



# INTENT LANGUAGE FOLLOW-UP FROM PRIOR YEARS

SOCIAL SERVICES APPROPRIATIONS SUBCOMMITTEE  
STAFF: RUSSELL FRANSEN

ISSUE BRIEF

**SUMMARY**

The objective of this issue brief is to determine if the Department of Health complied with the 25 intent language statements adopted by the Legislature during the 2011 General Session and 9 intent language statements from the 2010 General Session that had impacts through June 30, 2011. This issue brief provides a follow up to each of the pieces of intent language passed. The Analyst has no concerns of non-compliance. This brief is for informational purposes only requires no Legislative action.

**DISCUSSION AND ANALYSIS**

The Analyst has no concerns of non-compliance with any intent language issued last year, neither does the Department of Finance. The following is a list of 25 legislative intent statements from the 2011 General Session with the Department of Health’s response or comments by the Analyst. Intent language may be adopted by the Legislature to explain or place conditions on the use of funds. Intent language is binding for one year and may not contradict or change statutory language. Follow up to intent language related to ARRA (federal stimulus) funding can be found in the Issue Brief entitled “ARRA Funds Approval.” The Subcommittee may want to direct the agency to take further action on the information presented in the reports requested by the Legislature.

***Intent Language from the 2011 General Session***

There are 25 intent language statements reviewed below. These 25 statements can be grouped into the following three categories (intent language #24 requires a report and provides specific direction and is counted twice):

| <b><u>Nonlapsing Authority via Intent Language</u></b> |                         |                          |
|--|-------------------------|--------------------------|
| <b>Purpose</b>   | <b>Authorized Total</b> | <b>Actual Nonlapsing</b> |
| Medicaid Management Information System Replacement     | \$ 3,223,600            | \$ 2,488,400             |
| Primary Care Grants Program                            | \$ 400,000              | \$ -                     |
| Laboratory Equipment                                   | \$ 250,000              | \$ 250,000               |
| Facility Plan Review Activities                        | \$ 210,000              | \$ 67,100                |
| Equipment and Improvements                             | \$ 175,000              | \$ 175,000               |
| Computer Equipment                                     | \$ 90,000               | \$ 90,000                |
| Bleeding Disorders Program                             | \$ 50,000               | \$ 50,000                |
| Computer Equipment                                     | \$ 50,000               | \$ 40,400                |
| Children’s Health Insurance Program                    | all                     | \$ 649,300               |
| Emergency Medical Services - Fees                      | all                     | \$ 250,000               |
| Provider Trainings (Child Care)                        | all                     | \$ 85,600                |
| Civil Money Penalties                                  | all                     | \$ 19,400                |
| <b>Total</b>   | <b>\$ 4,448,600</b>     | <b>\$ 4,165,200</b>      |

1. Providing nonlapsing authority of more than \$4.5 million in FY 2012 from FY 2011 funds (13 intent language statements). The table above details the \$4.5 million of specific nonlapsing authority provided as well as the three areas with unlimited nonlapsing authority. The Department of Health has

\$4,165,100 in nonlapsing from these intent language statements. For more information on the purposes and uses of these nonlapsing balances, please see the Issue Brief entitled “Nonlapsing Balances.”

2. Requiring a report (10 intent language statements)
3. Providing specific direction (3 intent language statements)

### **1. Nonlapsing Authority for Computer Equipment in the Executive Director’s Office (H.B. 3, Item 72):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Executive Director’s Office in Item 95 of Chapter 2 Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to \$90,000 for computer equipment and/or software. (The agency nonlapsed \$90,000).*

**Agency Response: “The division anticipates the entire \$90,000 and more will be expended for [Data Processing] equipment and replacement in FY12.”**

### **2. Nonlapsing Authority for Civil Penalty Money from Childcare and Health Care Provider Violations (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that civil money penalties collected for Item 204 of Chapter 408, Laws of Utah 2010 from childcare and health care provider violations not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to trainings for providers. (The agency nonlapsed \$85,600).*

**Agency Response: “Non lapsing Childcare funds are used to deliver ongoing training throughout the state to assist providers in complying with the rules. Non lapsing funds are used for trainer salaries and for in-state travel costs and training materials. Funds collected in one year are used to pay for training in the next year. We anticipate spending all the nonlapsing funding this year.**

**The non-lapsing funds for Health Facility Licensing/Certification were not used this year. The Centers for Medicare/Medicaid Services (CMS) must authorize expenditures in this area for residents of nursing facilities. Some projects may be proposed by the Utah Health Care Association in the coming year to utilize these funds for the residents of nursing care facilities. Some of these funds may also be used for a CMS grant for background screening in the coming year.”**

### **3. Nonlapsing Authority for Primary Care Grants Program (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$400,000 of Item 204 of Chapter 408, Laws of Utah 2010 for Primary Care Grants Program not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to final Fiscal Year 2011 contract payments to contractors based on contract reviews. (The agency nonlapsed \$0).*

**Agency Response: “The Primary Care Grants Program had no nonlapsing funds in FY2011”**

### **4. Nonlapsing Authority for Bureau of Health Facility Licensure, Certification and Resident Assessment for Plan Reviews (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$210,000 of Item 204 of Chapter 408, Laws of Utah 2010 from fees collected for the purpose of plan reviews by the Bureau of Health Facility Licensure, Certification and Resident Assessment not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to plan review activities. (The agency nonlapsed \$67,100).*

**Agency Response: “The funds were used for evaluating health care facility new construction and remodel projects to ensure compliance with appropriate building and fire codes in accordance with state health facility**

**construction rules. The funds were used for salaries for architects and inspection staff to complete construction reviews.”**

**5. Nonlapsing Authority for People with Bleeding Disorders (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$50,000 of Item 204 of Chapter 408, Laws of Utah 2010 of unused funds appropriated for the Assistance for People with Bleeding Disorders Program not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to services to newly eligible clients. (The agency nonlapsed \$50,000).*

**Agency Response: “The nonlapsing funding will be used to assist newly eligible bleeding disorders clients.”**

**6. Nonlapsing Authority for Testing Supplies and Processes for Emergency Medical Services (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$250,000 of Item 204 of Chapter 408, Laws of Utah 2010 for Emergency Medical Services not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to testing, certifications, background screenings, replacement testing equipment, and testing supplies. (The agency nonlapsed \$250,000).*

**Agency Response: “The nonlapsing funds will be used for practical and written testing for EMS certification. Training requirements include classroom hours, certain hours of clinical experience, and a competency exam. Quality assurance reviews will also be conducted by staff for courses, recertification practical testing and licensing.”**

**7. Nonlapsing Authority for Criminal Fine and Forfeiture Money for Emergency Medical Services (H.B. 3, Item 73):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that criminal fines and forfeiture money collected for Emergency Medical Services in Item 204 of Chapter 408, Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to purposes outlined in Section 26-8a-207(2). (The agency nonlapsed \$19,300).*

**Agency Response: “The nonlapsing funds will be used in accordance with statute, which includes EMS grants and administrative costs. These funds will be distributed to all local EMS agencies and training centers to be used for the purchase of equipment, supplies, and EMS training to help deliver emergency medical services to the citizens of the state.”**

**8. Nonlapsing Authority for Laboratory Equipment (H.B. 3, Item 74):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Disease Control and Prevention in Item 202 of Chapter 408 Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to the following: \$250,000 for laboratory equipment, computer equipment and/or software and building improvements for the Unified State Laboratory. (The agency nonlapsed \$250,000).*

**Agency Response: “The nonlapsing funds were expended for replacement of aging laboratory equipment and updating of software needed to support testing equipment. Laboratory equipment must maintain high levels of sensitivity and accuracy. Their useful lifetime is often limited and as technology advances they rapidly become obsolete. Continuous replacement or upgrading is required to maintain accuracy, meet required laboratory testing standards, and certifications.”**

**9. Nonlapsing Authority for Equipment and Improvements for the Medical Examiner (H.B. 3, Item 74):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Disease Control and Prevention in Item 202 of Chapter 408 Laws of Utah 2010 not*

*lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to the following: \$175,000 for replacement computer equipment, software, laboratory equipment, and for facility improvements/expansion for the Office of the Medical Examiner. (The agency nonlapsed \$175,000).*

**Agency Response:** “The nonlapsing funds were used to replace obsolete computer equipment, upgrade the autopsy and specimen handling facilities, and equipment. Upgrading and replacement is necessary to maintain the required national medical examiner standards and proper documentation while handling a significantly large and increasing workload of cases.”

**10. Authority Changing Allowed Use of FY 2010 Nonlapsing Funds for Drug Prevention Programs (H.B. 3, Item 74):**

*Notwithstanding the intent language included in Item 66 of Chapter 408, Laws of Utah 2010, the Legislature intends that any nonlapsing funds authorized by that item that carried forward into FY 2011 be used to address FY 2011 appropriation reductions resulting from revenue shortfalls in the Tobacco Restricted Account. Use of these funds is limited to alcohol, tobacco, and drug prevention, reduction, cessation, and control programs or for emergent disease control and prevention needs. (The agency nonlapsed \$0).*

**Agency Response:** “Nonlapsing funds carried forward into FY2011 were expended in support of the continuation of tobacco use reduction, cessation, and control programs conducted statewide and to ensure the continued availability of quit-line services.”

**11. Nonlapsing Authority for Computer Equipment in Health Care Financing (H.B. 3, Item 75):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Health Care Financing in Item 101 of Chapter 2 Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to \$50,000 for the purchase of computer equipment. (The agency nonlapsed \$40,400).*

**Agency Response:** “The division anticipates the entire non laps amount and more will be expended for [Data Processing] equipment and replacement in FY12.”

**12. Nonlapsing Authority for Medicaid Management Information System Replacement (H.B. 3, Item 76):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Medicaid Management Information System Replacement in Item 207 of Chapter 408 Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to \$3,223,600 for the redesign and replacement of the Medicaid Management Information System. (The agency nonlapsed \$2,488,400).*

**For more information please see the budget brief entitled “Medicaid Management Information System Replacement.”**

**13. Nonlapsing Authority for the Children’s Health Insurance Program (H.B. 3, Item 79):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for the Children’s Health Insurance Program in Item 104 of Chapter 2 Laws of Utah 2010 not lapse at the close of Fiscal Year 2011. The use of any nonlapsing funds is limited to caseload and utilization increases. (The agency nonlapsed \$649,300).*

**Agency Response:** “The Department anticipates this funding will be expended in FY 2012 for CHIP caseload and utilization.”

**14. Report on Implementing Medicaid Audits (S.B. 2, Item 78):**

*The Legislature intends that the Department of Health provide a report to the Office of the Legislative Fiscal Analyst by December 1, 2011 on the status of implementing recommendations from the following audits: (1) A Performance Audit of Utah Medicaid Provider Cost Control and (2) A Follow-up of Utah's Medicaid Implementation of Audit Recommendations. The items to be followed up on would be less to the extent that an Independent Medicaid Inspector General is established and takes over the responsibility for implementation of some recommendations. The report would not be needed if a follow up audit is prioritized for the Legislative Auditor General by July 1, 2011.*

**Analyst Note:** The Legislative Auditor General released a follow up audit report in January 2012, which is available at [http://le.utah.gov/audit/12\\_03rpt.pdf](http://le.utah.gov/audit/12_03rpt.pdf).

**15. Report on Reimbursement Alternatives for Inpatient Hospital Outlier Payments (S.B. 2, Item 78):**

*The Legislature intends that the Department of Health report by October 1, 2011 to the Office of the Legislative Fiscal Analyst on reimbursement alternatives for inpatient hospital outlier payments that would give the State more control over inflationary increases and/or move away from a reimbursement based on billed charges. The report also shall explain the measures the Department takes to verify the validity of outlier claims. This report should include a report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011 and options for moving away from paying as a percentage of billed charges.*

**Agency Response:** The full report can be found at <http://health.utah.gov/medicaid/stplan/LegReports/Inpatient%20Outlier%20Payment%20Report%20to%20LFA%209-30-2011.pdf> and is Appendix A.

**16. Requests for Information on SB 180 (S.B. 2, Item 78):**

*The Legislature intends that if SB 180 Medicaid Reform passes, the Department of Health shall issue requests for information and report back a summary of the results to the Office of the Legislative Fiscal Analyst by four months prior to providing services via new contracts.*

**Agency Response:** "The requirement is that we report four months prior to providing services via new contracts. At this time we are further than four months from providing services and have not completed a report to submit."

**17. Quarterly Status Reports on Replacement of Medicaid Management Information System (S.B. 2, Item 79):**

*The Legislature intends that the Department of Health report quarterly to the Office of the Legislative Fiscal Analyst on the status of replacing the Medicaid Management Information System replacement beginning September 30, 2011. The reports should include, where applicable, the responses to any requests for proposals.*

**Agency Response:** The most recent quarterly report can be found at [http://health.utah.gov/medicaid/stplan/LegReports/HB2%20MMIS%20Quarterly%20Report\\_2012-01-01.pdf](http://health.utah.gov/medicaid/stplan/LegReports/HB2%20MMIS%20Quarterly%20Report_2012-01-01.pdf) and is Appendix B.

**18. Report on Increasing Public Awareness of Reporting Medicaid Fraud (S.B. 2, Item 80):**

*The Legislature intends that the Departments of Health, Human Services, and Workforce Services report to the Office of the Legislative Fiscal Analyst by November 1, 2011 on how they will increase public awareness of their fraud reporting systems and encourage the public to report Medicaid fraud.*

**Agency Response:** The full report can be found at [http://www.le.utah.gov/lfa/reports/bbib/appsoc\\_1-24-12\\_5.pdf](http://www.le.utah.gov/lfa/reports/bbib/appsoc_1-24-12_5.pdf) and is Appendix C. This report came on December 30, 2011.

**19. Report on Agency Suggestions from Medicaid Survey (S.B. 2, Item 80):**

*The Legislature intends that the Departments of Health, Human Services, Workforce Services, and the Medicaid Fraud Control Unit report to the Office of the Legislative Fiscal Analyst by July 1, 2011 on how they will coordinate their response to the 34 recommendations within the State's control from State agencies contained in the issue brief entitled Medicaid Survey Results (<http://le.utah.gov/interim/2011/pdf/00000179.pdf>). Additionally, these agencies shall report by December 1, 2011 on specific plans of action or reasons for not acting on the 34 recommendations so that the Legislature may decide what additional action may be needed.*

**Agency Response:** The full report can be found at [http://www.le.utah.gov/lfa/reports/BBIB/APPSOC\\_1-26-12\\_1.pdf](http://www.le.utah.gov/lfa/reports/BBIB/APPSOC_1-26-12_1.pdf).

**20. Report on Suggestions from the Public in Medicaid Survey (S.B. 2, Item 80):**

*The Legislature intends that the Departments of Health, Human Services, Workforce Services, and the Medicaid Fraud Control Unit report to the Office of the Legislative Fiscal Analyst by January 1, 2012 on plans to follow up feasible recommendations that could be implemented from the 945 comments from the public in the issue brief entitled Medicaid Survey Results (<http://le.utah.gov/interim/2011/pdf/00000179.pdf>). This report will allow the Legislature to decide what additional action may be needed.*

**Agency Response:** The full report can be found at [http://www.le.utah.gov/lfa/reports/BBIB/APPSOC\\_1-26-12\\_2.pdf](http://www.le.utah.gov/lfa/reports/BBIB/APPSOC_1-26-12_2.pdf).

**21. Report on Additional Screening Tools in Medicaid (S.B. 2, Item 80):**

*The Legislature intends the Department of Health and the Department of Workforce Services study the cost and benefits of potentially using additional tools for provider screening, asset verification, and beneficiary screening and report back recommendations for further action to the Office of the Legislative Fiscal Analyst by September 1, 2011.*

**Agency Response:** The full report can be found at <http://health.utah.gov/medicaid/stplan/LegReports/2011%20Additional%20Tools%20Screening%20and%20Verification%20Report.pdf>.

**22. Report on Single Point of Entry to Determine Medicaid Long Term Care Eligibility (S.B. 2, Item 81):**

*The Legislature intends the Department of Health and the Department of Human Services study the cost and benefits of having a single point of entry to determine eligibility for clients seeking any type of Medicaid long term care services. The Departments shall additionally report on the potential cost and benefits of using a non-State entity to provide the single point of entry services. The Departments shall report back recommendations for further action in one combined report to the Office of the Legislative Fiscal Analyst by September 1, 2011.*

**Agency Response:** The full report can be found at <http://health.utah.gov/medicaid/stplan/LegReports/2011%20Long%20Term%20Care%20Single%20Point%20of%20Entry%20Study.pdf> and is Appendix D.

**23. No Interruption of Outpatient Hospital Payments (S.B. 3, Item 112):**

*The Legislature intends that when the Department of Health moves to Medicare-like outpatient payment methodologies beginning July 1, 2011 that hospital outpatient payments not be stopped or held pending adoption of this new methodology but rather that payments continue at the current rate until the department fully implements this new payment methodology so that no payment disruptions occur.*

**Agency Response:** “The agency reports that payments continued at the current rate until the new payment methodology was fully implemented on September 1, 2011.”

**24. Report on Pharmacy Inflation Not Being Funded (S.B. 3, Item 113):**

*The Legislature intends that the Department of Health not adjust Medicaid pharmacy rates as a result of the Legislature not providing new funding for new pharmacy inflation in FY 2012. Additionally, the Legislature intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by December 1, 2011 on pharmacy inflation experienced during fiscal year 2012.*

**Agency Response:** The full report can be found at [http://health.utah.gov/medicaid/stplan/LegReports/LFA%20Report%20on%20Pharmacy%20Inflation%20\(2011-12-01\).pdf](http://health.utah.gov/medicaid/stplan/LegReports/LFA%20Report%20on%20Pharmacy%20Inflation%20(2011-12-01).pdf) and is Appendix E.

**25. Internally Fund Change to Capitated Dental Service Program (S.B. 3, Item 113):**

*The Legislature intends that the Department of Health fund the \$485,600 one-time General Fund costs of changing to a capitated dental service program in Medicaid within existing appropriations. If existing appropriations prove to be insufficient, the Legislature intends that the Department of Health request funding in future years to cover the one-time costs of changing to a capitated dental service program in Medicaid.*

**Agency Response:** “The Governor’s Budget recommends that this amount be funded in FY 2013 through a one-time General Fund appropriation.”

**Intent Language from the 2010 General Session**

The following ten items of intent language were passed in the 2010 General Session. These items could not be fully reviewed until the close of FY 2011. Most of these items were partially reviewed in an Issue Brief from the 2011 General Session entitled “Intent Language Follow-Up From Prior Year” (<http://le.utah.gov/interim/2011/pdf/00000376.pdf>).

There are ten intent language statements reviewed below. These ten statements can be grouped into the following three categories:

1. Providing nonlapsing authority of more than \$1,760,000 in FY 2011 from FY 2010 funds (8 intent language statements). For more information on the purposes and uses of these nonlapsing balances, please see the 2011 Issue Brief entitled “*Nonlapsing Balances*,” available at <http://le.utah.gov/interim/2011/pdf/00000378.pdf>.
2. Requiring a report (1 intent language statement)
3. Providing specific direction (1 intent language statement)

**1. Medicaid Outpatient Fee Schedule Changes (H.B. 2, Item 70):**

*The Legislature intends that the Department of Health establish a fee schedule for each of the following types of facilities: rural hospitals, urban hospitals, and ambulatory surgical centers. The first twenty-five percent of the new fee schedule should be implemented no later than July 1, 2010. Fifty percent should be implemented no later than October 1, 2010. Seventy-five percent should be implemented no later than January 1, 2011. The project should be completed by July 1, 2011.*

**The agency discussed its implementation of the fee schedule at the February 2, 2012 meeting of the Social Services Appropriations Subcommittee.**

**2. Quarterly Status Reports on Replacement of Medicaid Management Information System (H.B. 2, Item 207):**

*The Legislature intends that the Department of Health report quarterly to the Office of the Legislative Fiscal Analyst on the status of replacing the Medicaid Management Information System replacement beginning September 30, 2010. The reports should include, where applicable, the responses to any requests for proposals.*

**Analyst Note: For more information please see the budget brief entitled “*Medicaid Management Information System Replacement*” available at [http://www.le.utah.gov/lfa/reports/BBIB/APPSOC\\_2-2-12\\_7.pdf](http://www.le.utah.gov/lfa/reports/BBIB/APPSOC_2-2-12_7.pdf).**

**3. Nonlapsing Authority for Medicaid Management Information System (H.B. 2, Item 69):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$350,000 of Item 99 of Chapter 1, Laws of Utah 2007, Volume 1 for funding of the Medicaid Management Information System not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to the redesign of the Medicaid Management Information System and implementing recommendations from the Legislative Auditor General's audits in Medicaid.*

**Agency Response: “The Division non-lapsed \$250,000 at the close of FY2010. The funds were used to procure Medicare software to implement the Legislative mandate to adopt the Medicare reimbursement system for outpatient hospital payments. See MMIS Budget Brief for work progress status.”**

**4. Nonlapsing Authority for Laboratory Equipment (H.B. 2, Item 67):**

*Under Section 63J-1-603 of the Utah Code the Legislature intends that appropriations provided for Epidemiology and Laboratory Services in Item 96 of Chapter 396 Laws of Utah 2009, Volume 2 not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to \$250,000 for laboratory equipment, computer equipment and/or software and building improvements.*

**Agency Response: “USL [Utah State Laboratories] uses its nonlapsing account monies to fund replacement of critical laboratory equipment and provide required upgrades to our computer system. Because USL has no equipment fund to replace or upgrade these critical systems, yet relies on the proper functioning of millions**

of dollars worth of scientific equipment to keep Utahns safe, these funds are nearly always used to replace broken equipment or dysfunctional computer systems. Such are our plans for the remainder of FY2011.”

#### 5. Nonlapsing Authority for Primary Care Grants Program (H.B. 2, Item 68):

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$400,000 of Item 94 of Chapter 396, Laws of Utah 2009, Volume 2 for Primary Care Grants Program not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to final Fiscal Year 2010 contract payments to contractors based on contract reviews.*

**Agency Response:** “Due to the stipulations contained in the intent language no funds were carried over to FY2012 from FY2011. All payments for primary care contracts were completed in FY2011 therefore no ending balances could be considered for nonlapsing authority. \$110,717 was lapsed back to the General fund from FY2011 due to the strict stipulations of the intent language.”

#### 6. Nonlapsing Authority for Bureau of Health Facility Licensure, Certification and Resident Assessment for Plan Reviews (H.B. 2, Item 68):

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$210,000 of Item 94 of Chapter 396, Laws of Utah 2009, Volume 2 from fees collected for the purpose of plan reviews by the Bureau of Health Facility Licensure, Certification and Resident Assessment not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to plan review activities.*

**Agency Response:** “The funds were used for evaluating health care facility new construction and remodel projects to ensure compliance with appropriate building and fire codes in accordance with state health facility construction rules. The funds were used for salaries for architects and inspection staff to complete construction reviews. \$67,100 was carried forward to FY12 and has been spent on plan review activities.”

#### 7. Nonlapsing Authority for People with Bleeding Disorders (H.B. 2, Item 68):

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$50,000 of Item 94 of Chapter 396, Laws of Utah 2009, Volume 2 of unused funds appropriated for the Assistance for People with Bleeding Disorders Program not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to services to newly eligible clients.*

**Agency Response:** “The nonlapsing funds were used for newly eligible bleeding disorders clients. The entire \$50,000 nonlapsing fund has been paid to the Utah Hemophilia Foundation.”

#### 8. Nonlapsing Authority for Civil Penalty Money from Childcare and Health Care Provider Violations (H.B. 2, Item 68):

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that civil penalties money collected for Child Care Licensing and Health Care Licensing in Item 94 of Chapter 396, Laws of Utah 2009, Volume 2 from childcare and health care provider violations not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to trainings for providers.*

**Agency Response:** “Non lapsing Childcare funds were used to deliver ongoing training throughout the state to assist providers in complying with the rules. Non lapsing funds were used for trainer salaries and for in-state travel costs and training materials. Funds collected in one year are used to pay for training in the next year. We anticipate spending all the nonlapsing funding this year.

**The non-lapsing funds for Health Facility Licensing/Certification were not used this year. The Centers for Medicare/Medicaid Services (CMS) must authorize expenditures in this area for residents of nursing facilities.”**

**9. Nonlapsing Authority for Drug Prevention and Reduction Programs (H.B. 2, Item 66):**

*Under Section 63J-1-603 of the Utah Code, the Legislature intends that up to \$500,000 of Item 97 of Chapter 396, Laws of Utah 2009, Volume 2 for the alcohol, tobacco, and other drug prevention reduction, cessation, and control programs not lapse at the close of Fiscal Year 2010. The use of any nonlapsing funds is limited to unexpended funds in contracts issued for Fiscal Year 2010 for the purposes outlined in those contracts.*

**Analyst Note: This nonlapsing authority was changed by intent language #10 from the 2011 General Session discussed above.**

**10. Nonlapsing Authority for Medicaid Sanctions (H.B. 3, Item 136):**

*The Legislature intends that funds collected as a result of sanctions imposed under Section 1919 of Title XIX of the federal Social Security Act and authorized in UCA 26-18-3 shall not lapse at the close of fiscal year 2011.*

**Agency Response: “FY10 Medicaid non Lapsing civil money penalties from HSI Health Facility Licensing \$383,400 and Medicaid MMS of \$699,500 were combined into a new line item Medicaid Sanctions for \$1,082,900. Use of these funds is limited by federal Statute for remediation of provider deficiencies in patient care. No expenditures we made in FY10.”**

**APPENDIX A - REIMBURSEMENT ALTERNATIVES FOR INPATIENT HOSPITAL OUTLIER PAYMENTS**

# Report to the Office of the Legislative Fiscal Analyst

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## Reimbursement Alternatives for Inpatient Hospital Outlier Payments

Prepared by the Division of Medicaid and Health Financing

September 30, 2011



## EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in Senate Bill 2, lines 868 through 878, by the 2011 Legislature:

The Legislature intends that the Department of Health report by October 1, 2011 to the Office of the Legislative Fiscal Analyst on reimbursement alternatives for inpatient hospital outlier payments that would give the State more control over inflationary increases and/or move away from a reimbursement based on billed charges. The report also shall explain the measures the Department takes to verify the validity of outlier claims. This report should include a report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011 and options for moving away from paying as a percentage of billed charges.

### **Reimbursement Alternatives for Inpatient Hospital Outlier Payments That Would Give the State More Control**

Staff researched several states and Medicare for outlier payment methodologies. All states researched pay a percent of charges when the outlier threshold is reached. The difference across programs relates primarily to how the claim is determined to have exceeded the threshold, and what percent of charges is paid.

Some states (MS, OK, PA, WA, OH, KY, and RI) determine whether the threshold is exceeded by estimating the costs of the claim, based on the hospital specific cost-to-charge ratio (CCR), and determining whether the costs exceed the base payment by a specified threshold. If the costs exceed the base payment by the predetermined threshold, some percentage of the estimated costs is paid.

Other states (NJ and TX), determine whether the threshold is exceeded by comparing total charges to the base payment. If the charges exceed the base payment by the predetermined threshold, they pay some percentage of charges based on the hospital specific CCR, and any other applicable reduction factors the state may have.

In some states (TX and PA), payment may also be made when the length of stay exceeds a predetermined outlier threshold. These generally pay a per diem that is set by using the average per diem rate (base DRG payment / avg. length of stay) and applying some adjustment factor to that amount. Texas does not allow for both a cost outlier and a length of stay (LOS) outlier payment. Pennsylvania, on the other hand, does allow for both simultaneously.

Some states (MS and RI) have a LOS outlier system in place only for inpatient hospital mental health related claims. In these cases, the LOS outlier payments take the place of the cost outlier payments.

Additionally, Medicare determines if the charges exceed the predetermined threshold and pays a percent of charges based on the hospital specific CCR.

| <b>Administrator</b> | <b>Method</b>  |
|----------------------|--|
| Mississippi          | Pays 50% of costs exceeding base DRG payment when costs exceed outlier threshold |
| Oklahoma             | Pays % of costs (based on hospital CCR) above outlier threshold                  |
| Pennsylvania (Costs) | Pays 100% of costs when costs exceed 150% of DRG base payment                    |
| Pennsylvania (LOS)   | Pays 60% of per diem DRG rate when LOS exceeds LOS outlier threshold             |
| Texas (Costs)        | Pays 70% of charges exceeding outlier threshold                                  |
| Texas (LOS)          | Pays 70% of per diem DRG rate when LOS exceeds LOS outlier threshold             |
| Washington           | Pays 100% of costs when costs exceed 175% of DRG base payment                    |
| Ohio                 | Pays 100% of costs when costs exceed outlier threshold                           |
| New Jersey           | Pays % of charges (based on hospital CCR) above outlier threshold                |
| Kentucky             | Pays 80% of costs exceeding the outlier threshold                                |
| Rhode Island         | Pays 60% of costs above Base DRG Payment when costs exceed outlier threshold     |
| Medicare             | Pays % of charges (based on hospital CCR) above outlier threshold                |

**Explanation of Measures the Department Takes to Verify the Validity of Outlier Claims**

Inpatient claims are reviewed by Program Integrity within the Office of Inspector General for Medicaid Services. Following are some pertinent provision in Rule:

**R414-1-12. Utilization Review.**

- (1) The Department conducts hospital utilization review as outlined in the Superior System Waiver in effect at the time service was rendered.
- (2) The Department shall determine medical necessity and appropriateness of inpatient admissions during utilization review by use of InterQual Criteria, published by McKesson Corporation.
- (3) The standards in the InterQual Criteria shall not apply to services in which a determination has been made to utilize criteria customized by the Department or that are:
  - (a) excluded as a Medicaid benefit by rule or contract;
  - (b) provided in an intensive physical rehabilitation center as described in Rule R414-2B; or
  - (c) organ transplant services as described in Rule R414-10A.

In these exceptions, or where InterQual is silent, the Department shall approve or deny services based upon appropriate administrative rules or its own criteria as incorporated in the Medicaid provider manuals.

R414-1-14. Utilization Control

(2) The Department may request records that support provider claims for payment under programs funded through the Department. These requests must be in writing and identify the records to be reviewed. Responses to requests must be returned within 30 days of the date of the request. Responses must include the complete record of all services for which reimbursement is claimed and all supporting services. If there is no response within the 30 day period, the Department will close the record and will evaluate the payment based on the records available.

**A report on any other reimbursements based on billed charges that totaled over \$1,000,000 total funds in FY 2011**

Aside from the outlier payments for inpatient hospital stays, the only other Medicaid reimbursement methodology paying more than \$1 million in FY 2011 was outpatient hospital reimbursement. As has been directed in previous legislative intent language, the Department of Health converted to a prospective payment system for outpatient hospital payments in FY 2012, but that had not been completed prior to the close of FY 2011.

**APPENDIX B - QUARTERLY STATUS REPORTS ON REPLACEMENT OF MEDICAID MANAGEMENT INFORMATION SYSTEM**



State of Utah

GARY R. HERBERT  
Governor

GREG BELL  
Lieutenant Governor

**Utah Department of Health**

W. David Patton, PhD  
Executive Director

**Division of Medicaid and Health Financing**

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

December 30, 2011

Jonathan Ball, Director  
Office of Legislative Fiscal Analyst  
State Capitol Complex  
House Building, Suite W310  
Salt Lake City, UT 84114

Reference: Medicaid Management Information System Quarterly Report

Dear Mr. Ball:

Legislative intent language from the 2011 Legislative General Sessions directs the Utah Department of Health to report quarterly on the status of replacing the Medicaid Management Information System (MMIS). This letter and its contents constitute the Department’s report for the quarter ending December 31, 2011.

**MMIS Replacement Project Status by Component**

*Pre-Payment Editing System*

The editing software has been in production since December 20, 2010. The total avoided claim payments for the fourth quarter of 2011 was \$608,751 for a cumulative total of \$2,024,438.

*Fraud and Abuse Detection System (FADS)*

The requirements for a FADS tool will be incorporated with the development of the new MMIS replacement. In the interim, the Department is providing the necessary data extracts and clarification of the data to the Medi-Medi contractor. The vendor is utilizing the State’s data to analyze Medicare-to-Medicaid claims.

*Point of Sale (POS) and Drug Rebate Management System (DRMS)*

The POS/DRMS contract was awarded to Goold Health Systems (GHS). In light of provider concerns on the timing of the proposed implementation dates and an extension from the federal government on the adoption of new prescription processing standards, the conversion to the new system was changed from January 1, 2012 to February 20, 2012. Implementation of the DRMS will follow based upon the CMS defined quarterly schedule. The first drug rebate cycle using the new DRMS will begin with the April – June 2012 claims data.

*Data Warehouse Upgrade*

The Data Warehouse upgrade was completed in February 2011 and is in production.



### *Core MMIS replacement*

The Department received \$3 million in general fund in FY2011 which is a portion of what is needed to replace the entire system. Using the initial appropriation, the Department proceeded with work on the system components mentioned above and carried forward a balance of \$2,488,000 into FY 2012. The Department received an additional \$3 million in general fund for FY2012 for a total of \$5,488,000. As of mid December, total (Federal and State) SFY 2012 FINET expenditures were approximately \$865,000.

The Department submitted an Implementation Advanced Planning Document (IAPD) to CMS to request enhanced federal funding for implementation, and a Request for Proposal (RFP) for the core system replacement. Assuming a timely approval by CMS, the anticipated time frame for releasing the RFP is the end of January 2012.

Three oversight/coordinating committees are meeting regularly. These are the Sub-Cabinet Committee, a program committee to work through technical issues and a multi-agency project committee (which includes DOH, DHS, DTS and DWS).

### **Specific Accomplishments of the Planning Project**

- State Self-Assessment completed
- Assessment of State Capabilities completed
- Gap Analysis completed
- Cost/Benefit Analysis completed
- Request for Information (RFI) completed
- Requirement Analysis and Documentation drafted
- Draft I-APD for System Design, Develop, Implement (DDI ) completed
- Draft RFP for Core System Development written
- FADS I-APD submitted to CMS Regional Office and approved
- FADS I-APD amendment approved by CMS
- FADS Request for Proposal (RFP) submitted to CMS Regional Office and approved
- FADS RFP posted on BidSync
- FADS canceled-5 year functionality provided free of charge by CMS Medi-Medi project
- Pre-Pay RFP posted and contract awarded
- Pre-Pay project implemented
- Point of Sale contract awarded to GHS
- Data Warehouse upgrade completed
- I-APD submitted to CMS for review and approval
- DDI RFP submitted to CMS for review and approval

Please let me know if you have any questions related to this report. You can reach me at (801) 538-6689.

Sincerely,



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

**APPENDIX C - REPORT ON INCREASING PUBLIC AWARENESS OF REPORTING MEDICAID FRAUD**

**DATE:** November 1, 2011

**TO:** Office of the Legislative Fiscal Analyst

**FROM:** Department of Health  
Department of Human Services  
Department of Workforce Services

**SUBJECT:** Report on Public Awareness of Fraud Reporting Systems

To keep costs as low as possible, ensure that tax dollars are being spent appropriately and ensure that low-income Utahns get the health care services they need, Utah's Medicaid program is committed to increasing public awareness of fraud reporting systems. Any Medicaid recipient, health care provider or private citizen may report suspected Medicaid fraud, waste or abuse. Anonymity is protected upon reporting suspected fraud, waste or abuse of the Medicaid program.

#### **Examples of Medicaid Provider Fraud**

When a doctor, hospital or health care professional:

- Bills Medicaid for services before the treatment is done or completed.
- Bills for patients who did not receive services by the provider or "phantom patients".
- Bills for services not medically necessary or required by the patient.
- Bills for a higher level of service than was actually provided or "up-coding".

#### **Examples of Medicaid Recipient Fraud**

It is considered recipient fraud when a person:

- Uses another Medicaid recipient's card with or without their knowledge.
- Loans a Medicaid identification card to other people to use.
- Uses more than one Medicaid identification card.
- Doctor shops to get multiple services or prescriptions.
- Forges or changes a prescription.
- Does not use items received through the Medicaid program as intended.
- Sells medical items and supplies for profit.
- Asks for and receives services or supplies that are not needed.

The Office of the Inspector General (OIG) enforces measures to identify, prevent and reduce fraud, waste and abuse in the Medicaid System. The OIG relies on referrals of suspected fraud, waste and abuse. If the referral concerns a provider, the OIG uses the information to initiate an investigation. Identifying inappropriate payments made to Medicaid providers allows the OIG to recover the overpayments made with Medicaid funds. The money is then returned to Medicaid and used to provide services to eligible Medicaid recipients. The OIG operates two fraud reporting systems, including a toll-free hotline and a website ([health.utah.gov/mpi](http://health.utah.gov/mpi)) where individuals can fill out an online form or send an email to report suspected fraud, waste or abuse.

Although the Department of Workforce Services' (DWS) role in the Medicaid program is limited to determining eligibility for Medicaid applicants, it pursues referrals of suspected recipient fraud, waste or abuse. Displayed prominently on the DWS website ([jobs.utah.gov](http://jobs.utah.gov)) is an option to "Report Fraud". This section provides the public with a toll-free fraud hotline that they can call 24-hours a day to report suspected fraud, waste or abuse. Individuals are also provided an email address to which they can report suspected fraud. All referrals are directed to DWS's full-time fraud investigations unit who will then proceed with determining whether the referral merits additional review. DWS aggressively pursues cases of fraud and abuse, and substantiated cases are set-up for fraud penalties, which in many cases involve criminal prosecution.

In addition to partnering with the Department of Health (DOH), DWS warns applicants about the consequences of committing fraud in their application and obligates them to provide accurate and complete information on an ongoing basis. DWS has an established operational policy dictating the proper procedure for identifying and referring possible cases of Medicaid recipient fraud for investigation. DWS trains its new employees, as well as implements ongoing training about identifying and referring Medicaid recipient fraud for investigation.

DWS is presently restructuring its entire communications platform, moving aggressively toward online mediums, including social media such as Facebook and Twitter. Among the planned areas for emphasis is educating and encouraging the public to report suspected fraud among all public assistance recipients, including Medicaid recipients. DWS's revamped online presence will prominently display the option to report suspected fraud. DWS's new media efforts will also proactively direct the public to that option through ongoing "tweets" and Facebook status updates.

Additionally, DWS will be focusing on point-of-sale communication, helping customers at the point of interaction with DWS to understand their consequences of recipient fraud, and also how to report it. The primary method of point-of-sale contact will be through MyCase, which is DWS's online gateway for its customers to access their public assistance cases, including Medicaid.

To educate and inform the public about the reporting mechanisms in place, DOH uses the following communication tools:

- Annual Provider Training – Medicaid staff travel statewide to facilitate provider trainings which include information about billing Medicaid, prior authorizations and care coordination. In addition, providers and their office staff are educated about reporting suspected fraud. Attendees are provided contact information in order to make a referral if fraud, waste or abuse is suspected.
- Website – The DOH homepage has a section entitled, “Online Services”. The first online service listed is a link to report Medicaid fraud, waste or abuse. In addition to this website, DOH will be adding links on the homepages of other medical program websites, including Medicaid, the Children’s Health Insurance Program (CHIP), Utah’s Premium Partnership for Health Insurance (UPP) and the Primary Care Network (PCN). Upon following the link to the OIGs website, a referrer can either fill out an online form to submit a referral, or call the fraud hotline.
- Member Guide – Upon eligibility approval for a medical assistance program, each new client is sent a member guide, which includes co-pay schedules, covered benefits, rights and responsibilities, etc. In addition, DOH has added contact information for reporting fraud, waste or abuse. The Medicaid member guide currently includes this added section, however DOH also plans to add this information to other program member guides like CHIP and PCN.
- Medicaid Information Bulletin (MIB) – Every quarter, DOH disseminates an electronic newsletter for providers. Articles change from month to month. In the past, the MIB has included an article with contact information for provider offices to report suspected fraud, waste or abuse. DOH will be adding a standing section on the last page, which includes the hotline and email contacts for reporting suspected fraud, waste or abuse.

The Department of Human Services (DHS) has taken the following actions to increase awareness of fraud and encourage fraud reporting:

- Developed and implemented two DHS policies regarding reporting Medicaid and other fraud, waste and abuse (<http://www.hspolicy.utah.gov>):
  - a. Contractors - DHS Policy 03-02
  - b. Employees - DHS Policy 03-03
- Included a section on false claims reporting in the employee handbook (see attached).
- Included training on false claims reporting in New Employee Orientation.
- Amended service contracts to include a specific section on Deficit Reduction Act and Federal False Claims Act reporting (see attached).
- Posted on the Department's website the DHS fraud reporting hotline and information on Deficit Reduction Act and Federal False Claims Act reporting.

**APPENDIX D - REPORT ON SINGLE POINT OF ENTRY TO DETERMINE MEDICAID LONG TERM CARE ELIGIBILITY**

# Report to the Office of the Legislative Fiscal Analyst

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## Single Point of Entry for Long Term Care Services Eligibility

Prepared by

The Utah Department of Health and The Utah Department of Human Services

September 1, 2011



## **Background**

This report is submitted in response to the following intent language passed in Senate Bill 2 during the 2011 Legislative General Session:

“The Legislature intends the Department of Health and the Department of Human Services study the cost and benefits of having a single point of entry to determine eligibility for clients seeking any type of Medicaid long term care services. The Departments shall additionally report on the potential cost and benefits of using a non-State entity to provide the single point of entry services. The Departments shall report back recommendations for further action in one combined report to the Office of the Legislative Fiscal Analyst by September 1, 2011.”

Single Point of Entry Systems vary widely from state to state. Some states focus on providing access to a wide variety of long term care information, regardless of the funding source, while others focus on a specific segment of the population or a specific type of long term care service.

As the Utah Departments of Health and Human Services’ staff (Agency staff) conducted research for this report, it was evident that Maine’s system most closely resembled the study parameters identified in Senate Bill 2. Consequently, a significant segment of the report will focus on the method used in Maine.

In order to better understand the long term care eligibility determination process, the report discusses national Medicaid long term care eligibility criteria development, describes the systems currently used in Utah and Maine and compares general demographic and programmatic information. Questions about the potential benefits of a Single Point of Entry System are discussed and a cost analysis is presented.

## **Introduction**

The Utah Departments of Health and Human Services appreciate the opportunity to study the single point of entry concept for determining long term care eligibility.

According to the *Single Entry Point Systems: State Survey Results*<sup>i</sup> (Survey) conducted by the National Academy of State Health Policy, August 2003, Single Entry Point (SEP) systems are defined as “a system that enables consumers to access long term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, eligibility determination, care planning, service authorization, and reassessment.”

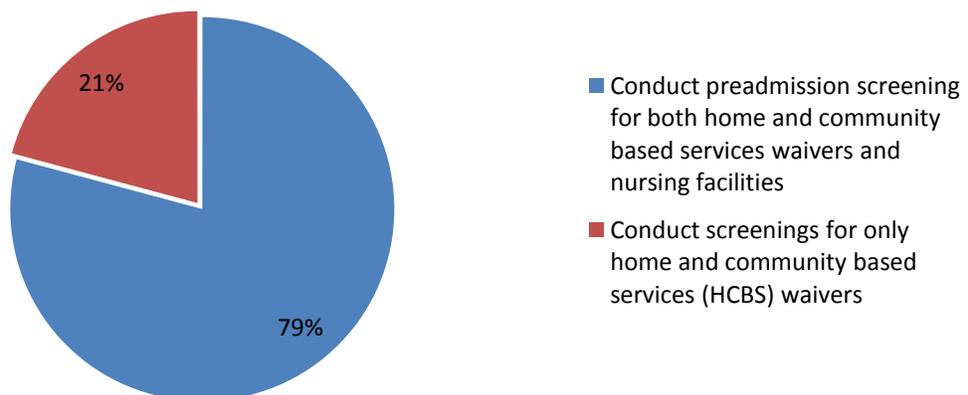
Individual states implement Single Entry Point Systems, also known as Single Points of Entry, in a variety of ways:

- *Who provides SEP services?* Of those responding to the Survey, thirty-two states and the District of Columbia reported that they utilize a total of 43 SEP's. Sixteen reported use of state agency regional/field offices, thirteen states use Area Agencies on Aging, eight states use county departments, three states use Independent Living Centers, two states use managed care organizations, and one state uses a for-profit company.

- *What populations are served in SEP Systems?* The majority of responding states, twenty-two, report serving only individuals who are elderly and those with physical disabilities, twelve states serve individuals who are elderly, adults with physical disabilities and those with intellectual disabilities, and eight states reported serving only those with intellectual disabilities.

- *How many states perform long term care preadmission screening as a component of SEP?* Twenty-four states reported conducting preadmission screenings. Of those states, nineteen reported conducting preadmission screening for both home and community based services waivers and nursing facilities and five states conduct screenings for only home and community based services (HCBS) waivers.

***The Number of States that Perform Long Term Care Preadmission Screening as a Component of SEP***



Although Single Entry Point System methods vary across the nation, this report will focus on the following principles in order to follow the Legislative intent language:

- Only Medicaid long term care services will be considered;
- All potentially eligible populations will be considered, including: individuals who are aged, adults and children with physical disabilities, including brain injuries, and adults and children with intellectual disabilities;
- Activities related to nursing facility, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID)<sup>1</sup> and HCBS waiver pre-admission assessment and eligibility determination are the focal point of the analysis;
- Some states without Medicaid managed care plans include home health, private duty nursing, and personal care services when determining long term care eligibility. Because Utah's Medicaid program utilizes managed care, these services are not included in the analysis; and
- Medicaid long term care eligibility is different from Medicaid financial eligibility. Medicaid long term care eligibility, commonly referred to as *Level of Care* is a determination of medical necessity only. An applicant's financial eligibility is determined through a separate process completed by the Utah Department of Workforce Services and is not the subject of this report.

## **Medicaid Long Term Care Eligibility**

Agency staff reviewed other states' long term care criteria development processes and approaches to determining long term care eligibility.

Each state develops and implements its own Medicaid long term care eligibility (Level of Care) based on its interpretation of federal law. Medicaid long term care has two general Level of Care (LOC) categories: Nursing Facility and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID). There is no nationally accepted standard practice for either creating Medicaid LOC policy or for the process used to determine eligibility.

## **Criteria Development**

In a 2000 report completed for the Maryland Department of Health and Mental Hygiene<sup>ii</sup> three categories of State LOC criteria were identified:

- 17 states used eligibility criteria that were based on general definitions and guidelines (Utah's criteria falls into this category.)
- 19 states used eligibility criteria that required a minimum number of needs or impairments.
- 7 states required a threshold score based on an assessment that may have an added clinical review component.

<sup>1</sup> Utah's use of the term ICF/ID has the same meaning as ICF/MR under Federal law.

## **Utah's Current Criteria and Process for Determining Eligibility for Long Term Care Services**

Medicaid long term care eligibility criteria are defined in Administrative Code *R414-502, Nursing Facility Levels of Care*. The criteria apply to both facility and HCBS based options.

### **Nursing Facility Based Eligibility**

Registered nurses (nurses or RNs) from the Utah Department of Health, Division of Family Health and Preparedness review individual cases to determine if an applicant meets nursing facility LOC. Individual case documentation is submitted by the nursing facility and includes, at a minimum, a comprehensive assessment that is required by the Centers for Medicare and Medicaid Services (CMS) called the *Minimum Data Set (MDS)*, a history and physical report completed by a physician, a screening for the presence of mental illness or intellectual disability called the *Pre-Admission Screening Resident Review (PASRR)* and physician's orders for medication and treatments. The documentation is reviewed against the LOC criteria and a determination is made. To assure ongoing eligibility, Department of Health (DOH) nurses conduct follow-up reviews ninety days after the initial determination and every six months thereafter.

### **ICF/ID Based Eligibility**

RNs from the Utah Department of Health, Division of Family Health and Preparedness review individual cases to determine if an applicant meets ICF/ID LOC. The individual case documentation is submitted by the ICF/ID. Required documentation includes assessment of functional limitations, documentation of intellectual disability or other related conditions, a social summary, any psychological assessments, medical assessments and physician's orders for medication and treatments. The documentation is reviewed against the LOC criteria and a determination is made. To assure ongoing eligibility, Department of Health (DOH) nurses conduct follow-up reviews ninety days after the initial determination date and every six months thereafter.

### **Home and Community Based Waiver Eligibility**

In addition to meeting LOC requirements, applicants must meet specific targeting criteria associated with each HCBS waiver. Utah has six HCBS waiver programs:

- Waiver for Individuals Aged 65 and Older
- Waiver for Individuals with Acquired Brain Injury
- Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions
- New Choices Waiver
- Waiver for Individuals with Physical Disabilities
- Waiver for Individuals who are Technology Dependent

A description of the eligibility determination process for the each waiver is listed below:

***Waiver for Individuals Aged 65 and Older – Aging Waiver (AW)***

The Utah Department of Human Services, Division of Aging and Adult Services (DAAS) is the operating agency for this waiver. A referral (self or other) is made to a local Area Agency on Aging (AAA). Utah has twelve AAAs that administer the majority of the aging services in the state for their geographic regions. When a referral is received, an AAA staff person completes a *Demographic Intake and Risk Score* form for each applicant. Based on the applicant's score, if it appears the person will meet LOC and Medicaid financial eligibility, the form is submitted to DAAS.

When funding is available to support new waiver participants, DAAS staff identify the applicants with the highest risk score(s) and notify the appropriate AAA(s). At this point, a nurse from the AAA assesses the applicant to determine LOC. AAA nurses are trained by DAAS to determine LOC.

The nurse is sent to the applicant's home to conduct a comprehensive, face-to-face assessment. The assessment tool used is the *Minimum Data Set-Home Care* © (MDS-HC.) The MDS-HC is a derivative of the full MDS tool that is used to conduct facility based assessments. The assessment must be completed within 14 days of the AAA notification. Based on the results of the assessment the nurse makes the LOC determination. Once completed, the assessment, LOC determination, and care plan are sent to DAAS for approval. A nurse within DAAS reviews the submitted documentation to assure concurrence with the AAA's determination. If the DAAS nurse does not agree with the AAA's determination, the application is referred to the Utah Department of Health, Division of Medicaid and Health Financing (DMHF) for a final determination.

Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, assessments and LOC determinations are completed annually or more frequently if the participant experiences a significant change in condition. These assessments and determinations follow the same steps as defined above.

***Waiver for Individuals with Acquired Brain Injury – Acquired Brain Injury Waiver (ABI)***

The Utah Department of Human Services, Division of Services for People with Disabilities (DSPD) is the operating agency for this waiver. An ABI intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located throughout the State or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, a documented diagnosis of an acquired brain injury, a *Comprehensive Brain Injury Assessment* (face-to-face assessment), a social summary, and physician's or other medical reports. The eligibility review process is completed by a certified, bachelor level DSPD staff person. Completion of the assessments requires specialist knowledge, experience and training.

Once the eligibility process has been successfully completed, the participant is placed on the program and an individual support plan is developed. To assure ongoing eligibility, certified DSPD staff complete a new assessment at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, the case is submitted to the DSPD Eligibility Review Committee for a more comprehensive evaluation and recommended course of action.

***Community Supports Waiver for Individuals with Intellectual Disabilities and other Related Conditions – (CSW)***

DSPD is the operating agency for this waiver. A CSW intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located throughout the State or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, a documented diagnosis of an intellectual disability or other related condition, a social summary, and psychological assessments. The eligibility review process is completed by a bachelor level DSPD staff person with specialist training and experience working with this population. Completion of the assessments requires specialist knowledge, experience and training. Once the eligibility process has been successfully completed, the participant is placed on the program and an individual support plan is developed.

To assure ongoing eligibility, qualified DSPD staff complete a re-determination of eligibility at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, the case is submitted to the DSPD Eligibility Review Committee for a more comprehensive evaluation and a recommended course of action.

***New Choices Waiver (NCW)***

Applications for the NCW are submitted to DMHF staff. A targeting criterion of the NCW requires that the applicant is a current resident in a nursing facility for 90 days or greater. Because the applicant has been a resident of facility based care, the applicant's eligibility has already been determined through the "Facility Based Eligibility" process described above. To assure ongoing eligibility, a nurse from the NCW case management agency completes a comprehensive, face-to-face assessment, the *Minimum Data Set- Home Care (MDS-HC.)*

Upon completion of the MDS-HC, if there is a question about whether the applicant continues to meet LOC, the case is submitted to the DOH nurses who complete the "Facility Based Eligibility" for further review. Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, NCW case management nurses complete a new assessment at least annually or more frequently with a significant change in condition.

***Waiver for Individuals with Physical Disabilities – Physical Disabilities Waiver (PDW)***

DSPD is the operating agency for this waiver. A PDW intake is initiated either through an applicant's use of DSPD's toll free number or by contacting one of eight regional offices located

throughout the state or the State office located in Salt Lake City. Application forms and instructions are given to the applicant through the mail or through an in-home or in-office meeting.

The following documentation is required to determine eligibility: an assessment of functional limitations, documentation of a diagnosed physical disability, the *Minimum Data Set- Home Care (MDS-HC) assessment*, and pertinent medical records. The eligibility review process is completed by a DSPD Registered Nurse with specialist training and experience working with this population. Once the eligibility process has been successfully completed, the participant is placed on the program and a care plan is developed. To assure ongoing eligibility, DSPD Registered Nurses complete an eligibility determination at least annually or more frequently with a significant change in condition. If there is a question about whether the client continues to meet LOC, a consultation may be held with Utah Department of Health, DMHF staff.

***Waiver for Individuals who are Technology Dependent – Technology Dependent Waiver (TDW)***

A referral is made to the Department of Health, Division of Family Health and Preparedness (DFHP), which has responsibility for day-to-day waiver administrative activities. Most referrals come directly from Primary Children’s Medical Hospital or from a home health agency. Additional referrals come from state agencies, non-profit groups or the public. The nurse waiver coordinator completes a *Preliminary Level of Care Screening* form. This form provides basic demographic information, describes the type of technology upon which the applicant is dependent and scores the applicant based upon the required technology.

When funding is available to support new waiver participants, priority for admission to the waiver is given to the applicant with the highest numerical ranking. The nurse waiver coordinator will make a home visit with the applicant and their family. During this visit, the coordinator will complete a comprehensive assessment. The comprehensive assessment instrument for this waiver, known as the *Initial Comprehensive Assessment Form*, assists the coordinators to determine nursing facility LOC and eligibility based on TDW admission criteria. The coordinators are responsible for collecting the needed information and for making the initial LOC determinations.

The coordinators are trained by the Department of Health, DMHF staff regarding nursing facility LOC eligibility and specific waiver targeting criteria requirements. The waiver coordinator will then complete the *Initial and Annual Level of Care/Freedom of Choice Certification* form with the potential participant and a preliminary Plan of Care if it is determined that the potential participant meets all waiver criteria.

To assure ongoing eligibility LOC is reevaluated at least every 12 months. Reassessments are conducted by an RN waiver coordinator and completed during a reassessment home visit.

## **Maine’s Current Process for Determining Eligibility for Long Term Care Services:**

The State of Maine utilizes an approach that most closely illustrates the system described in the legislative intent language.

Since the 1990s, Maine has contracted with a non-state, for-profit company, Goold Health Systems, to be the single entry point for long term care eligibility determinations. Under this contract, Goold Health Systems (GHS) conducts preadmission screening for Medicaid long term care including: state plan home health, personal care and private duty nursing services, HCBS waivers and nursing facility services. Eligibility for ICFs/ID and HCBS waivers for individuals with intellectual disabilities are excluded from this contract. In addition, GHS conducts eligibility determinations for services funded by sources other than Medicaid.

The GHS website explains their long term care eligibility determination program as:

“GHS’ Community Assessment Program is comprised of 30+ nurses, who perform assessments in the field or provide support at GHS’ home office. Assessments are provided wherever the patient is located: hospitals, nursing facilities, individuals’ homes, and other health care facilities. Nurses in our office are available to support field nurses with their assessments. We also staff a toll-free help desk to receive referrals from medical providers and answer questions about existing or past cases.

We administer long-term care assessments for elderly and disabled people over 19 years of age, through a referral from a medical service provider. We also administer healthcare assessments to children under the age of 19 through the MaineCare Katie Beckett eligibility program.

Currently GHS processes 300 calls and 100 referrals every day. Our nurses conduct over 1500 onsite assessments monthly across the State of Maine. GHS is proud to administer Maine’s Community Assessment program, which leads the nation in innovation and efficiency.<sup>iii</sup>”

Agency staff contacted a representative from GHS who provided the following additional information:

- GHS performs assessments using the *Medical Eligibility Determination (MED)*,<sup>iv</sup> a tool that was developed by the State of Maine.
- Using the MED, GHS nurses assign the applicant to one of nine levels of care.
- GHS provides program eligibility information to the applicant. For example, if an applicant meets nursing facility LOC, the client would be eligible for any one of the HCBS waiver programs that require nursing facility LOC as long as the applicant also meets the waiver-specific targeting criteria. In Maine the relevant programs would be: Elderly HCB, Physical Disabilities HCB, Consumer Directed HCB, and Brain Injury HCB, etc.
- Applicants are free to choose the program in which they would like to enroll.

- GHS also develops the care plan, then forwards this information to one of two case management agencies for the ongoing oversight of the case once the applicant enters the waiver program.
- GHS does not perform Medicaid financial eligibility determinations.
- GHS staff complete assessments and reassessments at the following intervals:
  - For HCBS Programs
    - initial eligibility determinations;
    - a follow-up assessment ninety days after admission, then annually thereafter
  - Nursing Facility Services
    - initial assessments only<sup>2</sup>
- The typical cost of an assessment is \$172; the cost of a brain injury assessment is \$174.

### **General Demographic and Programmatic Comparisons**

In 2010, Maine's population was 1,328,361 and 314,000 (23.64%) residents were Medicaid recipients. During the same timeframe, Utah's Population was 2,763,885 and 338,130 (12.23%) residents were Medicaid recipients. The average annual Medicaid expenditure per client in Maine was \$8,019.05 while the average Utah Medicaid expenditure was \$4,818.43 per client.

### **Long Term Care Spending**

According to the Kaiser Family Foundation, State Health Facts, *Distribution of Medicaid Spending by Service, FY2009*, long term care spending accounted for 30.8% of Maine's overall Medicaid expenditures, ranking Maine 22<sup>nd</sup> in lowest percentage of spending on long term care services. In the same report, long term care spending accounted for 27.3% of Utah's overall Medicaid expenditures, ranking Utah 12<sup>th</sup> in lowest percentage of spending on long term care services.

According to the Kaiser Family Foundation, State Health Facts, *Distribution of Medicaid Spending on Long Term Care, FY 2009*, Maine spent 52.3% of its long term care budget on HCBS, ranking Maine 11<sup>th</sup> in highest percentage spent on HCBS. In the same report, Utah spent 49% of its long term care budget on HCBS, ranking Utah 13<sup>th</sup> in highest percentage spent on HCBS.

<sup>2</sup> Previously, the nursing facility assessments occurred at more frequent intervals, but the regularity was reduced recently due to the State's budgetary constraints.

### 2009-2010 State Data Comparison Table<sup>v</sup>

|   | Utah                     | Maine                    |
|---|--------------------------|--------------------------|
| <b>State Population</b>   | 2,763,885                | 1,328,361                |
| <b>Medicaid Recipients</b>  | 338,130                  | 314,100                  |
| <b>Total Medicaid Expenditures</b>  | \$1,629,254,870          | \$2,517,981,111          |
| <b>Percentage of Population Receiving Medicaid</b>  | 12.23%                   | 23.64%                   |
| <b>Average Expenditure Per Recipient</b>  | \$4,818.43               | \$8,019.05               |
| <b>Total Long Term Care Expenditures</b>  | \$445,387,637            | \$776,152,002            |
| <b>Long Term Care Percentage of Total Expenditures</b>  | 27.30%                   | 30.80%                   |
| <b>National Ranking in Long Term Care Service Spending</b>  | 12 <sup>th</sup> Lowest  | 22 <sup>nd</sup> Lowest  |
| <b>Home and Community Based Services Percentage of Long Term Care Expenditures</b>                              | 49%                      | 52.30%                   |
| <b>National Ranking in Percentage of Long Term Care Expenditures Spent on Home and Community Based Services</b> | 13 <sup>th</sup> Highest | 11 <sup>th</sup> Highest |
| <b>Nursing Facility Occupancy Rate</b>  | 63.70%                   | 91.70%                   |
| <b>Number of Nursing Facilities in the State</b>  | 97                       | 107                      |
| <b>Number of People Residing in Nursing Facilities</b>  | 5,236                    | 6,164                    |
| <b>Average Nursing Facility Private Pay Daily Rate</b>  | \$151                    | \$233                    |

### **Analysis of Using a Single Non-State Entity to Perform Medicaid LTC Eligibility**

*Would using a single, non-state entity provide greater consistency in long term care eligibility assessments results?*

#### ***Agency Response***

Although it is possible that use of a non-state entity could produce greater consistency in long term care eligibility assessment results, Utah has multiple controls in place to assure eligibility determinations are made in an objective and consistent way across all programs. These controls include:

- Routine training of individuals who complete assessments for both facility based and HCBS services;
- Agency staff routinely review eligibility assessments;
- Agency staff make all final eligibility determinations. Because Agency staff are responsible for serving individuals within each program's limited, established budgets,

there is a strong incentive to assure that people receiving services truly meet program eligibility criteria;

- Routine quality assurance reviews are performed using representative sampling to assure level of care determinations have been properly made;

There are no indications that Utah's long term care eligibility assessment results are inconsistent. On the contrary, indicators such as low nursing facility census and balanced Medicaid spending between facility based and HCBS services suggest that prudent and consistent long term care eligibility decisions are being routinely made.

***Would using a single assessment tool (such as Maine's MED) to determine Medicaid long term care eligibility result in increased consistency in eligibility determinations across programs?***

***Agency Response:***

Although Utah does not use one, exclusive tool for assessing eligibility for long term care services, the State uses the MDS, the MDS-HC, or a combination of the two as the basis for making level of care determinations in four of the six Medicaid long term care programs that require nursing facility LOC. The four programs that use these instruments are: nursing facility services and the New Choices, Aging and Physical Disabilities waivers. Both the MDS and the MDS-HC have undergone extensive validity and reliability testing. CMS mandates the use of the MDS for Medicare- and Medicaid-funded nursing facility care. By using these two instruments, there is a significant amount of consistency in determining eligibility for these four programs:

The two remaining programs: the ABI and Tech Dependent waivers have very distinctive characteristics that make the use of alternate assessment tools preferable. For example, Tech Dependent waiver applicants have highly complex medical issues such as ventilator or tracheostomy dependence. In these cases, there is little question that the applicant meets nursing facility LOC. The specialized assessment tool is used to determine nursing facility LOC and the client's needs simultaneously. Allowing this flexibility results in the efficient administration of the program and a reduction in the number of assessments required.

In addition, development of a tool such as Maine's MED is a substantial undertaking that requires significant financial and human resources to conduct research, development, validity and reliability testing.

***Would cost savings result from having a non-state entity perform long term care eligibility determinations?***

***Agency Response***

Agency staff asked GHS if any studies had been completed or objective data collected to demonstrate cost-effectiveness or cost-savings associated with this methodology. GHS staff indicated they were not aware of any specific studies. GHS recommended that Agency staff contact state agency officials in Maine to determine if any studies had been completed. Department staff attempted to contact Maine's Office of Elder Services to inquire about the

existence of any studies or reports of this nature. Utah staff did not receive a reply to this inquiry.

Appropriate, cost-effective, “gate-keeping functions” currently exist in Utah’s long term care system. For residents living in nursing facilities, DOH nurses monitor eligibility at the time of admission, ninety days after the initial determination, then every six months thereafter. For all HCBS programs, Agency staff reassess eligibility at least annually or more frequently if a significant change in condition occurs.

There are no indications that Utah’s long term care eligibility assessment processes results in inappropriate use or over-utilization of long term care services. On the contrary, indicators such as low nursing facility census, relatively low long term care services spending as a percentage of the State’s total Medicaid expenditures, and balanced Medicaid spending between facility based and HCBS services suggest that appropriate utilization of long term care services occurs.

Utah manages its long term care services programs in a very cost-effective manner. On average, the typical cost of a fiscal year 2010 assessment was \$60.13. A comparable assessment completed under the Maine system would typically cost \$172. The following information details the costs of completing long term care eligibility determinations in Utah’s programs and the projected comparison cost under the Maine system:

| <b>Utah’s Total Number of Assessments Completed during 2010</b> | <b>Utah’s Cost Per Assessment</b> | <b>Utah’s Total Cost</b> | <b>Cost Per Assessment Under the Maine System</b> | <b>Projected Total Cost Under the Maine System</b> | <b>Cost Difference Between the Maine System and Utah’s Current System</b> |
|---|-----------------------------------|--------------------------|---|--|---|
| 19,487  | \$60.13                           | \$1,171,820              | \$172   | \$3,351,764  | \$2,179,944   |

If the State adopted a system like the one that is currently operating in Maine and paid the same \$172 rate per assessment, the increased cost to the state would be approximately \$2,179,944 per year in administrative expenditures with little expectation that it would result in less costly placements on the program expenditure side.

## **Recommendations**

Although using a non-State entity to make long term care eligibility determinations has been implemented successfully in Maine, the information provided in this report shows that Utah's current system of determining long term care eligibility is very successful as well.

Agency staff measured success by comparing relevant indicators such as cost per assessment, utilization management indicators such as Medicaid long term care costs, distribution of long term care spending between facility and home and community based care, number of people living in nursing facilities, census in nursing facilities, etc. Based on the results of this evaluation, the recommendation is to not pursue a single entry point at this time.

## End Notes:

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<sup>i</sup> Mollica, Robert, Gillespie, Jennifer, Single Entry Point Systems: State Survey Results. National Academy of State Health Policy. August 2003. URL:

[http://www.nashp.org/sites/default/files/CLE\\_single\\_entry\\_point.pdf](http://www.nashp.org/sites/default/files/CLE_single_entry_point.pdf)

<sup>ii</sup> Determining Medicaid Nursing Facility Level of Care Eligibility in Maryland. University of Maryland Baltimore County, Center for Health Promotion Development and Management. December 2000. URL:

<http://www.hilltopinstitute.org/publications/DeterminingMedicaidNFLLevelOfCareEligibilityInMD-December2000.pdf>

<sup>iii</sup> *Clinical Assessment Programs: Long-term Care & Katie Beckett*. Goold Health Systems. URL:

<http://www.ghsinc.com/clinical/assessments>

<sup>iv</sup> <http://www.maine.gov/dhhs/oes/medxx/medxx.htm>

<sup>v</sup> U.S. Census Bureau, State and County QuickFacts. URL:

<http://quickfacts.census.gov/qfd/states/23000.html>

The Kaiser Family Foundation, statehealthfacts.org. Table: *Medicaid Spending, 2009*. URL:

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=21&cat=4&rgn=46&sub=47>

Maine Total Number of Medicaid Recipients, 2009 URL:

<https://gateway.maine.gov/dhhs-apps/dashboard/>

Utah Total Number of Medicaid Recipients, 2009 URL:

[http://www.health.utah.gov/medicaid/pdfs/annual\\_report2010.pdf](http://www.health.utah.gov/medicaid/pdfs/annual_report2010.pdf)

The Kaiser Family Foundation, statehealthfacts.org: *Distribution of Medicaid Spending by Service, FY2009*, URL:

<http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=178&cat=4&sub=47&sortc=2&o=a>

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The Kaiser Family Foundation, statehealthfacts.org: *Certified Nursing Facility Occupancy Rate, 2009*, URL:

<http://www.statehealthfacts.org/profileind.jsp?cmprgn=21&cat=8&rgn=46&sub=97>

The Kaiser Family Foundation, statehealthfacts.org: *Total Number of Certified Nursing Facilities, 2009*. URL:

<http://www.statehealthfacts.org/profileind.jsp?ind=411&cat=8&rgn=46&cmprgn=21>

The Kaiser Family Foundation, statehealthfacts.org: *Total Number of Residents in Certified Nursing Facilities, 2009*. URL:

<http://www.statehealthfacts.org/profileind.jsp?ind=408&cat=8&rgn=46&cmprgn=21&print=1>

*Utah Medicaid Nursing Home Rates, 2009*. URL:

[http://health.utah.gov/medicaid/stplan/NursingHomes/Rates/NF/NH\\_RateModel\\_FY09\\_Q4%20vPostFinal.pdf](http://health.utah.gov/medicaid/stplan/NursingHomes/Rates/NF/NH_RateModel_FY09_Q4%20vPostFinal.pdf)

Long Term Care in Maine, December 2009, AARP URL:

[http://assets.aarp.org/rgcenter/health/state\\_ltc\\_b\\_09\\_me.pdf](http://assets.aarp.org/rgcenter/health/state_ltc_b_09_me.pdf)

**APPENDIX E - REPORT ON PHARMACY INFLATION NOT BEING FUNDED**

# Report to the Office of the Legislative Fiscal Analyst

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## Pharmacy Inflation Experienced During Fiscal Year 2012

Prepared by the Division of Medicaid and Health Financing

December 1, 2011



## EXECUTIVE SUMMARY

This report is submitted in response to the following intent language passed in SB 3 by the 2011 Legislature:

The Legislature intends that the Department of Health not adjust Medicaid pharmacy rates as a result of the Legislature not providing new funding for new pharmacy inflation in FY 2012. Additionally, the Legislature intends that the Department of Health report to the Office of the Legislative Fiscal Analyst by December 1, 2011 on pharmacy inflation experienced during fiscal year 2012.

### **Do Not Adjust Medicaid Pharmacy Rates as a Result of the Legislature Not providing New Funding for New Pharmacy Inflation**

The Department complied with this intent. The Estimated Acquisition Cost (EAC) for drugs remains at 17.4 percent off Average Wholesale Price (AWP).

Effective July 1, 2011, the Department adjusted the Utah Maximum Allowable Cost (UMAC) for many drugs in order to obtain the needed savings based on the budgetary cuts.

### **Pharmacy Inflation Experienced During Fiscal Year 2012**

Department staff calculated the inflation experienced to date in FY 2012 by using the weighted average allowed charge in FY 2011 as compared to year-to-date FY 2012. The FY 2012 inflation numbers, based on brand-name and generic drug categories, is as follows:

| Category | Inflation |
|----------|-----------|
| Brand    | 10.4%     |
| Generic  | 1.2%      |

As of the report due date, there were only four and a half months of FY 2012 data available. If the data were available for the full FY 2012, then the utilization drug mix would be complete and the comparison more comprehensive.

It is important to note that generic drugs account for only 27 percent of the drug expenditures paid by Utah Medicaid, but account for 75 percent of the drug volume. The net result is a fiscal year-to-date pharmacy program inflation experience of 7.94 percent.