.5%	14.3%	14.4%	14.6%	15.0%

MEDICAID DELIVERY AND PAYMENT OF SERVICES

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

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

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

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

Providers

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

TABLE 17: Number of Participating Fee For Service Providers by Category of Service

Category of Service	2011	2012	2013	2014	2015
Aging Waiver Service	192	230	321	360	361
Ambulatory Surgical Services	48	43	42	43	47
Buy Out	1,312	1,316	1,312	1,343	1,254
Chiropractic Services	205	192	183	169	150
Contracted Mental Health Services	317	235	190	208	224
Custody Medical	130	137	131	265	247
Dental Services	728	781	820	803	860
Early Intervention	17	16	16	16	16
ESRD Kidney Dialysis Services	43	42	41	42	40
Federally Qualified Health Centers	27	27	27	31	35
Group Pre/Postnatal Education	6	5	8	6	9
Health Choice of Utah	0	0	0	1	1
Healthy U HMO	0	0	1	1	1
HIT Dual Eligible Hospital Yr1 Meaningful Use	0	13	16	19	3
HIT Dual Eligible Hospital Yr2 Meaningful Use	0	0	1	6	21
HIT Dual Eligible Hospital Yr3 Meaningful Use	0	0	0	11	5
HIT Dual Eligible Hospital Yr4 Meaningful Use	0	0	0	0	9
HIT Eligible Hospital Yr1 Adopt	0	0	1	1	0
HIT Eligible Hospital Yr2 Meaningful Use	0	0	0	1	0
HIT Eligible Hospital Yr3 Meaningful Use	0	0	0	0	1
HIT Eligible Provider Yr1 Adopt	0	105	218	331	90
HIT Eligible Provider Yr2 Meaningful Use	0	0	17	92	114
HIT Eligible Provider Yr3 Meaningful Use	0	0	0	9	48
HIT Eligible Provider Yr4 Meaningful Use	0	0	0	0	2
Home Health Services	161	183	189	200	186
Home/Community Waiver Contract Services	238	253	371	191	189
Houghton Lawsuit Pay Out	0	1,367	3	0	0
ICF/MR1 (LOC 4)	15	15	15	16	17
Independent Lab and/or X-Ray Services	95	110	107	115	115
Inpatient Hospital Services, General	164	192	204	202	179
Inpatient Hospital Services, Mental	1	1	1	1	1
Inpatient Hospital Services, Mental Youth Center	1	1	1	1	1
Intensive Skilled Care	12	12	16	12	10
Medical Supply Services	485	481	472	456	452
Medical Transportation	113	129	115	116	121
Mental Health Services	11	11	71	129	169
New Choices Waiver Services	192	212	256	276	287
Nursing Facility I (NF I)	118	112	109	114	134
Nursing Facility II (NF II)	95	91	84	87	79
Nursing Facility III (NF III)	101	95	96	104	109
Nutritional Assessment Counseling	6	8	6	5	5
Occupational Therapy	40	36	36	42	36
Optical Supply Services	10	10	12	12	13
Osteopathic Services	322	372	386	393	455
Outpatient Hospital Services, General	378	395	382	361	333
PCN - UPP	334	254	216	268	455
Pediatric/Family Nurse Practitioner	188	215	229	260	412
Perinatal Care Coordination	11	10	14	12	10
Personal Care	59	60	59	56	47
Pharmacy	580	580	583	603	604
Physical Therapy Services	229	252	247	245	234
Physician Services	3,516	3,827	3,619	3,460	3,206
Podiatry Services	111	123	117	114	121
Pre/Postnatal Home Visits	10	7	8	9	10
Private Duty Nursing	1	1	1	1	1
Psychologist Services	93	103	111	109	112
QMB-Only Services	159	213	203	206	201
Rural Health Clinic Services	17	23	23	20	19

TABLE 17: Number of Participating Fee For Service Providers by Category of Service Continued					
Category of Service	2011	2012	2013	2014	2015
Skills Development	32	33	34	35	34
Specialized Nursing Services	115	129	125	123	145
Specialized Wheel Chairs	2	1	1	2	3
Speech and Hearing Services	75	87	95	96	84
Substance Abuse Treatment Services	34	40	45	55	59
Targeted Case Management Services	38	27	26	27	25
USTS IMR-1 Services	1	1	1	1	1
Vision Care Services	256	263	259	272	259
Well Child Care (EPSDT) Services	645	601	545	483	544
Other	852	920	1,243	980	868

Table 18 shows the reimbursement amounts to FFS providers by category of service.

TABLE 18: Reimbursement Amounts to Fee For Service Providers by Category of Service					
Category of Service	2011	2012	2013	2014	2015
Aging Waiver Service	$3,544,227	$4,215,258	$4,249,457	$4,036,627	$4,262,250
Ambulatory Surgical Services	$7,879,125	$6,770,591	$5,875,878	$5,296,708	$5,088,685
Buy Out	$418,334	$398,689	$393,456	$416,555	$360,372
Chiropractic Services	$145,550	$131,114	$114,637	$120,756	$53,806
Contracted Mental Health Services	$15,493,599	$15,617,509	$15,748,807	$16,307,799	$18,393,881
Custody Medical	$152,787	$54,146	$47,740	$150,903	$66,704
Dental Services	$35,542,560	$38,728,100	$42,073,480	$23,443,132	$21,847,060
Early Intervention	$9,087,244	$8,173,456	$8,593,202	$8,661,819	$8,917,070
ESRD Kidney Dialysis Services	$1,323,767	$1,900,079	$1,621,087	$1,643,086	$1,575,597
Federally Qualified Health Centers	$6,021,939	$5,703,555	$5,399,829	$4,544,932	$4,845,354
Group Pre/Postnatal Education	$2,139	$2,262	$1,299	$218	$149
Health Choice of Utah	$0	$0	$0	$0	$193,256
Healthy U HMO	$0	$0	$22,783,994	$963,423	$1,835,121
HIT Dual Eligible Hospital Yr1 Meaningful Use	$0	$8,203,094	$9,870,794	$13,534,332	$653,788
HIT Dual Eligible Hospital Yr2 Meaningful Use	$0	$0	($417,076)	$3,672,705	$14,562,813
HIT Dual Eligible Hospital Yr3 Meaningful Use	$0	$0	$0	$631,167	$324,322
HIT Dual Eligible Hospital Yr4 Meaningful Use	$0	$0	$0	$0	$643,731
HIT Eligible Hospital Yr1 Adopt	$0	$0	$904,075	$2,333,732	$0
HIT Eligible Hospital Yr2 Meaningful Use	$0	$0	$0	$723,260	$0
HIT Eligible Hospital Yr3 Meaningful Use	$0	$0	$0	$0	$90,408
HIT Eligible Provider Yr1 Adopt	$0	$3,987,933	$5,301,181	$6,268,757	$1,848,756
HIT Eligible Provider Yr2 Meaningful Use	$0	$0	$289,000	$1,164,508	$918,008
HIT Eligible Provider Yr3 Meaningful Use	$0	$0	$0	$221,000	$447,668
HIT Eligible Provider Yr4 Meaningful Use	$0	$0	$0	$0	$102,000
Home Health Services	$27,510,570	$27,502,534	$30,611,550	$21,480,791	$21,554,727
Home/Community Waiver Contract Services	$154,214,187	$160,007,224	$171,057,522	$172,644,581	$186,096,532
Houghton Lawsuit Pay Out	$0	$2,332,174	$242	$0	$0
ICF/MR1 (LOC 4)	$31,509,701	$32,305,120	$31,741,658	$32,166,519	$34,289,057
Independent Lab and/or X-Ray Services	$3,218,630	$3,105,092	$2,939,175	$3,567,790	$4,644,996
Inpatient Hospital Services, General	$509,246,701	$511,698,139	$410,531,054	$254,964,434	$245,748,213
Inpatient Hospital Services, Mental	$80,969	$433,495	$642,922	$696,983	$1,226,160
Inpatient Hospital Services, Mental Youth Center	$16,530,364	$16,120,753	$15,918,029	$19,729,227	$15,363,614
Intensive Skilled Care	$13,633,763	$16,057,685	$17,829,546	$19,476,207	$20,266,553
Medical Supply Services	$14,385,922	$15,893,641	$13,974,800	$10,651,891	$11,339,779
Medical Transportation	$4,167,269	$4,360,675	$4,400,543	$5,682,986	$6,893,273
Mental Health Services	$5,924,827	$4,735,206	$3,910,231	$3,391,055	$3,062,734
New Choices Waiver Services	$21,991,503	$24,780,831	$29,608,034	$35,795,841	$39,944,112
Nursing Facility I (NF I)	$7,046,034	$6,222,594	$4,707,485	$4,080,642	$2,153,631

TABLE 18: Reimbursement Amounts to Fee For Service Providers by Category of Service Continued					
Category of Service	2011	2012	2013	2014	2015
Nursing Facility II (NF II)	$54,022,422	$46,548,330	$27,487,328	$16,247,347	$10,224,451
Nursing Facility III (NF III)	$86,359,981	$102,670,193	$120,421,665	$138,192,448	$155,665,672
Nutritional Assessment Counseling	$7,112	$5,792	$3,587	$218	$25
Occupational Therapy	$111,920	$109,944	$77,475	$48,038	$51,201
Optical Supply Services	$35,895	$37,485	$34,454	$31,794	$40,236
Osteopathic Services	$7,975,076	$7,968,697	$7,496,957	$6,197,454	$7,204,051
Other	$77,066	$60,331	$954,281	$14,031,012	$15,475,509
Outpatient Hospital Services, General	$107,002,345	$103,480,950	$70,138,392	$63,882,803	$68,071,953
PCN - UPP	$365,089	$303,021	$237,672	$280,869	$494,321
Pediatric/Family Nurse Practitioner	$521,460	$503,238	$479,665	$418,338	$867,257
Perinatal Care Coordination	$252,316	$221,337	$186,852	$163,156	$119,064
Personal Care	$2,068,311	$2,768,360	$3,456,788	$2,917,170	$3,023,762
Pharmacy	$172,624,285	$182,991,163	$136,960,310	$115,882,545	$139,812,421
Physical Therapy Services	$475,668	$472,008	$353,764	$305,858	$353,155
Physician Services	$112,574,120	$101,566,097	$86,757,199	$70,405,880	$81,974,132
Podiatry Services	$457,467	$453,329	$479,389	$389,748	$404,692
Pre/Postnatal Home Visits	$104,900	$105,648	$85,016	$56,507	$41,730
Private Duty Nursing	$27,025	$28,520	$38,760	$28,335	$29,860
Psychologist Services	$312,676	$305,509	$320,240	$320,360	$388,331
QMB-Only Services	$320,248	$389,664	$415,683	$432,139	$454,430
Rural Health Clinic Services	$1,249,330	$1,186,550	$1,224,106	$1,039,414	$970,520
Skills Development	$25,336,993	$22,483,135	$26,893,632	$30,166,118	$31,955,114
Specialized Nursing Services	$3,365,908	$3,078,175	$2,555,444	$1,927,046	$2,051,021
Specialized Wheel Chairs	$0	$0	$12,901	$873	$1,012
Speech and Hearing Services	$348,032	$372,083	$321,471	$184,284	$255,548
Substance Abuse Treatment Services	$9,705,307	$9,811,796	$2,377,473	$2,258,895	$1,898,258
Targeted Case Management Services	$55,381	$50,143	$60,036	$9,654	$1,996
USTS IMR-1 Services	$25,053,824	$24,413,531	$24,280,624	$28,591,402	$29,821,834
Vision Care Services	$2,265,837	$2,209,277	$1,888,818	$1,525,469	$1,762,622
Well Child Care (EPSDT) Services	$11,250,497	$10,714,013	$8,403,621	$6,706,504	$7,528,376

Managed Care

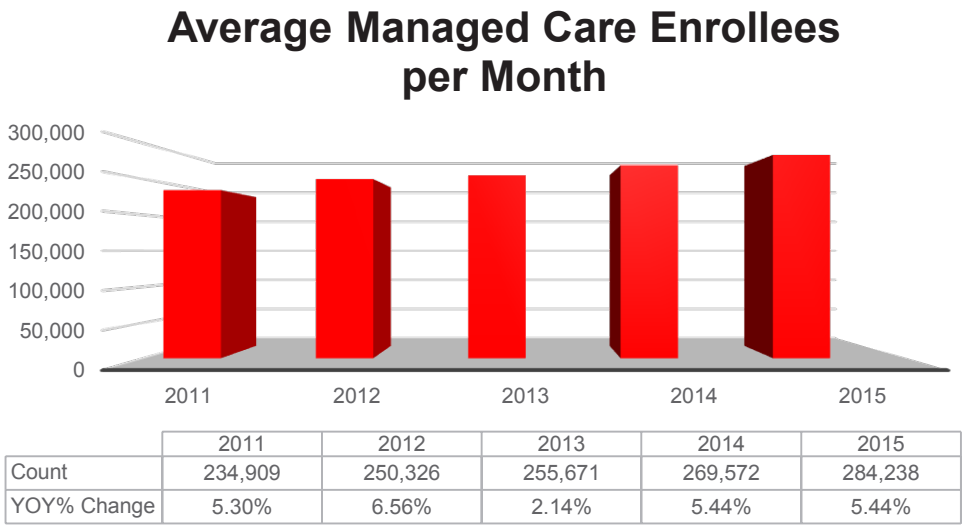
Managed care has been part of the Medicaid service delivery system since the 1990s. In a managed care delivery system, Medicaid recipients receive their health care through an organization under contract with DMHF to provide Medicaid covered services. DMHF uses waiver authority under Section 1915(b)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

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

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

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

Figure 14 illustrates the monthly average number of Medicaid recipients receiving managed care services through a Managed Care Organization. This includes Physical Health, Mental Health, Substance Abuse, and Dental Services.

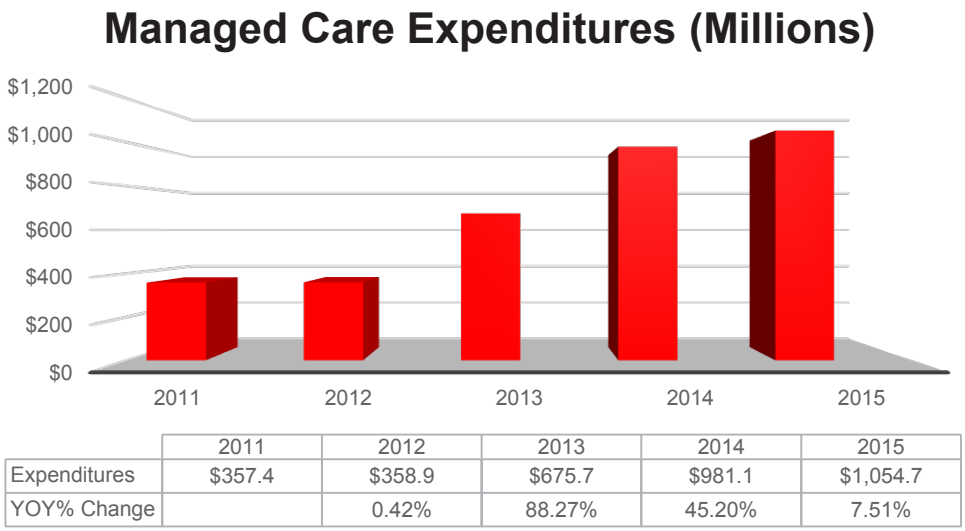


	2011	2012	2013	2014	2015
Count	234,909	250,326	255,671	269,572	284,238
YOY% Change	5.30%	6.56%	2.14%	5.44%	5.44%

FIGURE 14

**Figure 14 has been revised from previous reports to include enrollees from all of the ACOs, PMHPs, and Dental Providers participating in Utah Medicaid.*

Figure 15 illustrates statewide managed care expenditures by fiscal year. The large year-to-year percent growth seen between SFYs 2012 and 2014, is attributed to the shift to Accountable Care Organizations (ACOs). With this shift, some of the recipients and expenditures that were previously classified as fee for service are now categorized as managed care services. These include FFS hospital, FFS physician services, FFS pharmacy services, and other FFS long-term care services.



	2011	2012	2013	2014	2015
Expenditures	$357.4	$358.9	$675.7	$981.1	$1,054.7
YOY% Change		0.42%	88.27%	45.20%	7.51%

FIGURE 15

**Figure 15 has been revised from previous reports to include expenditures for all capitated ACOs, PMHPs, and Dental Providers participating in Utah Medicaid.*

MANAGED CARE: ACCOUNTABLE CARE ORGANIZATIONS

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

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

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

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

Figure 16 is a breakdown of the monthly average number of Medicaid recipients by rate cell served by all ACOs during SFY 2015. The children from ages one through 18 years old, both male and female together, constitute over 60 percent of ACO recipients. Non-traditional females (ages 19 through 64) make up about 8.7 percent, which is about 2.6 times more than non-traditional males. Males and females of all ages with disabilities account for about 14.5 percent of all recipients, followed by the birth-to-one-year-old category at 7.6 percent. All of the other rate cells, aggregated, compose about 4.9 percent of the recipient total.

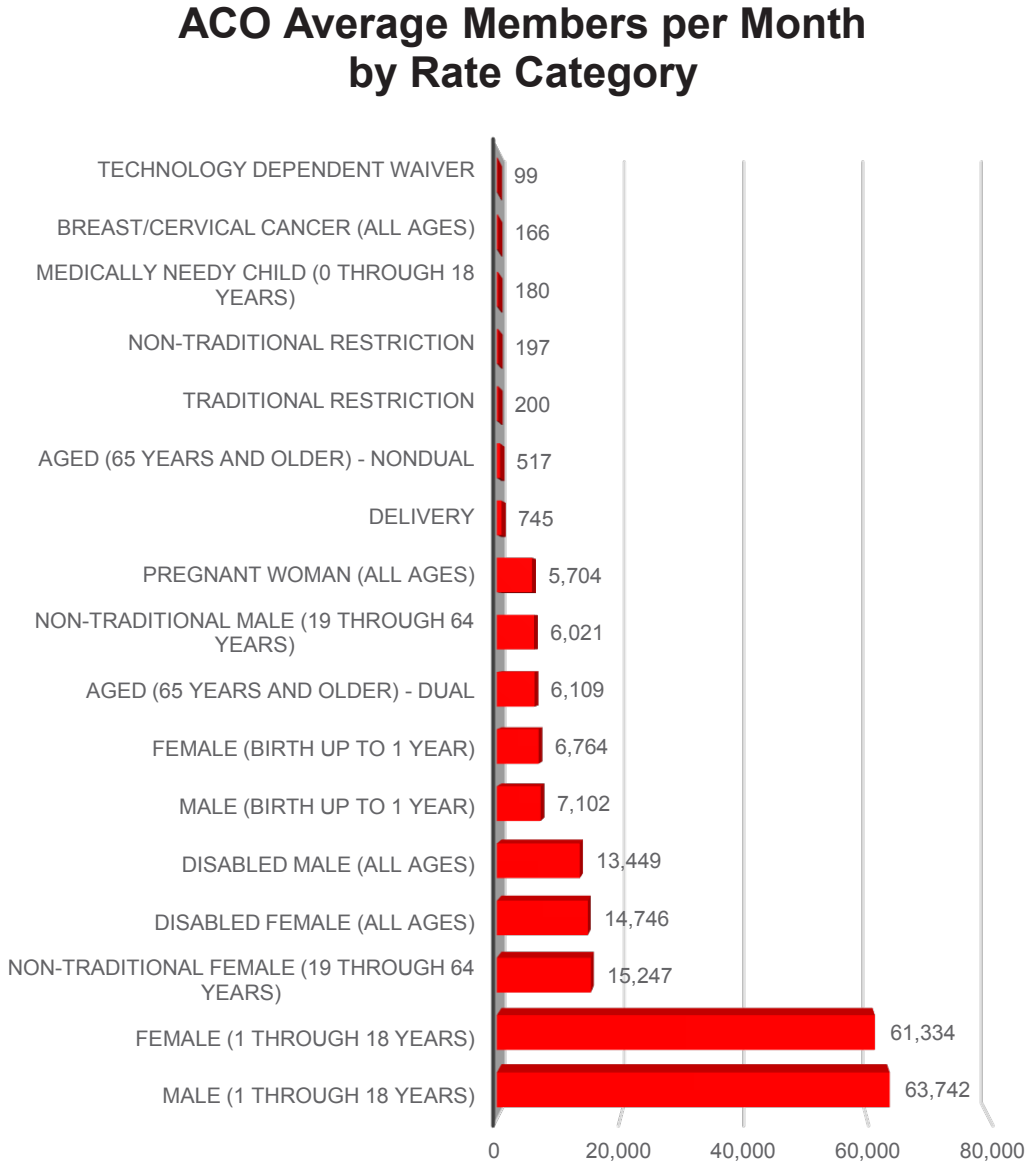


FIGURE 16

Figure 17 shows the weighted average base rates for each rate cell in SFY 2015. The Technology Dependent Waiver rate cell has the largest base rate but the least amount of member months. By contrast the males and females between the ages of 1 and 18 account for the lowest base rates but the highest number of member months.

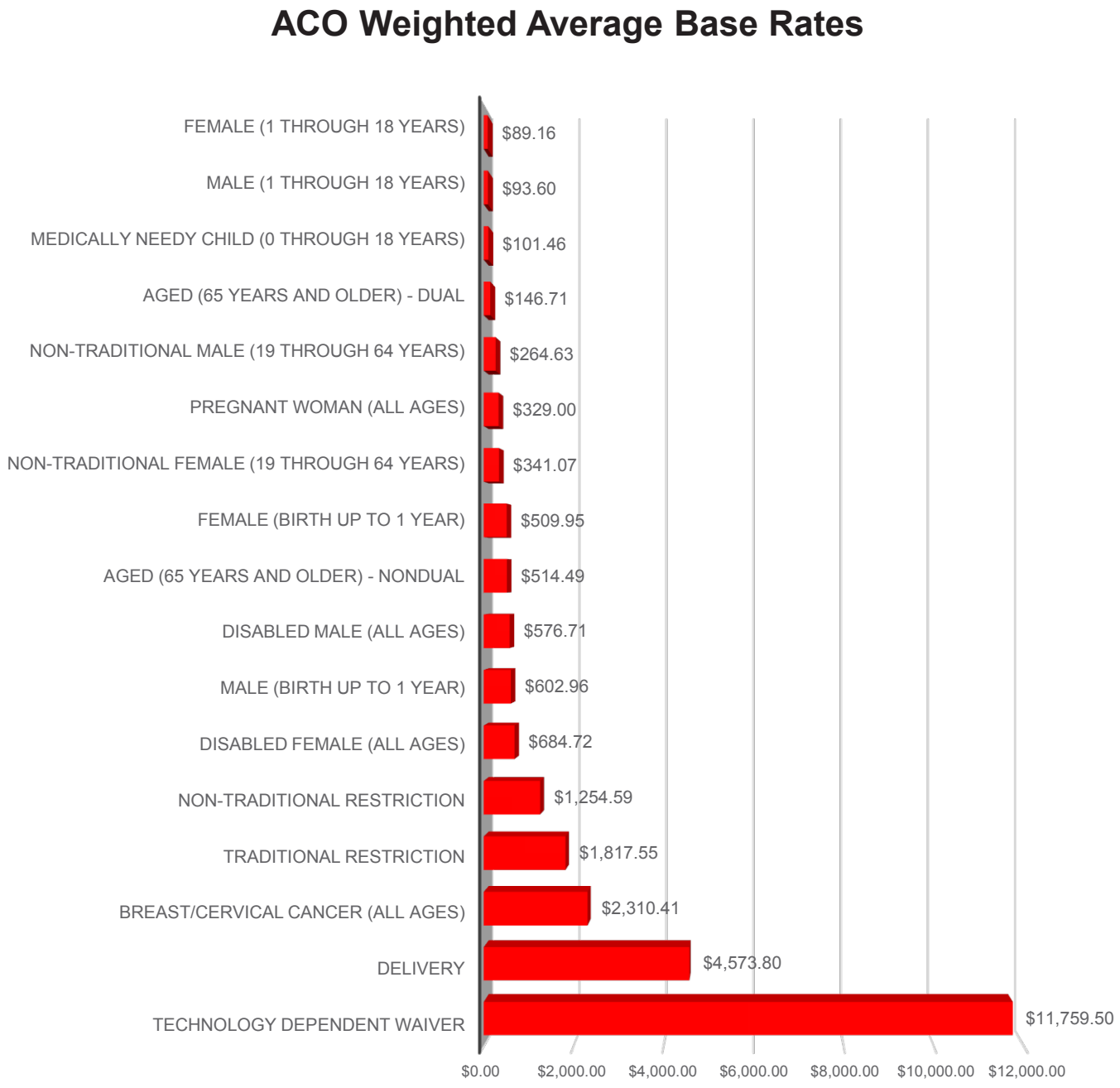


FIGURE 17

MANAGED CARE: BEHAVIORAL HEALTH

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

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

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

TABLE 19: Behavioral Health Average Monthly Enrollment by County

County	2011	2012	2013	2014	2015
BEAVER, GARFIELD, IRON, KANE & WASHINGTON	21,564	23,339	23,699	24,818	26,645
CACHE, BOX ELDER & RICH	13,672	14,361	14,743	15,678	17,135
CARBON, EMERY & GRAND	4,756	4,919	5,057	5,267	5,347
DAGGET, DUCHESNE & UINTAH	4,619	4,853	4,816	8,402	8,962
DAVIS	18,984	20,425	20,939	22,006	23,340
HEBER	42	58	44	0	0
JUAB, MILLARD, PIUTE, SANPETE, SEVIER & WAYNE	7,965	8,396	8,207	8,582	9,129
MORGAN & WEBER	23,277	25,212	25,763	26,466	27,646
SALT LAKE, SUMMIT & TOOELE	98,729	105,236	108,200	112,189	116,379
UTAH & WASATCH	40,660	42,860	43,443	45,344	48,637

**Table 19 has been revised from previous reports to include all of the PMHPs participating in Utah Medicaid.*

Fee For Service (FFS)

HOSPITAL CARE

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

Figure 18 shows the number of hospital care service claims for both inpatient and outpatient hospital facilities. The decline in the number of FFS claims in SFYs 2013, 2014 and 2015 were offset by the increase in the number of managed care claims ("MC claims" in the charts) in both years. The shift in claims between FFS and managed care is attributable to the implementation of the ACO model during SFY 2013.

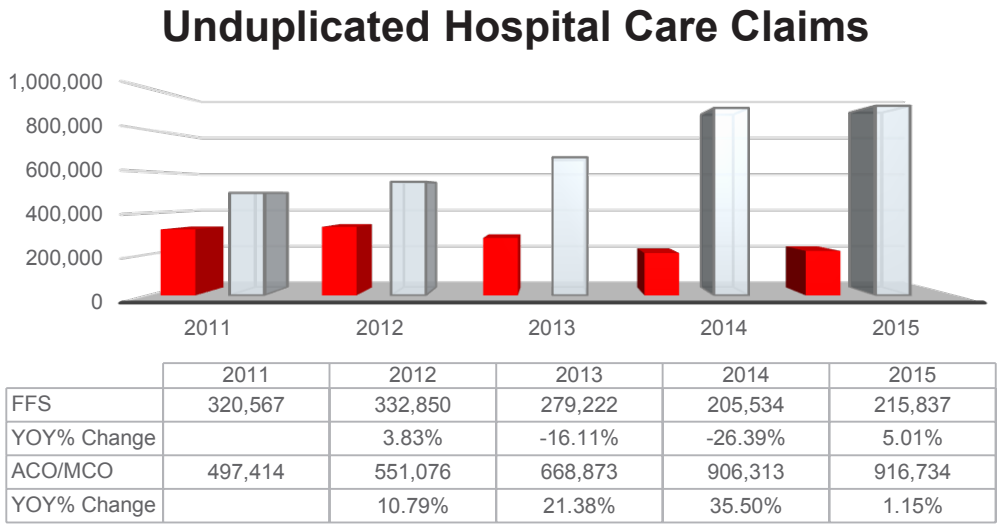
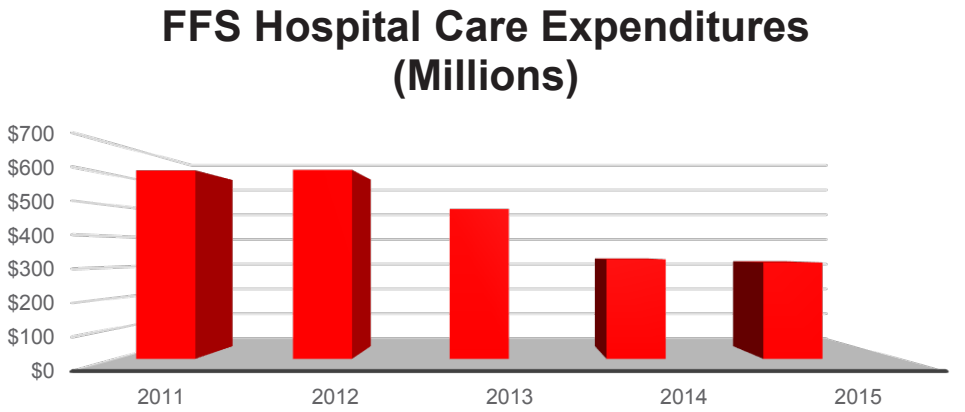


FIGURE 18

**Figure 18 has been revised from previous reports. Claim counts now reflect distinct instances of services, rather than the number of times claims were submitted to the division.*

Figure 19 shows expenditures for FFS hospital care services. The dramatic drop in SFY 2014 and again in SFY 2015 is largely attributable to the establishment of ACOs. Given that managed care expenditures are capitated, they are not included in figure 19.



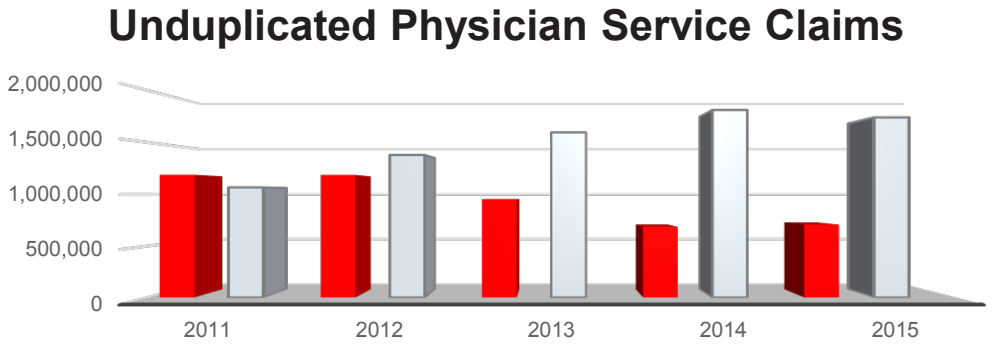
	2011	2012	2013	2014	2015
Expenditures	$617.07	$618.52	$490.73	$325.26	$314.89
YOY% Change		0.24%	-20.66%	-33.72%	-3.19%

FIGURE 19

PHYSICIAN SERVICES

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

Figure 20 displays a statewide look at the number of claims of Medicaid members who have utilized physician services. The decline in the number of FFS claims in FY 2014 and FY 2015 were offset by the increase in the number of managed care claims in both years. The shift in claims between FFS and managed care is attributable to the establishment of ACOs during SFY 2013.

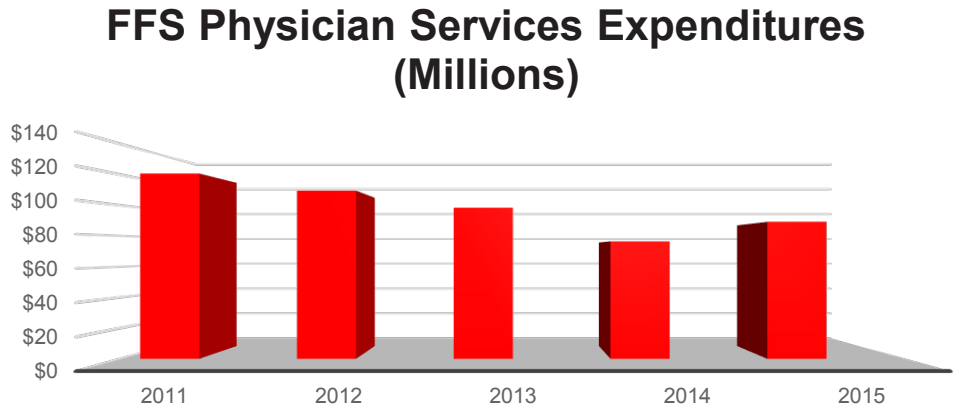


	2011	2012	2013	2014	2015
FFS	1,188,917	1,187,870	951,840	683,837	705,961
YOY% Change		-0.09%	-19.87%	-28.16%	3.24%
ACO/MCO	1,067,448	1,379,456	1,596,312	1,811,763	1,740,320
YOY% Change		29.23%	15.72%	13.50%	-3.94%

FIGURE 20

**Figure 20 has been revised from previous reports. Claim counts now reflect distinct instances of services, rather than the number of times claims were submitted to the division.*

Figure 21 provides a look at statewide FFS physician services associated expenditures. The decline in SFY 2013 and again in SFY 2014 is largely attributable to the establishment of ACOs. On the other hand, the increase between SFY 2014 and SFY 2015 is, in many ways, due to the increased enrollment associated with the Affordable Care Act (ACA). Furthermore, given that managed care expenditures are capitated, they are not included in Figure 20.



	2011	2012	2013	2014	2015
Expenditures	$120.74	$109.60	$98.47	$76.49	$89.20
YOY% Change		-9.22%	-10.16%	-22.32%	16.62%

FIGURE 21

PHARMACY SERVICES

DMHF provides coverage for nearly all available prescription drugs approved by the Food and Drug Administration (FDA).

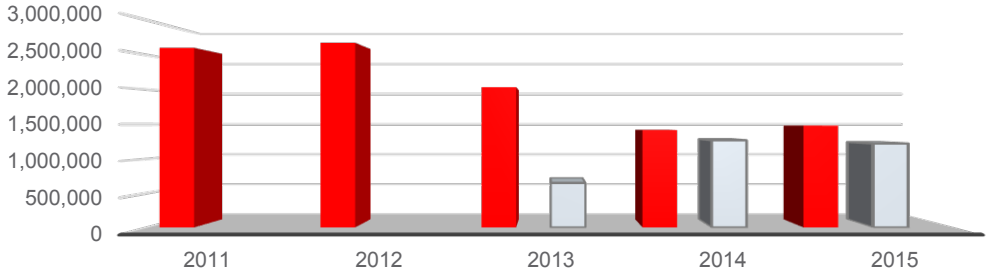
To manage the costs of prescription drugs, the Division has a generic-first requirement. If a generic product is available in a drug class and it is not more expensive than the brand name product, then the pharmacy must dispense the generic.

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

Some drugs require prior approval based on clinical criteria. The clinical criteria is developed by the Drug Utilization Review Board and is intended to ensure Medicaid recipients receive safe and effective treatments. The clinical criteria are separate and distinct from the criteria used for a non-preferred drug; however, there may be instances where a drug may be subject to clinical and non-preferred drug criteria.

Figure 22 shows the number FFS and managed care claims of Medicaid members utilizing pharmacy services. The decline in the number of FFS claims in SFYs 2013, 2014 and 2015 compared to SFY 2012 were offset by the increase in the number of managed care claims in both years. The shift in claim counts between FFS and managed care is attributable to the establishment of the ACO model during SFY 2013.

Unduplicated Pharmacy Service Claims



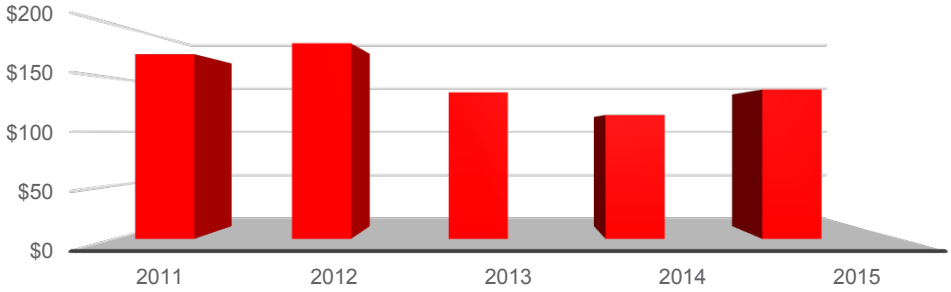
	2011	2012	2013	2014	2015
FFS	2,606,828	2,680,493	2,037,675	1,416,388	1,481,552
YOY% Change		2.83%	-23.98%	-30.49%	4.60%
ACO/MCO			647,950	1,268,877	1,221,304
YOY% Change				95.83%	-3.75%

FIGURE 22

**Figure 22 has been revised from previous reports. Claim counts now reflect distinct instances of services, rather than the number of times claims were submitted to the division.*

Figure 23 illustrates statewide expenditures on FFS pharmacy services. The decline in SFY 2013 and again in SFY 2014 is largely due to the implementation of the ACO model. Moreover, the increase between SFYs 2014-15 is due to ACA associated enrollment increases and general increases in the costs of pharmaceuticals. Managed care expenditures are not included in Figure 23 since these expenditures are capitated.

FFS Pharmacy Services Expenditures (Millions)

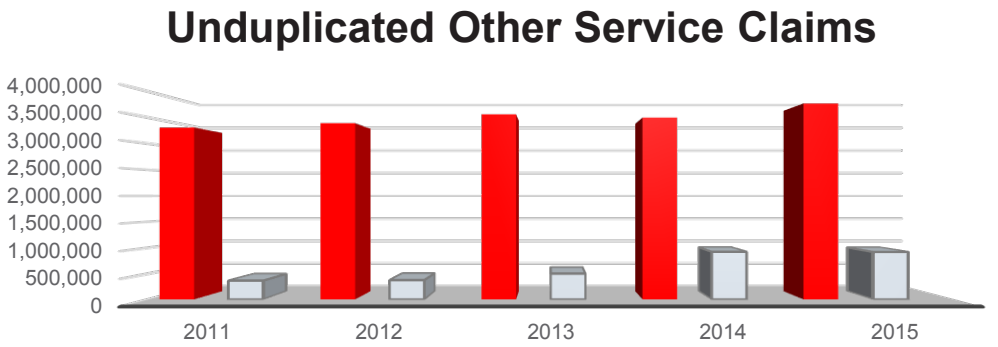


	2011	2012	2013	2014	2015
Expenditures	$172.65	$182.87	$136.93	$115.78	$139.64
YOY% Change		5.91%	-25.12%	-15.45%	20.61%

FIGURE 23

OTHER SERVICES

Figure 24 illustrates the number of claims of Medicaid members utilizing all other services. The "other" group includes services provided via medical and non-medical transportation, outpatient hospitals, home health services/hospices, dental facilities, vision care, occupational therapists, rural health facilities, physical therapists, podiatrists, chiropractors, nutritionists, and psychologists.

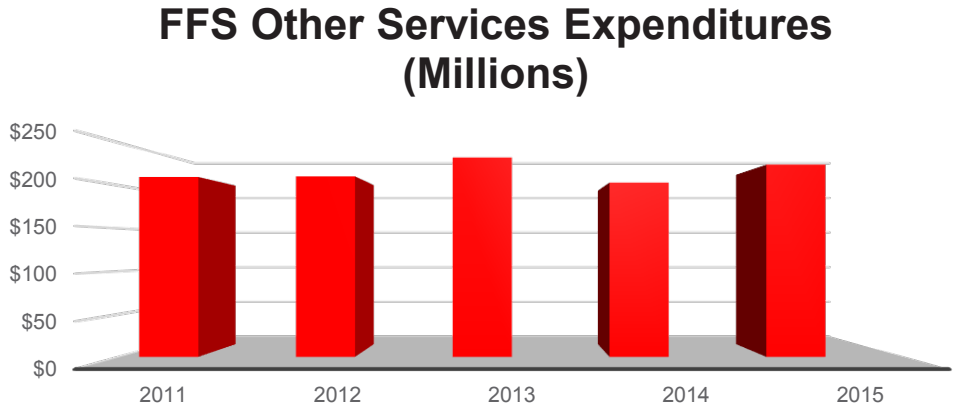


	2011	2012	2013	2014	2015
FFS	3,311,734	3,396,191	3,563,903	3,501,559	3,773,085
YOY% Change		2.55%	4.94%	-1.75%	7.75%
ACO/MCO	362,278	371,669	498,717	919,930	916,373
YOY% Change		2.59%	34.18%	84.46%	-0.39%

FIGURE 24

**Figure 24 has been revised from previous reports. Claim counts now reflect distinct instances of services, rather than the number of times claims were submitted to the division.*

Figure 25 depicts statewide expenditures on the other services category. Managed care expenditures are not included in Figure 25 given that they are capitated.



	2011	2012	2013	2014	2015
Expenditures	$210.24	$210.93	$233.00	$203.62	$224.67
YOY% Change		0.33%	10.46%	-12.61%	10.34%

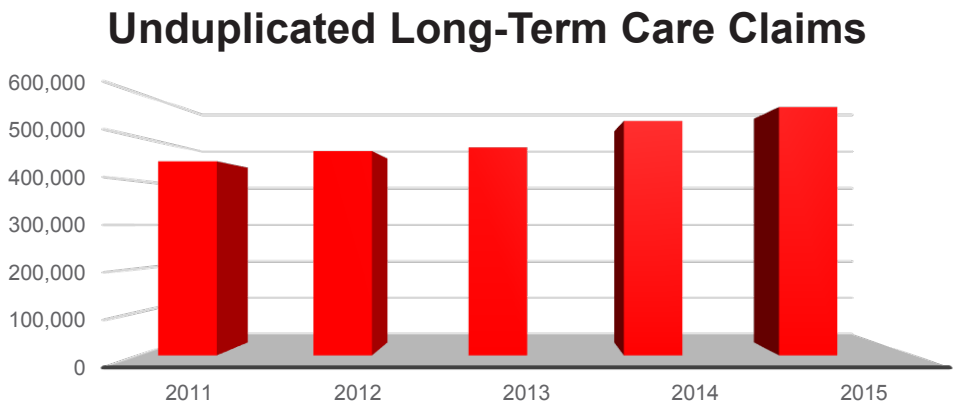
FIGURE 25

**Figure 25 has been revised from previous reports. Expenditures now exclude capitated expenditures for all ACOs, PMHPs, and dental providers participating in Utah Medicaid.*

Long-Term Care

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

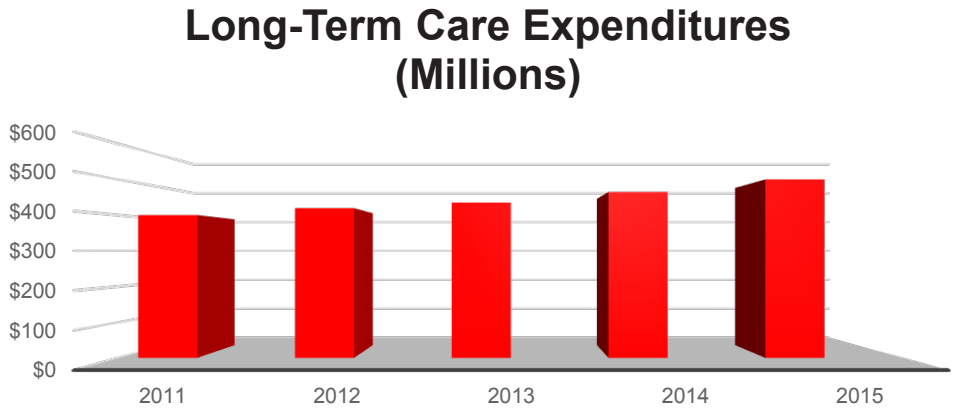
Figure 26 displays the number of claims of Medicaid members utilizing long-term care services.



	2011	2012	2013	2014	2015
ClaimCount	445,347	468,643	477,165	537,539	569,387
YOY% Change		5.23%	1.82%	12.65%	5.92%

FIGURE 26

Figure 27 illustrates statewide long-term care related expenditures.



	2011	2012	2013	2014	2015
Expenditures	$400.3	$419.8	$435.3	$465.5	$500.4
YOY% Change		4.87%	3.71%	6.92%	7.51%

FIGURE 27

**Figure 27 has been revised from previous reports. Expenditures now include expenditures for all HCBS Waiver and Nursing Home providers participating in Utah Medicaid.*

LONG-TERM CARE: NURSING HOME SERVICES

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

Table 20 provides nursing home expenditures for the Wasatch Front (Davis, Salt Lake, Utah and Weber Counties) and non-Wasatch Front Counties.

TABLE 20: Nursing Home Expenditures by Locality

	2011	2012	2013	2014	2015
DAVIS	$17,733,400	$19,545,900	$20,008,800	$20,888,600	$22,204,300
SALT LAKE	$75,010,700	$80,224,600	$78,576,400	$82,994,100	$87,899,800
UTAH	$59,688,900	$60,810,700	$60,960,100	$64,911,000	$66,563,100
WEBER	$21,395,000	$22,264,500	$24,015,400	$22,207,000	$23,017,600
All Other Counties	$44,314,000	$45,436,100	$42,935,900	$47,929,700	$54,721,100
Total	**$218,142,000**	**$228,281,800**	**$226,496,600**	**$238,930,400**	**$254,405,900**

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

Utah Medicaid operates seven HCBS 1915(c) waivers, authorized through Section 1915(c) of the Social Security Act. HCBS waivers provide LTC services in home and community-based settings as an alternative to nursing home services or services provided in an intermediate care facility for individuals with intellectual disabilities. The day-to-day administration and state funding of four of the HCBS waivers is provided by the Department of Human Services (DHS): 1) Waiver for Individuals Aged 65 and Older, 2) Waiver for Individuals with Acquired Brain Injuries, 3) Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions, and 4) Waiver for Individuals with Physical Disabilities. The New Choices Waiver and Technology Dependent Waiver are managed internally and funded through DMHF. The Medicaid Autism Waiver is funded through DMHF and the day-to-day operations are managed by DHS. DMHF retains final administrative oversight of the HCBS waivers in its role as the Single State Medicaid Agency.

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

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

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

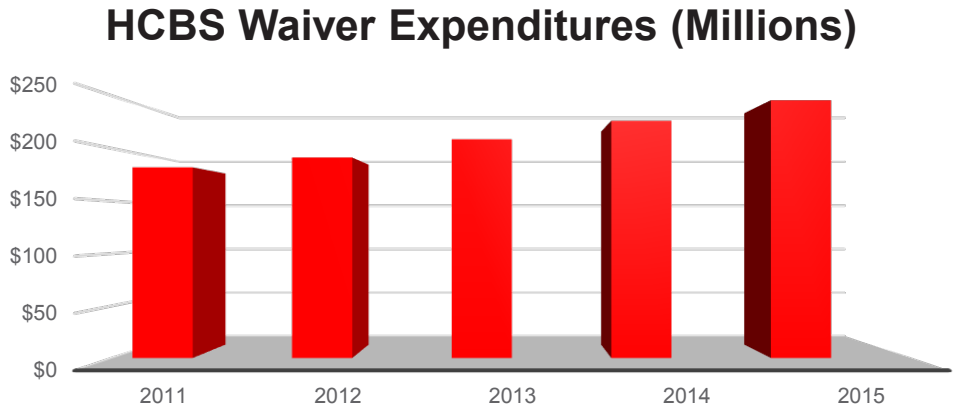
Waiver for Individuals with Physical Disabilities – This program's primary focus is to provide services to adults who have physical disabilities. Services are provided in an individual's own home or the home of a loved one. This program seeks to prevent or delay the need for nursing home care. DHS Division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

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

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

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

Figure 28 shows the expenditures associated with Home and Community-Based Services (HCBS).



	2011	2012	2013	2014	2015
Expenditures	$182.1	$191.5	$208.9	$226.5	$246.0
YOY% Change		5.13%	9.06%	8.47%	8.60%

FIGURE 28

**Figures 28 and Table 21 have been revised from previous reports. Expenditures now include expenditures for all HCBS Waiver providers participating in Utah Medicaid.*

The values in Table 21 reflect the expenditures by specific HCBS Waiver. Although the expenditures for the New Choices Waiver fall into Appropriation LJH – Other Optional Services, it is included in Figure 28 and Table 21 to more accurately detail the Home and Community Based Services as a whole.

TABLE 21: HCBS Waiver Expenditures					
	2011	2012	2013	2014	2015
Acquired Brain Injury Waiver	$2,642,600	$2,690,400	$3,406,200	$3,594,300	$4,108,300
Aging Waiver	$3,547,800	$4,245,500	$4,275,000	$4,059,100	$4,286,900
Autism Waiver	$0	$0	$929,700	$5,380,100	$6,027,000
Community Supports Waiver	$149,681,700	$155,357,800	$165,675,900	$172,646,400	$186,096,500
New Choices Waiver	$22,000,300	$24,808,100	$29,614,400	$35,808,300	$40,132,700
Physical Disabilities Waiver	$1,889,900	$1,959,200	$2,125,100	$2,175,900	$2,089,300
Tech Dependent Waiver	$2,386,000	$2,439,000	$2,825,300	$2,867,200	$3,281,900
Grand Total	**$182,148,300**	**$191,500,000**	**$208,851,600**	**$226,531,300**	**$246,022,600**

Table 22 shows long-term care expenditures by institutional and non-institutional settings. Institutional costs include nursing facility and ICF/ID expenditures. Non-Institutional costs include home and community based waivers, personal care, private duty nursing and home health expenditures.

TABLE 22: Utah Medicaid Long Term Care Institutional and Non Institutional State Fund Expenditure Comparison						
Fiscal Year	Institutional Total State Costs	Non Institutional Total State Costs	Total Combined State Costs	Difference between Non Institutional and Institutional Total	Institutional Percentage of Total Costs	Non Institutional Percentage of Total Costs
SFY 2011	$61,811,300	$63,354,800	$125,166,100	$1,543,500	49.4%	50.6%
SFY 2012	$64,589,300	$64,434,500	$129,023,800	($154,800)	50.1%	49.9%
SFY 2013	$66,530,100	$71,795,400	$138,325,500	$5,265,300	48.1%	51.9%
SFY 2014	$67,754,200	$69,325,600	$137,079,800	$1,571,400	49.4%	50.6%
SFY 2015	$68,756,200	$74,926,600	$143,682,800	$6,170,400	47.9%	52.1%

MEANS OF FINANCE

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

CHIP is a joint federal-state sponsored health insurance plan for uninsured children from households up to 200 percent of the federal poverty level (FPL). In 2015, a family of four with an income of $48,500 or less would qualify (See Appendix A).

In accordance with Section 26-40-106, Utah Code Annotated, CHIP benefits for fiscal year 2015 were actuarially equivalent to the benefits received by members in Select Health's Small Business Account plan, the commercial plan with the largest enrollment in the state. In SFY 2015, CHIP contracted with two managed care plans to provide CHIP medical services: Molina Healthcare of Utah and SelectHealth.

DMHF contracted with two dental managed care plans to provide CHIP dental services: Premier Access and DentaQuest.

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 2015, the state funding also included an appropriation from the General Fund.

- For SFY 2010, the Legislature decreased the ongoing General Fund to $0.5 million and increased the Tobacco Settlement Restricted Fund to $14.1 million to cover the loss in the General Fund. The program also had $2.9 million carried forward from SFY 2009.
- For SFY 2011, the Legislature appropriated an additional $2.4 million of one-time General Fund dollars for a total of $2.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to $11.7 million. The program was not allowed to carry forward the $2.9 million from SFY 2009. However, the program was allowed to carry forward $0.6 million into SFY 2012 through non-lapsing authority.
- For SFY 2012, the Legislature appropriated an additional $3.0 million of one-time General Fund dollars for a total of $4.9 million. This appropriation was due to a shortfall in the Tobacco Settlement Restricted Fund. The Tobacco Settlement Restricted Fund appropriation was reduced to $11.1 million. The program was allowed to carry forward the $0.6 million from SFY 2011. The program was also allowed to carry forward $2.9 million into SFY 2013 through non-lapsing authority.
- For SFY 2013, the Legislature appropriated $5.4 million in General Fund and $11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2012 of $2.9 million. The program was also allowed to carry forward $1.4 million into SFY 2014 through non-lapsing authority.
- For SFY 2014, the Legislature appropriated $2.8 million in General Fund and $11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2013 of $1.4 million.

- For SFY 2015, the Legislature appropriated $6.7 million in General Fund and $11.5 million in Tobacco Cost Settlement Restricted Fund. In addition, the program had General Fund carried forward from SFY 2014 of $1.4 million.

Cost Sharing Benefits

In SFY 2015 families paid a premium of up to $75 per quarter for enrollment in CHIP. The amount of premium varied depending upon a family's income. American Indian and Alaska Native families and families with incomes below 100 percent FPL do not pay quarterly premiums. As of July 1, 2009, premiums for families from 151 to 200 percent FPL increased from $60 to $75. In addition, the Department began charging a $15 late fee if families failed to pay their premiums on time. In SFY 2015, CHIP collected $1.8 million in premiums and late fees. Premiums are used to fund the CHIP program and are appropriated as dedicated credits in the annual CHIP budget.

In FY 2015, most CHIP families paid co-payments in addition to their quarterly premiums. Native American families are not required to make co-payments. As established in federal regulations, no family on CHIP is required to spend more than five percent of their family's annual gross income on premiums, co-payments and other out-of-pocket costs combined during their eligibility certification period.

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

Major Budget Categories

MEDICAL

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

DENTAL

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

UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP)

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

CHIP Expenditures

Table 23 shows CHIP expenditures in SFY 2015. Total CHIP expenditures increased by 1.3 percent between FY 2014 and FY 2015. The "CHIP-I-CAID" transfer line refers to expenditures incurred by the group of children that shifted from CHIP to Medicaid coverage. This shift has occurred because of the ACA changes in Medicaid eligibility to 133 percent, the elimination of a Medicaid asset test for children, and the application of the 5 percent disregard. Furthermore, the ACA allows "CHIP-I-CAID" related expenditures to be funded through title XXI and that the CHIP enhanced FMAP be applied to those expenditures.

TABLE 23: CHIP Expenditures

Service Expenditures - Actual	**TOTAL**	**Percent of Total**
Capitated Managed Health Care		
SelectHealth	$16,181,700	16%
Molina	$6,587,400	6%
Dental Services		
Premier Access	$3,874,500	4%
DentaQuest	$759,900	1%
Immunization Services	$1,275,700	1%
Other Services	$292,900	0%
CHIP-I-CAID Transfer	$67,135,700	65%
Total CHIP Services	**$96,107,800**	**93%**
UPP Services	**$504,300**	**0%**
Total Service Expenditures	**$96,612,100**	**93%**
Administrative Expenditures		
DOH	$2,755,600	3%
DMHF Admin Allocation	$1,734,300	2%
BRFSS	$14,100	0%
OIG Admin Allocation	$85,300	0%
DWS	$2,458,200	2%
Total Administrative Expenditures	**$7,047,500**	**7%**
TOTAL	**$103,659,600**	**100%**

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

Utah's Premium Partnership for Health Insurance (UPP)

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

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

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

CHIP ENROLLMENT

Eligibility Requirements and the Enrollment Process

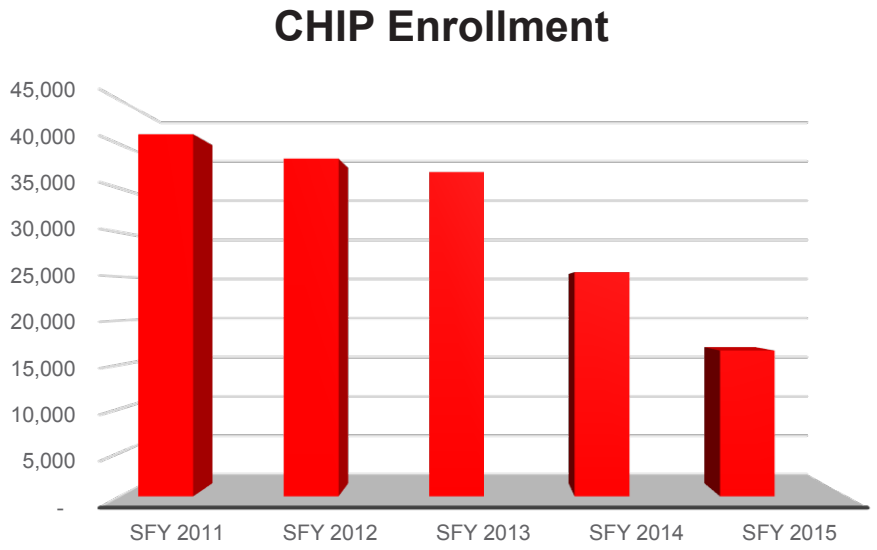
As required by Utah Code 26-40-105, CHIP is required to keep enrollment continuously open. Applications for CHIP can be submitted through the mail, in-person, and online.

Basic eligibility criteria:

1. Gross family income cannot be higher than 200 percent FPL (for a family of four, 200 percent FPL is $48,500).
2. The child must be a resident of the state of Utah, and a U.S. citizen or legal alien.
3. The child must be 18 years of age or younger.
4. The child must be uninsured and not eligible for Medicaid.

Enrollment Statistics

Figure 29 shows the unduplicated count of CHIP and UPP enrollment between SFY 2011 and SFY 2015. The large drop between SFY 2013 and SFY 2014 and again in SFY 2015 is mostly attributable to ACA requirements. Children who were on CHIP were allowed to move to Medicaid when the ACA removed the asset test and increased the required income level.



	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Count	41,182	38,405	36,881	25,508	16,595
YOY % Change		-6.7%	-4.0%	-30.8%	-34.9%

FIGURE 29

Figure 30 breaks out CHIP enrollment by FPL. Please note, UPP enrollment is not included in this chart.

CHIP Enrollment by Federal Poverty Level

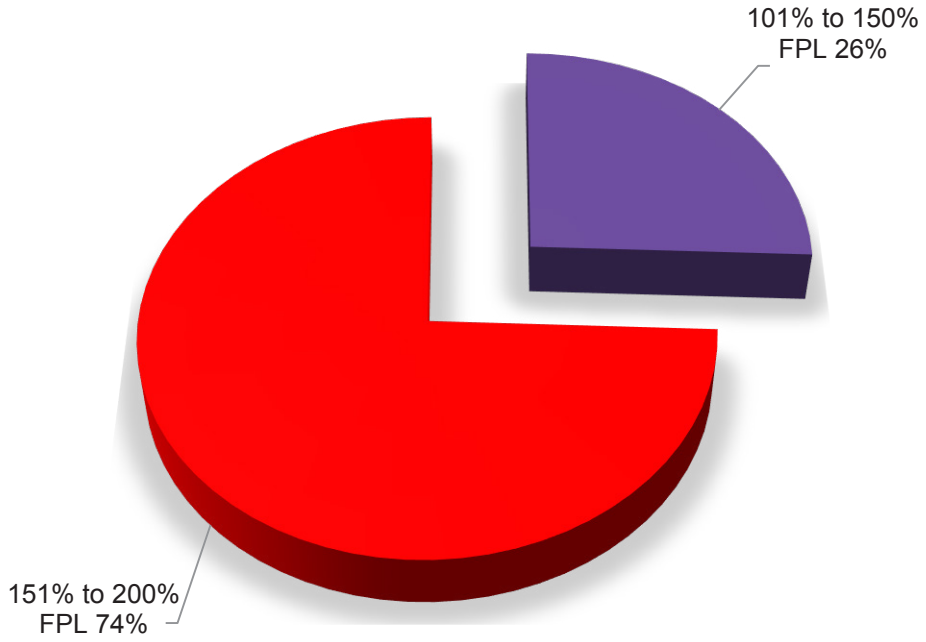


FIGURE 30

Table 24 shows that sixty-nine percent of CHIP and UPP children reside in the Wasatch Front (Davis, Salt Lake, Weber, and Utah counties). Thirty-one percent reside in the remaining 25 counties.

TABLE 24: Unduplicated CHIP Enrollment by Fiscal Year, Location and FPL

Location	Federal Poverty Guide	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015
Non-Wasatch Front	101% to 150% FPL	4,679	4,435	4,215	2,864	1,097
	151% to 200% FPL	2,923	2,652	2,530	2,731	3,146
	Less than 100% FPL	5,476	4,972	4,495	1,954	0
	UPP	106	73	56	72	93
Non-Wasatch Front Total		13,184	12,132	11,296	7,621	4,336
Wasatch Front	101% to 150% FPL	10,325	10,003	10,034	7,073	3,039
	151% to 200% FPL	6,442	5,929	5,909	6,541	8,880
	Less than 100% FPL	10,915	10,078	9,421	4,084	0
	UPP	316	263	221	190	340
Wasatch Front Total		27,998	26,273	25,585	17,888	12,259
Grand Total		**41,182**	**38,405**	**36,881**	**25,509**	**16,595**

Figure 31 shows the urban and rural percentages of enrollment between FY 2011 and FY 2015.

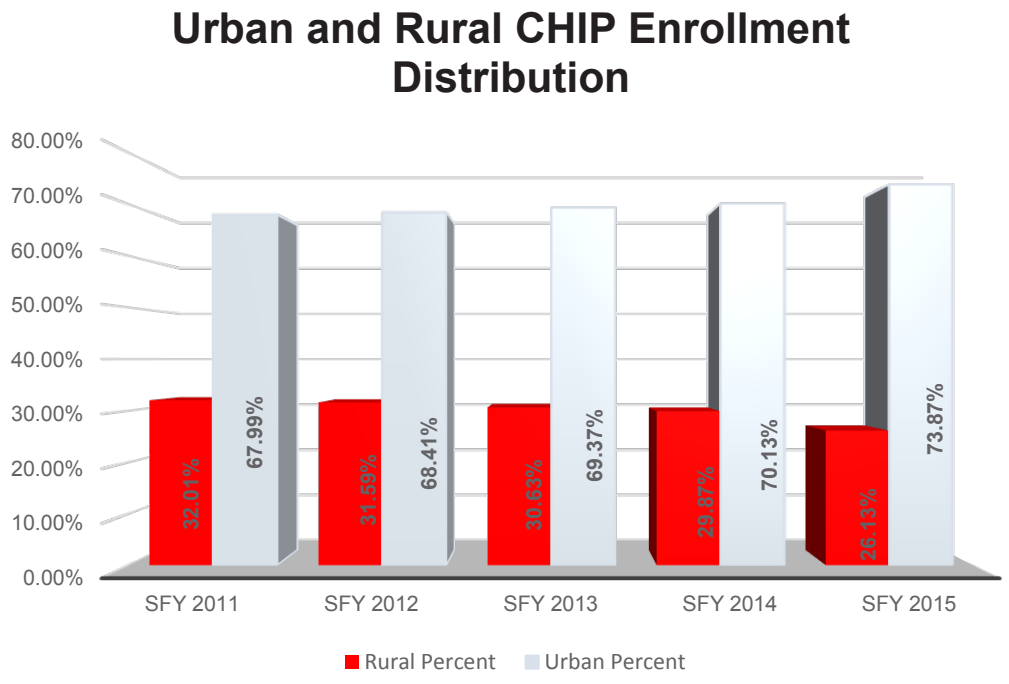


FIGURE 31

Figure 32 shows how CHIP enrollment is distributed by age range.

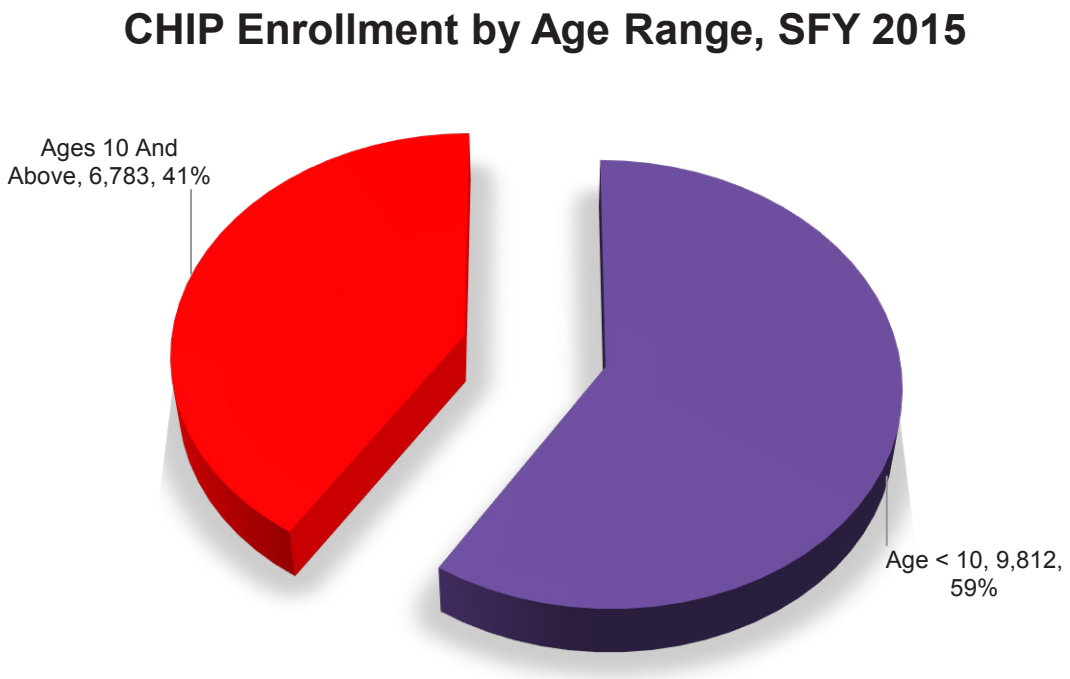


FIGURE 32

Figure 33 illustrates CHIP enrollment distribution by self–reported race. As such, in cases where members do not provide their race they are placed in the "other" category.

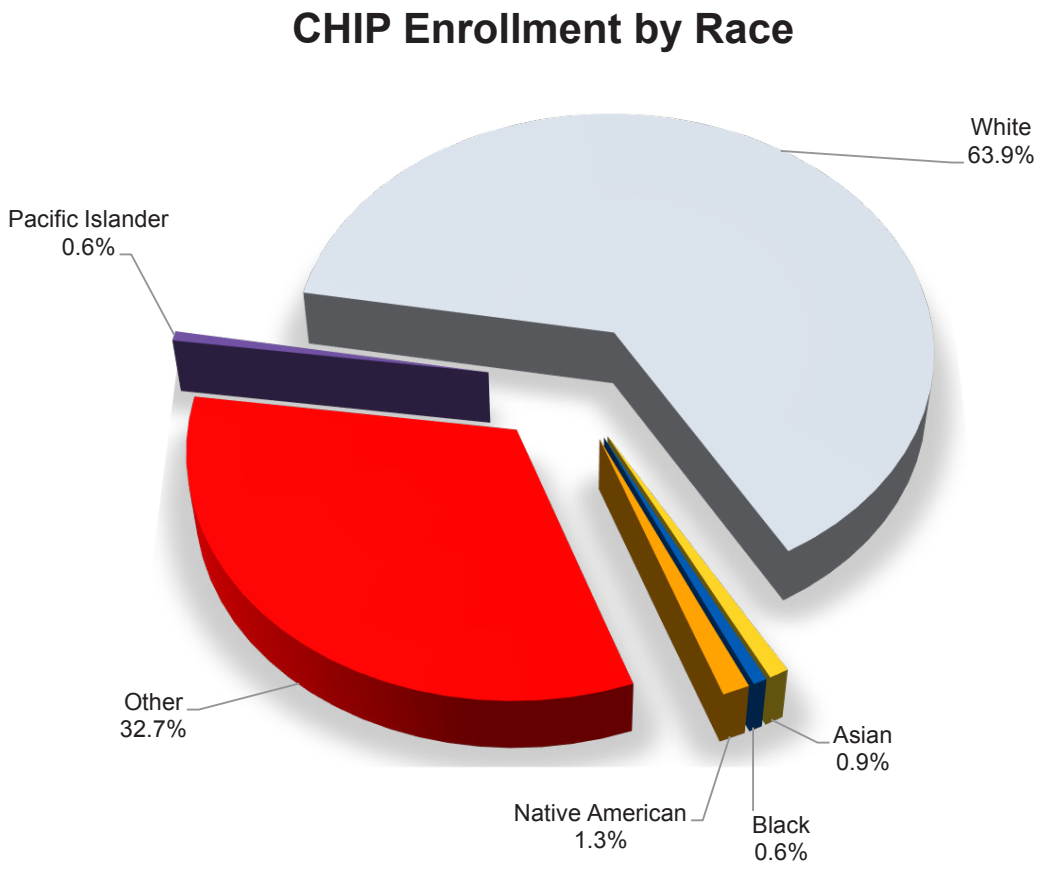


FIGURE 33

Table 25 presents CHIP enrollment by age and race.

TABLE 25: CHIP Enrollment by Age Range and Race						
Age Range	**Race**	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**
Age < 10	Asian	290	250	220	170	59
	Black	273	201	176	112	44
	Native American	272	208	200	170	97
	Other	461	1,675	2,631	2,868	4,588
	Pacific Islander	256	198	145	106	50
	White	19,278	16,211	14,383	9,536	4,974
Age < 10 Total		20,830	18,743	17,755	12,962	9,812
Ages 10 And Above	Asian	397	377	338	234	92
	Black	266	267	248	190	63
	Native American	385	345	320	240	112
	Other	269	1,021	1,415	948	831
	Pacific Islander	239	217	175	124	53
	White	18,796	17,435	16,630	10,810	5,632
Ages 10 And Above Total		20,352	19,662	19,126	12,546	6,783
Grand Total		**41,182**	**38,405**	**36,881**	**25,508**	**16,595**

CHIP Benefits

MEDICAL

CHIP provides 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 and x-rays
- Prescriptions
- Hearing and vision screening exams
- Mental health services

DENTAL

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

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

Appendix A: Federal Poverty Levels

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

TABLE A: HHS Poverty Guidelines				
Persons in family/household	100% FPL	133% FPL	150% FPL	200% FPL
1	$11,770	$15,654	$17,655	$23,540
2	$15,930	$21,187	$23,895	$31,860
3	$20,090	$26,720	$30,135	$40,180
4	$24,250	$32,253	$36,375	$48,500
5	$28,410	$37,785	$42,615	$56,820
6	$32,570	$43,318	$48,855	$65,140
7	$36,730	$48,851	$55,095	$73,460
8	$40,890	$54,384	$61,335	$81,780
For each additional person, add:	$4,160	$5,533	$6,240	$8,320

Table B contains poverty level comparison between the United States, as a whole, and the state of Utah.

TABLE B: United States versus Utah Federal Poverty Level Comparison		
Poverty Level	United States	Utah
Below 100% Poverty	14.50%	8.30%
101% - 125% of Poverty	4.70%	5.00%
126% - 138% of Poverty	2.40%	2.60%
138% - 150% of Poverty	2.70%	2.30%
150% - 185% of Poverty	6.70%	6.70%
186% - 200% of Poverty	2.90%	3.60%

Source: United States' Census Bureau http://www.census.gov/

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

Income Limits for Medical Assistance & Medicaid Cost-Sharing Programs

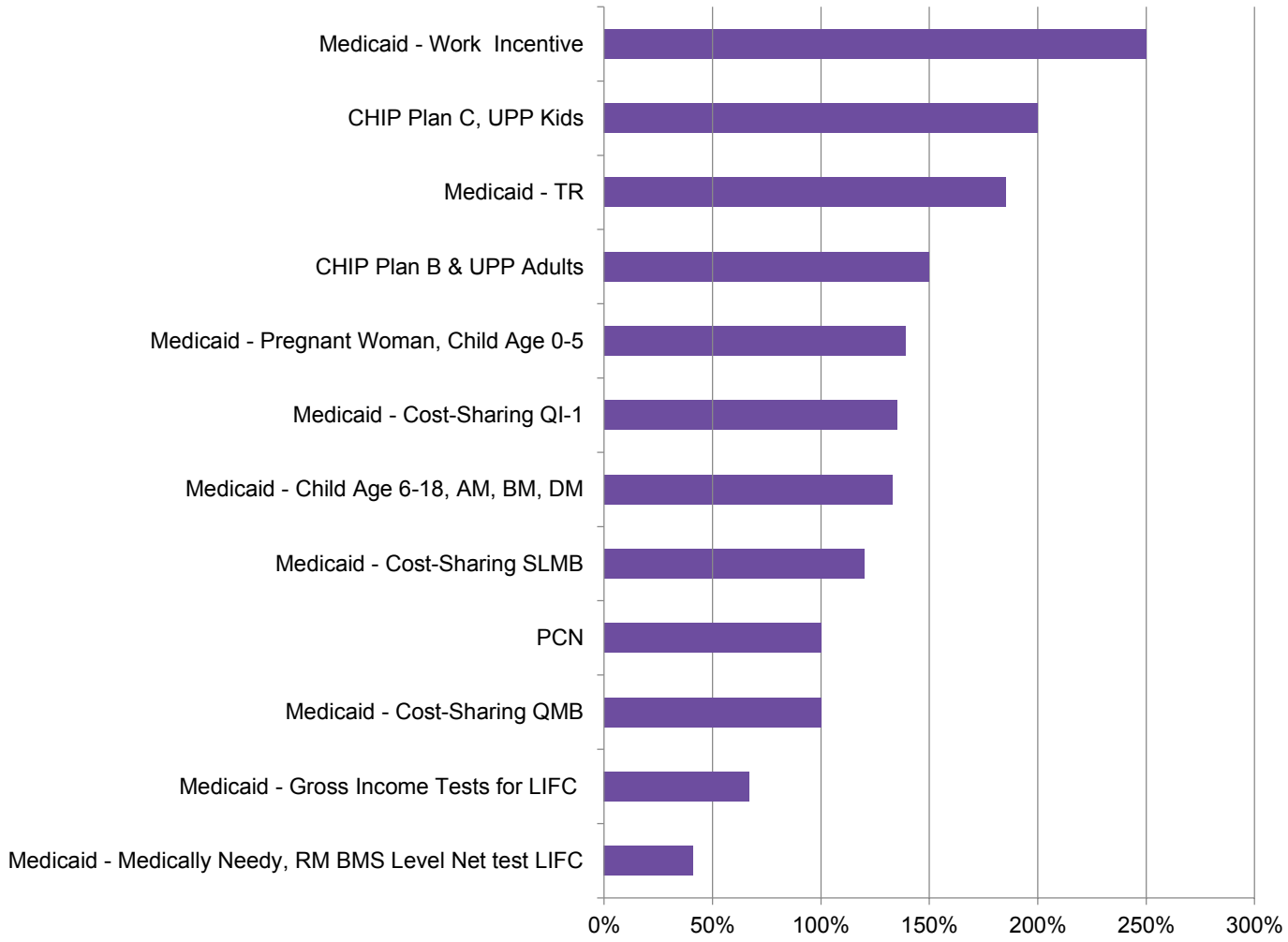


FIGURE A

Appendix B: Glossary

TITLE XIX - MEDICAID	Title XIX of the Social Security Act requires states to establish Medicaid programs to provide medical assistance to low income individuals and families. Within broad federal rules, each state decides eligible coverage groups, eligibility criteria, covered services, payment levels, and administrative and operating procedures.
TITLE XXI – STATE CHILDREN'S HEALTH INSURANCE PROGRAM	The purpose of Title XXI is to provide funding to assist states in providing medical coverage to uninsured, low income children in an effective manner.
AID CATEGORIES	A designation under which a person may be eligible for medical assistance.
ARREARS	The amount of money owed to a state or to a Non-IV-A participant that was not paid when due.
CAPITATION	A reimbursement method where the contractor is paid a fixed amount (premium) per member per month.
CATEGORY OF ASSISTANCE	A group of aid categories consisting of clients with similar Medicaid eligibility. Examples include the Elderly, Visually Impaired, and People with Disabilities.
CATEGORY OF SERVICE	A group of services that are provided by a common provider. Examples include Inpatient Hospital, Outpatient Hospital, and Physician Services.
CHIP	The Children's Health Insurance Program is a state health insurance plan for children. Depending on income and family size, working Utah families who do not have other health insurance may qualify for CHIP.
CHIP-I-CAID	The population of children that were open for CHIP and became eligible for Medicaid as a result of the ACA.
CLAWBACK PAYMENTS	Federally required payments to the Medicare program that began in 2006 to cover the pharmacy needs of Medicare clients that were also eligible for Medicaid.
CMS	Centers for Medicare and Medicaid Services is a federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.
DOH	Refers to the Utah Department of Health.
DHS	Refers to the Utah Department of Human Services.
DSH	Disproportionate Share payments made by the Medicaid program to hospitals designated as serving a disproportionate share of low-income or uninsured patients. DSH payments are in addition to regular Medicaid payments for providing care to Medicaid members. 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.
MEMBER	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 behavioral health services to Medicaid clients.

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

Appendix C: DMHF Waivers

Waiver programs currently in effect in the state of Utah:

WAIVER TYPE 1115

Primary Care Network (PCN)

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

WAIVER TYPE 1915(b)

Choice of Health Care Delivery Program & Hemophilia Disease Management Program

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

Prepaid Mental Health Plan

This waiver allows Medicaid to mandatorily enroll most Title XIX recipients in 28 counties in this plan. Contracted mental health centers provide services covered under the waiver on an at-risk capitation basis.

WAIVER TYPE 1915(c)

Waiver for Individuals Aged 65 and Older (Aging Waiver)

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

Waiver for Individuals with Acquired Brain Injuries

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

Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions

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

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

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

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

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


UTAH DEPARTMENT OF
HEALTH
MEDICAID