COMPENDIUM OF BUDGET INFORMATION
FOR THE
2007 GENERAL SESSION

JOINT APPROPRIATIONS SUBCOMMITTEE FOR HEALTH AND HUMAN SERVICES

UTAH DEPARTMENT OF HEALTH

OFFICE OF THE LEGISLATIVE FISCAL ANALYST
WILLIAM GREER
NOVEMBER 21, 2006

UTAH STATE LEGISLATURE

COMPENDIUM OF BUDGET INFORMATION
FOR THE
2007 GENERAL SESSION

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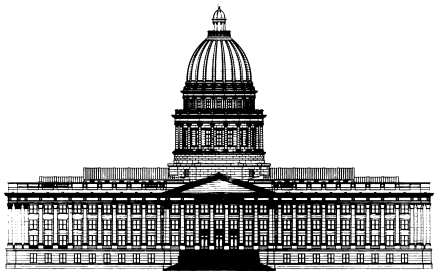

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November 21, 2006

Members of the Health and Human Services Appropriations Subcommittee
House Building
Utah State Capitol Complex
Salt Lake City, UT 84114

Dear Legislators:

Please find attached the third edition of the Utah Legislature's Compendium of Budget Information (COBI). COBI is one part of a three-pronged approach to staff budget analysis. It is designed as a reference document from which you may garner details on Utah state government activities within your subcommittee's jurisdiction. It includes program descriptions, references to statutory authority, accountability information, and, of course, budget data. COBI sets a baseline against which you can evaluate budgets proposed during the 2007 General Session.

Parts two and three of the Legislature's budget analysis – Budget Briefs and Issue Briefs – will be available throughout the 2007 General Session beginning in January. Both are succinct, decision oriented papers that build on COBI, presenting future budget options rather than COBI's *status quo*. Budget Briefs follow the structure of state government, documenting proposals for current year supplemental and future year budget action. Issue Briefs cut across "silos" to discuss subjects that impact state appropriations independent of program structure.

Detail on current state appropriations as they relate to your subcommittee are included in the "2007 Appropriated" column of the budget tables herein. Utah's total budget, by funding source, subcommittee, and category of expenditure, is summarized in the table on the following page.

If I or my staff can assist you further regarding this document or any other budget matter, please do not hesitate to contact me at (801) 538-1034.

Sincerely,

John E. Massey
Legislative Fiscal Analyst

Budget History - State of Utah

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,795,120,600	1,745,496,800	1,768,306,150	1,910,800,000	1,781,898,100
General Fund, One-time	28,962,750	(241,600)	117,058,700	121,540,040	398,634,200
Uniform School Fund	1,684,266,694	1,734,161,174	1,815,156,111	1,917,934,675	2,115,252,445
Uniform School Fund, One-time	10,436,000	5,891,000	34,800,900	43,725,000	44,375,000
Education Fund	4,908,000	112,000,000	200,520,900	235,260,900	548,663,800
Education Fund, One-time	1,935,100	(23,200,000)	52,073,500	19,496,600	53,882,000
Transportation Fund	389,538,000	391,891,100	437,416,000	421,112,200	350,269,200
Transportation Fund, One-time	0	0	277,100	126,371,900	74,200,000
Centennial Highway Fund	103,848,200	117,531,900	145,772,200	126,393,400	128,607,800
Centennial Highway Fund, One-time	0	1,796,800	0	0	0
General Fund Restricted	132,317,200	154,215,300	171,101,700	213,939,261	208,690,600
Uniform School Fund Restricted	78,400	72,000	90,700	14,306,100	15,176,100
Transportation Fund Restricted	27,573,800	29,813,200	30,720,100	37,215,500	38,781,500
Federal Funds	1,942,099,062	2,174,694,678	2,264,204,145	2,294,817,646	2,354,240,500
Dedicated Credits	774,058,339	614,539,399	730,196,287	654,136,650	693,383,100
Land Grant	771,000	804,700	1,040,435	1,807,732	1,058,500
Federal Mineral Lease	43,612,900	64,176,600	64,785,719	98,278,950	84,756,500
Restricted Revenue	9,606,100	2,944,000	273,700	17,930,800	0
Trust and Agency Funds	377,644,015	406,862,037	380,298,477	668,393,202	914,827,380
Transfers	310,161,147	312,446,922	314,413,473	350,828,925	322,837,300
Repayments/Reimbursements	12,260,800	15,206,500	11,107,200	11,816,900	31,263,900
Other Financing Sources	0	0	0	233,722	0
Pass-through	69,500	994,900	1,503,200	1,081,300	473,300
Beginning Balance	478,431,169	508,727,141	325,904,493	270,267,852	130,364,690
Closing Balance	(508,804,742)	(408,249,298)	(347,917,902)	(284,772,991)	(53,558,640)
Lapsing Balance	(88,457,656)	(56,071,454)	(20,646,900)	(23,958,400)	(1,893,200)
Total	$7,530,436,379	$7,906,503,799	$8,498,456,388	$9,248,957,863	$10,236,184,075
Subcommittees					
Executive Offices & Criminal Justice	544,478,400	582,590,000	618,377,000	650,467,161	712,137,300
Capital Facilities & Administrative Services	401,792,500	283,219,900	466,535,900	400,525,000	499,105,600
Commerce & Workforce Services	356,939,100	370,080,100	381,785,400	374,734,600	453,898,800
Economic Development and Revenue	176,396,500	193,681,700	174,955,900	250,681,500	370,173,200
Health & Human Services	1,796,226,868	1,988,592,616	2,145,033,300	2,307,382,500	2,414,290,200
Higher Education	888,515,400	934,067,900	991,420,900	1,058,618,425	1,099,975,500
Natural Resources	176,375,400	165,264,800	166,619,200	191,088,600	204,865,400
Public Education	2,330,739,161	2,438,357,683	2,593,642,788	2,771,942,577	3,012,993,025
Transportation & Environmental Quality	844,949,400	935,857,900	945,086,000	1,227,356,000	1,450,643,500
Legislature	14,023,650	14,791,200	15,000,000	16,161,500	18,101,550
Total	$7,530,436,379	$7,906,503,799	$8,498,456,388	$9,248,957,863	$10,236,184,075
Categories of Expenditure					
Personal Services	1,736,353,103	1,807,342,994	1,898,810,498	1,997,989,080	2,228,961,150
In-State Travel	14,134,072	14,500,846	15,669,609	17,335,576	14,024,500
Out of State Travel	4,523,469	4,889,409	5,479,600	5,828,400	5,746,100
Current Expense	1,004,437,498	854,645,604	955,825,491	960,742,005	1,232,024,400
DP Current Expense	77,976,393	82,210,862	84,165,900	87,515,600	111,994,800
DP Capital Outlay	178,527,153	12,440,919	12,629,500	14,617,900	13,038,700
Capital Outlay	62,331,514	483,846,765	318,051,916	553,655,321	444,070,300
Other Charges/Pass Thru	4,452,009,276	4,646,415,100	5,077,535,174	5,494,801,881	6,184,767,725
Cost of Goods Sold	(299,600)	(129,500)	(135,800)	(813,200)	881,800
Cost Accounts	4,600	(24,500)	0	6,600	38,000
Operating Transfers	182,600	144,300	172,900	157,000	98,000
Trust & Agency Disbursements	256,300	221,000	130,251,600	117,121,700	538,600
Total	$7,530,436,378	$7,906,503,799	$8,498,456,388	$9,248,957,863	$10,236,184,075
Other Data					
Budgeted FTE	32,789.7	33,066.0	33,462.5	33,965.5	35,792.6
Authorized Capital Outlay	21,594,700	25,731,100	20,812,900	20,904,000	41,049,400
Retained Earnings	15,795,336	16,314,149	17,763,119	27,740,867	17,518,307
Vehicles	11,255	10,701	9,386	9,299	9,319

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INTRODUCTION

Format

Staff budget analysis consists of three parts:

- Compendium of Budget Information (COBI). The document you are currently reading, the COBI provides comprehensive information on state agencies, institutions, and programs. It is a resource for decision-makers desiring further detail or background information beyond the summary provided in a Budget or Issue Brief. It is useful for reviewing base budgets, but does not contain staff recommendations.
- Issue Briefs. These relatively short documents (no more than a few pages) discuss issues that transcend line items or perhaps even departments. For example, if the Legislative Fiscal Analyst wishes to present a concern with law enforcement, an Issue Brief may be the best format. The analyst will prepare Issue Briefs just prior to the 2007 General Session.
- Budget Briefs. Another relatively short document, the budget brief is used to present issues, recommendations, performance measures, and line item-level budget tables. The purpose of this document is to bring budgets to the forefront and to discuss the analyst's recommendations. The analyst will prepare Budget Briefs just prior to the 2007 General Session.

Process

The Office of the Legislative Fiscal Analyst (LFA) – a non-partisan office – serves both chambers of the Legislature by making independent budget recommendations, determining the fiscal impact of proposed legislation, and preparing appropriations bills. Appropriations subcommittees review LFA's recommendations, vote upon, and report to the Executive Appropriations Committee proposed budgets for programs within their respective jurisdictions. The Executive Appropriations Committee, and ultimately the Legislature as a whole, considers multiple appropriation acts that, in turn, determine the final annual budget for each program of state government.

Timing

Utah does not budget on the calendar year, but on what is termed a Fiscal Year, which is the twelve-month period from July 1 to June 30 of the following year. A Fiscal Year is usually abbreviated FY, with the number follows "FY" designating the calendar year in which the second six months fall. The current fiscal year is FY 2007, which will end June 30, 2007. During the 2007 General Session, the Legislature can make supplemental changes to the already established budget for FY 2007. The next fiscal year, for which the Legislature is determining a new budget, is FY 2008. FY 2008 includes the period of time from July 1, 2007 to June 30, 2008.

Sources

In allocating resources for state government use, appropriations subcommittees may use funding from several sources. The following funding sources most commonly used by the subcommittees:

- General Fund
- School Funds
- Transportation Funds
- Federal Funds
- Dedicated Credits
- Restricted Funds
- Other Funds

A glossary of terms – included at the end of this document – defines these funding sources as well as other terms commonly used in Utah state budgeting.

CHAPTER 1 UTAH DEPARTMENT OF HEALTH

Function

The mission of the Utah Department of Health is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

Local Health Departments (LHDs) cover all areas of the state and provide local public health services. The State utilizes the local health departments to administer many of the services required by state law.

Significant Factors Impacting the Budget

Utah Department of Health budget is affected by five primary factors. These factors are:

1. Federal Mandates
2. Enrollment Growth, driven by:
   - demographics, especially the aging of the population
   - state and federal program changes and funding
   - program implementation impacts including "Dual Eligible Individuals"
3. The Utah State Economy, which impacts the:
   - federal allocation of funding
   - number of qualifying individuals
4. Inflationary Factors, including:
   - general inflation
   - medical inflation
   - fuel and transportation costs
   - provider personnel expenses
5. Program Changes which may increase program costs.

Statutory Authority

The Utah Department of Health is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-1 authorizes and establishes the Department; authorizes the Health Advisory Council; and outlines the powers and duties of the department.
- UCA 26-18 creates the Medical Assistance Act, the joint federal/state program that provides healthcare services to select population, commonly known as "Medicaid".
- UCA 26-23 grants enforcement authority and penalty provisions to the department.
- UCA 26-25 limits the usage of confidential medical information obtained by the department.
- UCA 26-26 requires institutions to obtain the department's authorization to obtain impounded animals for scientific and educational activities.

Funding Detail

The Department of Health utilizes significant funding from the state General Fund and Federal Funds. Additional sources of funding include dedicated credits, transfers, and various restricted funds.

Budget History - Department of Health

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	233,410,500	263,684,500	287,990,800	319,339,900	337,937,700
General Fund, One-time	0	(36,917,800)	0	19,152,000	20,040,600
Federal Funds	907,792,332	1,063,467,378	1,119,576,600	1,196,617,500	1,234,714,100
Dedicated Credits Revenue	85,923,291	99,305,499	114,623,000	107,074,300	123,169,900
GFR - Cigarette Tax Rest	2,868,400	3,131,500	3,131,500	3,131,500	3,131,700
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
GFR - Medicaid Restricted	1,573,000	0	0	0	0
GFR - Nursing Care Facilities Account	0	5,347,300	10,100,000	10,407,500	11,604,300
GFR - State Lab Drug Testing Account	270,800	277,600	293,600	293,600	293,300
GFR - Tobacco Settlement	11,558,500	13,064,900	13,155,200	16,531,800	16,624,500
Organ Donation Contribution Fund	113,000	113,000	113,000	76,100	113,000
Transfers	67,280,436	70,377,341	0	0	0
Transfers - Environmental Quality	0	0	30,800	22,500	31,900
Transfers - H - Medical Assistance	0	0	2,012,100	10,000	20,100
Transfers - Human Services	40,219,454	40,155,281	86,719,200	108,260,700	61,716,500
Transfers - Intergovernmental	0	0	(1,083,100)	(1,406,800)	(145,100)
Transfers - Medicaid	0	0	1,171,500	1,679,000	1,261,000
Transfers - Other Agencies	0	0	7,381,300	9,290,200	50,264,500
Transfers - Public Safety	0	0	136,600	218,400	236,600
Transfers - State Office of Education	0	0	175,200	6,400	8,400
Transfers - Within Agency	0	0	12,352,900	18,492,700	14,965,600
Transfers - Workforce Services	0	0	641,000	639,900	676,300
Beginning Nonlapsing	2,040,019	3,802,269	3,787,900	4,327,400	2,390,000
Closing Nonlapsing	(3,802,270)	(3,747,798)	(4,327,400)	(9,242,200)	(2,191,000)
Lapsing Balance	(6,249,780)	(979,554)	(1,988,200)	(2,162,000)	0
Total	$1,343,097,682	$1,521,181,416	$1,656,093,500	$1,802,860,400	$1,876,963,900
Line Items					
Executive Director's Operations	17,404,808	24,385,919	26,519,600	25,225,700	25,739,100
Health Systems Improvement	12,549,638	12,651,077	11,328,800	12,111,300	15,469,300
Workforce Financial Assistance	566,299	430,299	794,900	940,300	572,900
Epidemiology & Lab Services	14,701,088	15,259,670	15,865,400	16,634,800	18,153,800
Community & Family Health	93,136,967	94,064,434	98,790,300	100,010,000	105,305,800
Health Care Financing	72,941,682	64,274,904	67,679,400	75,944,300	71,084,000
Medical Assistance	1,100,162,664	1,274,428,494	1,397,207,200	1,518,090,800	1,587,204,900
Children's Health Ins Prog	29,548,836	33,674,019	35,866,700	51,847,500	51,341,900
Local Health Departments	2,085,700	2,012,600	2,041,200	2,055,700	2,092,200
Total	$1,343,097,682	$1,521,181,416	$1,656,093,500	$1,802,860,400	$1,876,963,900
Categories of Expenditure					
Personal Services	66,376,469	70,420,394	74,936,200	79,282,800	84,987,400
In-State Travel	657,077	609,646	610,000	723,700	708,000
Out of State Travel	531,098	539,009	600,300	589,400	633,000
Current Expense	43,324,250	48,220,204	45,167,300	57,447,400	48,344,100
DP Current Expense	6,244,917	7,108,762	7,545,200	7,298,600	6,525,500
DP Capital Outlay	53,109	722,219	1,034,400	307,500	0
Capital Outlay	375,314	399,465	725,900	404,700	177,800
Other Charges/Pass Thru	1,225,535,448	1,393,161,717	1,525,474,200	1,656,806,300	1,735,588,100
Total	$1,343,097,682	$1,521,181,416	$1,656,093,500	$1,802,860,400	$1,876,963,900
Other Data					
Budgeted FTE	1,244.6	1,308.9	1,315.8	1,336.4	1,337.6
Vehicles	52	52	55	73	54

Table 1-1

CHAPTER 2 EXECUTIVE DIRECTOR'S OPERATIONS

Function

The Utah Executive Director's Operations (EDO) includes those functions of the Department of Health that provide overall direction of policy, management, and administrative support to the divisions, offices, and programs of the Department. This organizational line item also includes the Office of the Medical Examiner, Bioterrorism Grants, and the Center for Health Data.

Statutory Authority

The Utah Department of Health is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-1-8 through 26-1-17 details the qualifications and powers of the executive director of the department.
- UCA 26-2 creates the Vital Statistics Act which is the State's repository of birth and death certificates.
- UCA 26-3 empowers the department to collect and maintain health data and utilize that data for analytical purposes.
- UCA 26-33a creates the Utah Health Data Authority Act and the Health Data Committee which uses the data collected through 26-3.
- UCA 26-4 establishes the Medical Examiner Act, which outlines procedures taken when dealing with various deaths in the State.
- UCA 26-18a creates the Kurt Oscarson Children's Organ Transplant Coordinating Committee with the purpose of providing financial assistance to children facing organ transplants.
- UCA 26-18b creates the Organ Donation Contribution Fund which promotes and supports organ donations through a statewide registry and donor awareness education.
- UCA 26-28 establishes criteria for organ donations and how those affect the Medical Examiner.

Accountability

The programs with the Executive Director's Operations and especially the Executive Director's Office closely monitor the performance of all program areas within the Department of Health. Specific accountability performance measures are included in each program section. Caseload levels, medical service utilization, incidences of diseases and system capacity are all used to determine the health of the state's population and establish systems to both improve health and prevent suffering in the event of a natural or man-made disaster.

Funding Detail

The Executive Director's Operations Division has five major programs and utilizes significant funding from the state General Fund and Federal Funds. Additional sources of funding include dedicated credits, transfers, and various restricted funds. Federal funds support the entire Bioterrorism program, although the level of funding is projected to decrease in the upcoming years.

Budget History - Health - Executive Director's Operations

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	5,963,100	5,388,200	5,670,800	5,888,700	6,264,300
General Fund, One-time	0	4,500	0	70,000	(16,500)
Federal Funds	9,657,921	16,483,149	18,155,200	16,235,100	16,536,600
Dedicated Credits Revenue	1,665,042	2,256,882	2,501,700	2,550,600	2,564,200
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
Organ Donation Contribution Fund	113,000	113,000	113,000	76,100	113,000
Transfers	350,036	71,938	0	0	0
Transfers - Other Agencies	0	0	0	246,400	0
Transfers - Within Agency	0	0	50,100	43,900	125,500
Beginning Nonlapsing	345,450	324,936	276,500	125,000	72,700
Closing Nonlapsing	(324,936)	(236,422)	(125,000)	(73,200)	(20,700)
Lapsing Balance	(464,805)	(120,264)	(222,700)	(36,900)	0
Total	$17,404,808	$24,385,919	$26,519,600	$25,225,700	$25,739,100
Programs					
Executive Director	1,834,107	1,833,551	1,859,000	2,144,800	2,413,600
Program Operations	3,240,372	3,378,430	3,535,000	3,452,400	3,839,700
Medical Examiner	1,920,356	1,957,937	2,029,200	2,107,100	2,130,100
Bio Terrorism Grants	4,946,158	12,237,308	13,890,700	12,894,300	12,675,800
Center for Health Data	5,463,815	4,978,693	5,205,700	4,627,100	4,679,900
Total	$17,404,808	$24,385,919	$26,519,600	$25,225,700	$25,739,100
Categories of Expenditure					
Personal Services	9,520,074	10,852,651	12,126,800	12,590,600	13,581,200
In-State Travel	56,494	64,273	86,900	81,100	100,400
Out of State Travel	105,393	90,090	130,400	138,400	165,800
Current Expense	2,370,999	4,258,666	5,933,400	6,265,100	6,444,800
DP Current Expense	787,283	1,025,338	1,095,600	976,300	838,600
DP Capital Outlay	18,436	236,944	157,900	67,300	0
Capital Outlay	234,975	163,506	313,100	109,300	0
Other Charges/Pass Thru	4,311,154	7,694,451	6,675,500	4,997,600	4,608,300
Total	$17,404,808	$24,385,919	$26,519,600	$25,225,700	$25,739,100
Other Data					
Budgeted FTE	160.4	209.2	208.9	206.4	209.0
Vehicles	5	5	9	26	5

Table 2-1

Special Funding

As shown in Table 2-2, a portion of the funding for this division comes from two restricted accounts, as detailed in the following table. The FY 2006 balance listed in the table is the fund balance as of June 30, 2006.

Restricted Funds Summary - Executive Director's Operations

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
Kurt Oscarson Children's Organ Transplant Trust Account	26-18a-4	Voluntary contributions on individual income tax return (see UCA 59-10-550)	Provide financial assistance for initial medical expenses of children who need organ transplants; obtain the assistance of volunteer and public service organization; and fund activities as the committee designates for the purpose of educating the public about the need for organ donors.	$168,339
Organ Donation Contribution Fund	26-18b-101	Voluntary donations collected with motor vehicle registrations and drivers' license or identification card applications or renewals (see UCA 53-3-214.7).	Grants to organizations that: promote and support organ donation; assist in maintaining and operating a statewide organ donation registry; and provide donor awareness education.	$80,850

Table 2-2

EXECUTIVE DIRECTOR'S OFFICE

Function

The Office of the Executive Director is responsible for the overall direction of policy and management of the Utah Department of Health. The following administrative support functions also report to this office:

- Legal Counsel – Provides legal counsel and support, drafts administrative rules, and conducts administrative hearings. Also coordinates the Department's legislative affairs.
- Human Resources Management and Employee Development – Responsible for providing personnel support services throughout the Department.
- Policy Support – Facilitates public health strategic and operational planning and coordinates issues and programs of local health departments with the Department of Health.
- Public Information – Directs the release of public information to the media.

Kurt Oscarson Organ Transplant Account

The Kurt Oscarson Children's Organ Transplant Account was established in 1992 to assist families with some of the ancillary expenses involved with an organ transplant. The account does not pay for transplants. The account is funded through a check off on the Utah State Income Tax Form. Collections from FY 1993 through FY 2006 have totaled almost $986,700, averaging approximately $82,800 per year over the past three years. Expenditures began

in FY 1997, and since that time, included $428,000 for administration and promotion expenditures and $390,300 in interest-free loans. The total revenue, less the expenditures, leaves a balance in the account of $168,300.

The five-member coordinating committee, established in UCA 26-18a, may award the financial assistance to eligible families. The committee establishes terms of repayment, which may include a waiver of repayment. The total number of recipients who have received assistance since FY 1997 is 84. In addition to the financial assistance, the committee has approved expenditures for marketing and public awareness campaigns, and for membership dues to Intermountain Organ Recovery. The code requires the committee to make an annual report to the Appropriations Subcommittee.

Organ Donation Contribution Fund

The 2002 Legislature approved the Organ Donation Contribution Fund in an effort to promote and support organ donation, assist in maintaining an organ donation registry, and provide donor awareness education. The fund receives revenue from voluntary donations collected with motor vehicle registrations and driver licenses. The FY 2006 expected amount of revenue was $113,000, which reflects the amount appropriated. Actual FY 2006 collections were $67,900. The Department's collections expenses (as authorized in UCA 26-18b-(1)(c)) were $10,600 resulting in an ending fund balance of $80,850 as of June 30, 2006. Payments for promotion and support of organ donations were $65,700. Revenue has been decreasing significantly each year the last three years. This is probably due, in part, to the competition from an increase in the number of check-off donation options through the State income tax. A large portion of the fund is used for administration which included promotion.

Funding Detail

Budget History - Health - Executive Director's Operations - Executive Director

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	932,900	865,500	855,000	1,055,200	1,089,200
General Fund, One-time	0	2,900	0	0	(3,200)
Federal Funds	797,942	863,816	814,300	941,700	1,112,600
Dedicated Credits Revenue	105,240	5,541	0	0	2,000
GFR - Kurt Oscarson Trans	100,000	100,000	100,000	100,000	100,000
Organ Donation Contribution Fund	113,000	113,000	113,000	76,100	113,000
Beginning Nonlapsing	0	0	40,100	0	0
Lapsing Balance	(214,975)	(117,206)	(63,400)	(28,200)	0
Total	$1,834,107	$1,833,551	$1,859,000	$2,144,800	$2,413,600
Categories of Expenditure					
Personal Services	1,496,877	1,177,161	1,247,000	1,498,800	1,622,700
In-State Travel	4,921	1,965	4,900	8,300	6,500
Out of State Travel	1,134	1,188	3,200	28,900	13,600
Current Expense	225,519	519,922	548,300	547,000	694,400
DP Current Expense	29,656	21,315	15,600	21,800	36,400
Other Charges/Pass Thru	76,000	112,000	40,000	40,000	40,000
Total	$1,834,107	$1,833,551	$1,859,000	$2,144,800	$2,413,600
Other Data					
Budgeted FTE	19.4	15.3	14.5	18.5	21.5
Vehicles	0	0	0	1	0

Table 2-3

PROGRAM OPERATIONS

Function

The following administrative support functions are organized into Program Operations and report to the Executive Director:

- Office of Fiscal Operations – Directs the following functions:
  1. Budget – manages the preparation of the Department's annual appropriations request and monitors expenditures within the appropriated budget.
  2. Finance – Provides purchasing, accounting, payroll, and financial information services.
  3. Financial Audit – Performs financial audits of contracts with outside agencies as well as internal audit activities.
- Information Technology – Provides computer and communication technology support.
- Employee Support Services – Provides administrative support for office function, building, equipment, and grounds.

Vehicle Responsibility

The State Fleet Services has shifted the responsibility for the daily motor pool to the Department. This accounts for the increase in the number of vehicles.

Funding Detail

Budget History - Health - Executive Director's Operations - Program Operations

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,845,900	1,586,800	1,681,900	1,653,500	1,805,400
General Fund, One-time	0	(4,900)	0	0	(5,200)
Federal Funds	1,497,210	1,762,204	1,792,000	1,470,500	1,892,300
Dedicated Credits Revenue	146,284	46,081	38,100	46,800	21,700
Transfers	65,066	71,938	0	0	0
Transfers - Other Agencies	0	0	0	246,400	0
Transfers - Within Agency	0	0	50,100	43,900	125,500
Lapsing Balance	(314,088)	(83,693)	(27,100)	(8,700)	0
Total	$3,240,372	$3,378,430	$3,535,000	$3,452,400	$3,839,700
Categories of Expenditure					
Personal Services	2,576,145	2,688,220	2,735,600	2,863,600	3,216,900
In-State Travel	18,826	16,356	16,100	19,500	20,900
Out of State Travel	2,624	7,678	15,100	13,500	13,200
Current Expense	270,890	403,143	337,400	329,200	290,800
DP Current Expense	353,418	263,033	338,700	247,500	297,900
DP Capital Outlay	18,436	0	92,100	(20,900)	0
Other Charges/Pass Thru	33	0	0	0	0
Total	$3,240,372	$3,378,430	$3,535,000	$3,452,400	$3,839,700
Other Data					
Budgeted FTE	42.4	42.8	44.0	44.1	44.1
Vehicles	1	1	1	17	1

Table 2-4

OFFICE OF THE MEDICAL EXAMINER

Function

The Office of the Medical Examiner (OME) is responsible for the investigation and certification of sudden and unexpected deaths that occur within the borders of the State. The specific circumstances surrounding any given death which place it under the jurisdiction of the OME are specified in UCA 26-4-7. Given that any resident or visitor to Utah may potentially die in circumstances defined in the Medical Examiners Act, the OME serves a population of approximately 2.3 million, not including visitors to the State.

Staff pathologists perform the majority of the examinations performed by the OME and all of the autopsies. Contracted physicians in local communities examine approximately 150 cases each year or approximately 6.5 percent of all exams performed. These physicians conduct external examinations only. Other OME personnel assist in examinations and maintain morgue operations 24 hours per day. Investigators (both employed and contracted) gather information needed to understand how a death happened. For the past several years, the appropriation has included funding to pay staff costs for their on-call coverage of the office.

The OME pays for transportation of bodies under its jurisdiction. A contracted transportation service is used along the Wasatch Front; funeral homes provide all other transportation.

Accountability

The following table lists the number of cases reported to, investigated and certified by, the Office of the Medical Examiner for the past four years, separated according to manner of death. The table includes inquiries received where it was determined that the death did not fall under the jurisdiction of the Medical Examiner.

The 2006 Legislature appropriated $70,000 one-time General Fund to the Office of the Medical Examiner to assist with the increased caseload and utilization of the Office. Though the overall autopsy caseload has not changed significantly, there are other funding factors to consider such as transportation and storage fees.

MEDICAL EXAMINER CASES

Case Type	FY 2003	% of Cases	FY 2004	% of Cases	FY 2005	% of Cases	FY 2006	% of Cases
Natural	728	38.00%	794	37.00%	658	34.89%	654	34.42%
Accidents	485	26.00%	412	23.00%	453	24.02%	457	24.05%
Suicides	352	18.00%	336	18.00%	370	19.62%	345	18.16%
Undetermined	264	14.00%	356	19.00%	347	18.40%	379	19.95%
Homicides	69	4.00%	54	3.00%	58	3.08%	65	3.42%
Pending	0	0.00%	0	0.00%	24	1.27%	0	0.00%
Total Autopsies	**1,898**	100.00%	**1,952**	100.00%	**1,886**	101.27%	**1,900**	100.00%
***Terminated**	1,359		1,416		1,461		1,455	
***Inquiries**	1,629		1,607		1,638		1,640	
Total Cases	**4,886**		**4,975**		**4,985**		**4,995**	

***Inquiries and Terminated Cases: Not examined at OME, but are processed and investigated.**

Table 2-5

The following chart details the Medical Examiners target and actual number of autopsies performed and investigations conducted. This does not account for any expenses or effort for the transportation of bodies that contributes to the time and resources necessary to accomplish the office mission.

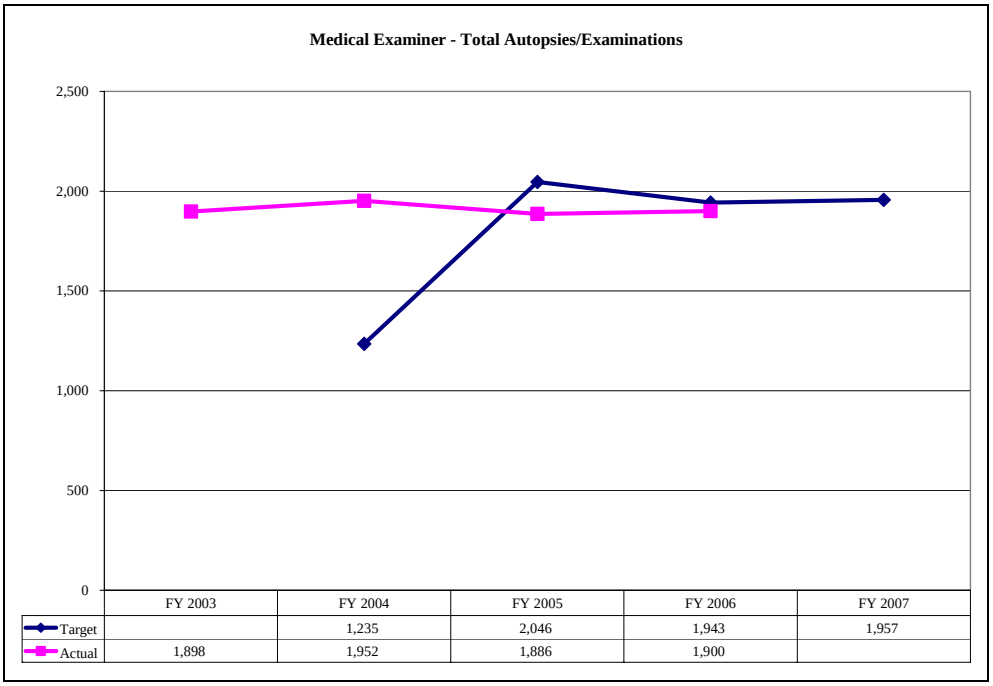


Figure 2-1

Funding Detail

The Medical Examiner's office is primarily funded with State General Fund. Dedicated Credit Revenue is available through fees and payment for services.

Budget History - Health - Executive Director's Operations - Medical Examiner

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,778,200	1,770,400	1,952,100	1,952,500	2,052,700
General Fund, One-time	0	4,300	0	70,000	(4,900)
Dedicated Credits Revenue	88,936	85,759	77,100	84,600	82,300
Lapsing Balance	53,220	97,478	0	0	0
Total	$1,920,356	$1,957,937	$2,029,200	$2,107,100	$2,130,100
Categories of Expenditure					
Personal Services	1,371,481	1,399,989	1,462,700	1,494,200	1,562,500
In-State Travel	3,292	3,021	2,900	4,200	3,200
Out of State Travel	0	1,211	0	0	1,300
Current Expense	537,618	543,184	548,700	578,800	547,400
DP Current Expense	7,965	10,532	13,800	29,700	15,700
Other Charges/Pass Thru	0	0	1,100	200	0
Total	$1,920,356	$1,957,937	$2,029,200	$2,107,100	$2,130,100
Other Data					
Budgeted FTE	19.2	19.6	21.1	21.5	21.5
Vehicles	4	4	3	3	4

Table 2-6

BIOTERRORISM GRANTS

Function

After September 11, 2001 and the ensuing anthrax scare, the federal government began funding a nationwide program for bioterrorism preparedness. The Utah Department of Health received $22.4 million in federal grants from the Center for Disease Control (CDC) for public health preparedness and response for bioterrorism. For FY 2006, the department received an additional $9.9 million in grants. The grant is broken down into six categories under nine preparedness goals. They are:

Prevent:

1. Increase the use and development of interventions known to prevent human illness from chemical, biological, radiological agents, and naturally occurring health threats.

Detect and Report:

2. Decrease the time needed to classify health events as terrorism or naturally occurring in partnership with other agencies.
3. Decrease the time needed to detect and report chemical, biological, radiological agents in tissue, food or environmental samples that cause threats to the public's health.
4. Improve the timeliness and accuracy of communications regarding threats to the public's health.

Investigate:

5. Decrease the time to identify causes, risk factors, and appropriate interventions for those affected to the public's health.

Control:

6. Decrease the time needed to provide countermeasures and health guidance to those affected by threats to the public's health.

Recover:

7. Decrease the time needed to restore health services and environmental safety to pre-event levels.
8. Improve the long-term follow-up provided to those affected by threats to the public's health.

Improve

9. Decrease the time needed to implement recommendations from after-action reports following threats to the public's health.

In addition to the CDC Bioterrorism grant, the Health Resources and Services Administration (HRSA) Hospital Preparedness Bioterrorism Grant was $8.5 million in FY 2006. This grant is designated for hospitals to increase training, education and supplies. The grant is broken into the following priority areas:

- Administration
- Regional Surge Capacity

- Communications and Information Technology
- Links to Public Health Departments
- Education and Preparedness Training
- Terrorism Preparedness Exercises
- Awardee wide planning

Both the CDC Bioterrorism grant and the HRSA Hospital Preparedness grant are projected to go through FY 2007. Note: Most of the FTE's associated with this grant are "AL" positions, indicating that they are temporary employees and are available only while there is funding from the grant. When the grant funding ends, the positions will be eliminated.

Accountability

The funding is from federal funds which maintain strict bookkeeping controls and oversight. This particular area is one that is better judged in cost avoidance rather than any savings at the moment. Preparation is key, but no one knows the exact nature of the event for which to prepare. Performance measures include items such as statewide Bioterrorism Preparedness and specifically preparing hospitals to be able to respond efficiently and effectively.

The Department reports preparations being made at the 12 local health departments and 42 hospitals throughout the state. The Governor also has a task force evaluating the potential need and alternatives. The benefit of this program is in the cost avoidance "when" and in case "something" happens.

Funding Detail

Funding is from federal funds. There have been adjustments made the last few years, but the overall funding has remained relatively stable.

Budget History - Health - Executive Director's Operations - Bio Terrorism Grants

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
Federal Funds	4,946,158	12,237,308	13,890,700	12,894,300	12,675,800
Total	$4,946,158	$12,237,308	$13,890,700	$12,894,300	$12,675,800
Categories of Expenditure					
Personal Services	1,091,569	2,282,886	3,271,000	3,275,900	3,562,400
In-State Travel	15,247	27,296	53,800	40,100	56,300
Out of State Travel	66,522	57,619	79,600	69,600	102,900
Current Expense	351,771	1,707,910	3,959,700	4,068,800	4,172,900
DP Current Expense	140,029	447,917	370,600	410,900	293,000
DP Capital Outlay	0	236,944	55,600	48,200	0
Capital Outlay	234,975	163,506	313,100	109,300	0
Other Charges/Pass Thru	3,046,045	7,313,230	5,787,300	4,871,500	4,488,300
Total	$4,946,158	$12,237,308	$13,890,700	$12,894,300	$12,675,800
Other Data					
Budgeted FTE	15.4	60.3	57.6	53.0	53.0
Vehicles	0	0	5	5	5

Table 2-7

CENTER FOR HEALTH DATA

Function

The Center for Health Data manages, analyzes, and provides appropriate access to strategic information resources that support Utah public health. The operating units of the Center are the Offices of Health Care Statistics, Public Health Assessment, Vital Records and Statistics, and the Utah Statewide Immunization Information System. The mission of the Center is to (1) provide statistical and epidemiological expertise to the Department so that high quality data are collected, analyzed, and interpreted for surveillance, planning, program evaluation, and policy development; (2) register, preserve, and certify vital records; (3) provide information for immunization coordination; and (4) disseminate health data to improve health care access, quality, and cost.

This mission is accomplished through the following functions:

- Registration, preservation, and certification of the public's vital records;
- Collection, tabulation, analysis, and publication of vital statistics and other health status and health system statistical reports;
- Providing health indicators to business and the public over the internet as an e-government service;
- Providing electronic access to childhood immunization records for physicians;
- Providing training and consultation on the intelligent use of data for planning and carrying out public health measures;
- Promoting patient safety initiatives in concert with Utah hospitals;
- Reporting managed care performance measures and enrollee satisfaction;
- Collecting and reporting of statewide hospitalization, surgery, and emergency department encounter data;
- Collecting and reporting of managed care organizations' performance measures and HMO enrollee satisfactions;
- Promoting and coordinating of statewide hospital patient safety initiatives using available hospital data.

The following table shows the historical trends of vital records generated and maintained by this office.

Vital Records Certificate Activity by Fiscal Year

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Births	48,147	48,763	49,409	50,816	51,884	51,711	53,507
Deaths	12,495	12,822	13,382	13,522	14,008	13,573	13,966
Fetal Deaths	246	247	273	294	282	311	307
Induced Abortions	3,024	3,380	3,594	3,618	3,277	3,554	3,556
Marriages	24,448	24,474	24,981	24,182	22,294	17,454	20,610
Divorces	9,218	8,192	9,607	7,172	9,114	6,818	7,205
Ancillary Records	5,453	5,591	5,403	5,047	4,609	4,669	6,701
Other New Records	2,108	1,793	2,019	2,378	2,033	2,456	2,624
Total	**105,139**	**105,262**	**108,668**	**107,029**	**107,501**	**100,546**	**108,476**
Certificate Copies Issued	79,343	84,779	89,795	95,940	88,234	86,509	92,869
Fees Collected	$718,911	$724,612	$806,234	$913,884	$1,081,821	$1,108,172	$1,245,359

Table 2-8

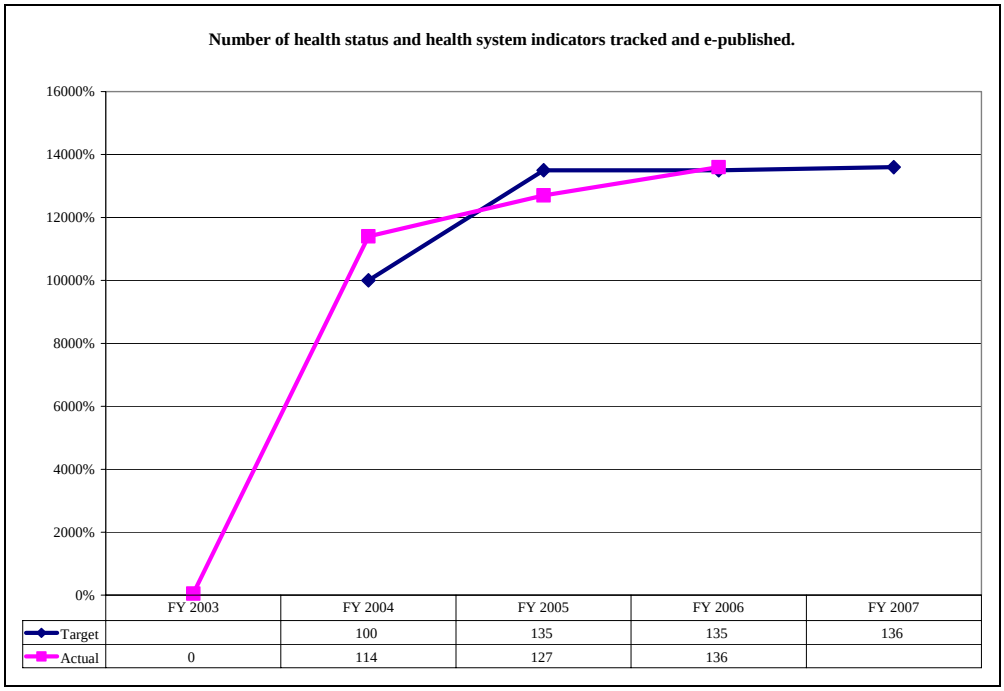


Figure 2-2

This program received supplemental funding in FY 1995 in the amount of $337,000 for a health status survey. The funding was designated as non-lapsing by intent language. Previously, this survey has been done on a five-year cycle. An appropriation of $400,000 ($320,000 one-time; $80,000 ongoing) was approved in FY 2001 for the next survey. This funding was also designated as non-lapsing. With this ongoing funding, the survey is more of an ongoing, continual process, which provides more timely, relevant information.

The survey results in a number of reports, among them: Health Insurance Coverage, Injuries in Utah, Health Status in Utah, Chronic Conditions in

Utah, Socioeconomic Status and Health, Limitations of Activities, Interpersonal Violence, Health Care Access and Utilization, Lifestyle Factors, and the Medical Outcomes Study.

Funding Detail

The funding for the Center for Health Data budget is distributed between the three major funds, General Fund, federal funds and Dedicated Credit Revenue. Though funding is stable, the demand for services continues to grow.

Budget History - Health - Executive Director's Operations - Center for Health Data

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,406,100	1,165,500	1,181,800	1,227,500	1,317,000
General Fund, One-time	0	2,200	0	0	(3,200)
Federal Funds	2,416,611	1,619,821	1,658,200	928,600	855,900
Dedicated Credits Revenue	1,324,582	2,119,501	2,386,500	2,419,200	2,458,200
Transfers	284,970	0	0	0	0
Beginning Nonlapsing	345,450	324,936	236,400	125,000	72,700
Closing Nonlapsing	(324,936)	(236,422)	(125,000)	(73,200)	(20,700)
Lapsing Balance	11,038	(16,843)	(132,200)	0	0
Total	$5,463,815	$4,978,693	$5,205,700	$4,627,100	$4,679,900
Categories of Expenditure					
Personal Services	2,984,002	3,304,395	3,410,500	3,458,100	3,616,700
In-State Travel	14,208	15,635	9,200	9,000	13,500
Out of State Travel	35,113	22,394	32,500	26,400	34,800
Current Expense	985,201	1,084,507	539,300	741,300	739,300
DP Current Expense	256,215	282,541	356,900	266,400	195,600
DP Capital Outlay	0	0	10,200	40,000	0
Other Charges/Pass Thru	1,189,076	269,221	847,100	85,900	80,000
Total	$5,463,815	$4,978,693	$5,205,700	$4,627,100	$4,679,900
Other Data					
Budgeted FTE	64.1	71.2	71.7	69.3	68.9

Table 2-9

CHAPTER 3 HEALTH SYSTEMS IMPROVEMENT

Function

The Division of Health Systems Improvement assures and improves the quality of the Utah health care system. Its mission is fulfilled through the examination, analysis, and actions to improve service availability, accessibility, acceptability, continuity, quality, and cost.

The Division includes the Director's office, the Office of Primary Care and Rural Health, the Bureau of Child Care Licensing, the Bureau of Emergency Medical Services (EMS), the Bureau of Health Facility Licensing, Certification, and Resident Assessment (HFLCRA) and the Bureau of Clinical Services (BCS). Through the four bureaus, Health Systems Improvement directs the regulation and oversight of the health care industry. Division-wide improvement strategies include training, certification, licensing, inspection, and pre-admission screenings for all Utah Medicaid recipients seeking nursing home or institutional care, and promoting primary care services to underserved populations. The Division additionally supports the Patient Safety Initiative, the Primary Care Grants Program, the Health Care Workforce Financial Assistance Program, and the Assistance to Persons with Bleeding Disorders Program.

Statutory Authority

The Division of Health Systems Improvement is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-6a sets up criteria for testing and workers' compensation for emergency medical services providers who are exposed to various diseases.
- UCA 26-8a creates the State Emergency Medical Services Committee, establishes the Statewide Trauma System, and outlines the criteria for emergency medical service personnel.
- UCA 26-9 outlines the Department's efforts in relation to primary health care services in rural areas of the State.
- UCA 26-18, Part 3 "Access to Health Care" outlines the requirements for the Department to make grants to public and non-profit entities for the cost of operation of providing primary health care services to medically underserved populations.
- UCA 26-21 outlines the necessary requirements for state licensing of various health care facilities.
- UCA 26-21a requires the department to license facilities using diagnostic mammography.
- UCA 26-39 details the licensing requirements for child care providers.
- UCA 26-47-103 created the Assistance to Persons with Bleeding Disorders Program. It outlines the criteria for granting awards for assistance with the cost of obtaining hemophilia services or the cost of insurance premiums for coverage of hemophilia services.

Intent Language

The Legislature included several items of intent language for the Division of Health Systems Improvement in the FY 2006 Appropriations Act. Most of these deal with nonlapsing funding.

In Item 84, S.B. 4, 2006 General Session, the Legislature stated that fees collected for the purpose of plan reviews in the Bureau of Health Facility Licensing, Certification and Resident Assessment and civil money penalties and all funding for the State Primary Care Grants Program be considered nonlapsing. Additionally, funds appropriated for assistance to people with bleeding disorders was also made nonlapsing.

Funding Detail

The Division's funding comes from three main sources - the state General Fund, Federal Funds, and dedicated credits.

Budget History - Health - Health Systems Improvement

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	3,987,200	4,014,500	4,404,600	4,705,200	5,336,200
General Fund, One-time	0	9,000	0	0	346,100
Federal Funds	4,180,414	4,328,255	3,595,200	3,539,100	4,789,700
Dedicated Credits Revenue	3,812,456	3,959,797	4,378,300	4,311,600	4,854,900
Transfers	156,027	222,183	0	0	0
Transfers - Public Safety	0	0	136,600	131,400	145,400
Transfers - Within Agency	0	0	0	52,100	0
Beginning Nonlapsing	1,274,983	845,431	724,900	1,716,600	1,196,400
Closing Nonlapsing	(845,431)	(724,929)	(1,716,600)	(2,341,100)	(1,199,400)
Lapsing Balance	(16,011)	(3,160)	(194,200)	(3,600)	0
Total	$12,549,638	$12,651,077	$11,328,800	$12,111,300	$15,469,300
Programs					
Director's Office	819,194	748,273	244,900	276,600	316,700
Emergency Medical Services	5,245,983	4,953,277	3,918,200	4,184,000	4,760,300
Child Care Licensing	3,004,179	2,043,614	2,374,500	2,281,900	2,562,600
Health Facility Licensure, Certification, and	2,914,942	4,279,256	3,699,700	4,116,300	5,275,000
Primary Care and Rural Health	565,340	626,657	1,091,500	1,252,500	2,554,700
Total	$12,549,638	$12,651,077	$11,328,800	$12,111,300	$15,469,300
Categories of Expenditure					
Personal Services	6,947,717	7,038,781	6,703,800	7,188,700	8,407,500
In-State Travel	216,521	190,340	163,100	235,100	237,400
Out of State Travel	80,115	82,257	70,100	97,100	114,800
Current Expense	2,853,210	2,785,694	2,479,100	2,405,300	3,466,100
DP Current Expense	167,804	261,606	434,700	288,300	287,500
DP Capital Outlay	0	0	42,200	24,000	0
Capital Outlay	5,874	10,529	7,800	0	0
Other Charges/Pass Thru	2,278,397	2,281,870	1,428,000	1,872,800	2,956,000
Total	$12,549,638	$12,651,077	$11,328,800	$12,111,300	$15,469,300
Other Data					
Budgeted FTE	136.2	130.4	130.7	135.6	136.0
Vehicles	22	22	22	23	24

Table 3-1

DIRECTOR'S OFFICE

Function

The administrative function of the Division of Health Systems Improvement includes planning and budget analysis, coordination of intradivisional activities, oversight of the four bureaus and one office, identification and implementation of information systems improvement, patient safety initiative, and division liaison with other public and private agencies and organizations.

Funding Detail

The HSI Director's budget is entirely General Fund. All federal funding has been shifted to program areas.

Budget History - Health - Health Systems Improvement - Director's Office

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	172,000	215,800	244,900	276,600	317,600
General Fund, One-time	0	600	0	0	(900)
Federal Funds	601,892	579,364	0	0	0
Dedicated Credits Revenue	0	(1,129)	0	0	0
Lapsing Balance	45,302	(46,362)	0	0	0
Total	$819,194	$748,273	$244,900	$276,600	$316,700
Categories of Expenditure					
Personal Services	357,560	339,038	174,600	139,600	145,800
In-State Travel	1,999	579	100	100	3,000
Out of State Travel	8,901	7,157	600	1,000	8,200
Current Expense	409,955	313,873	35,600	113,800	140,200
DP Current Expense	5,779	9,292	34,000	12,100	19,500
DP Capital Outlay	0	0	0	10,000	0
Capital Outlay	0	10,529	0	0	0
Other Charges/Pass Thru	35,000	67,805	0	0	0
Total	$819,194	$748,273	$244,900	$276,600	$316,700
Other Data					
Budgeted FTE	6.9	6.2	6.5	3.0	3.0

Table 3-2

EMERGENCY MEDICAL SERVICES

Function

The Bureau of Emergency Medical Services (EMS) is a leadership team functioning as a resource and providing assurance of a quality emergency medical system in the State. The Bureau of Emergency Medical Services has as its mission to promote a statewide system of emergency and trauma care to reduce morbidity and mortality, through prevention, awareness, and quality intervention.

The Bureau implements this mission by:

- Providing good customer service and establishing a teamwork model of services.
- Providing information, technical assistance and consultation to providers of emergency medical services to enhance the provision of quality emergency care.

- Assuring compliance by emergency medical providers to rules and regulations that promote quality emergency care.
- Promoting the highest standards possible for the statewide provision of emergency medical services, taking into consideration available resources, utilizing available resources and investigating alternative funding sources.
- Establishing an infrastructure to provide administrative support that will continually seek to improve, streamline, and find the most cost-effective way to meet the needs throughout the State.
- Recognizing Bureau personnel as valuable employees and empowering them to make decisions to facilitate their performance, provide good customer service, and to seek additional training for the attainment of Bureau goals.
- Encouraging EMS involvement and coordination with existing and new injury prevention and health promotion activities.
- Promoting and supporting programs and activities that address the physical and mental health and safety of EMS personnel.

Accountability

The Emergency Management Services has a variety of services and measures. Each program is discussed separately. A key measure for the EMS is the "Completion of relicensing or a re-designation quality assurance review. The Division has just begun tracking these reviews. Targets have been set and achieved in addition to the activities within the separate programs.

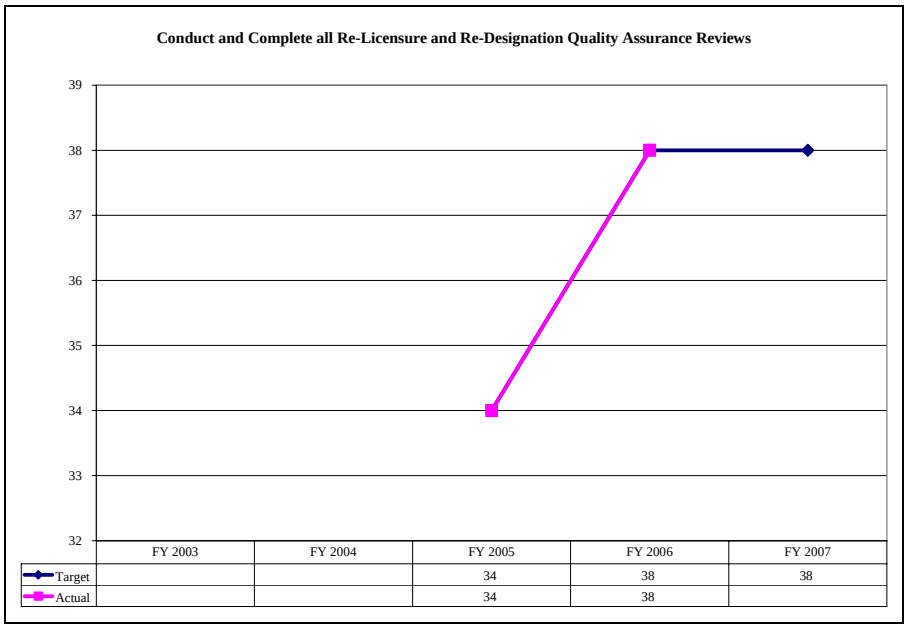


Figure 3-1

EMS Grants Program

The portion of the criminal fines and forfeitures surcharge that is allocated to EMS has restrictions on its usage established in the Utah Code. After funding staff support, administrative expenses and trauma system development, the

Bureau then allocates 15 percent of the remaining balance to emergency medical training programs developed for high school students, 42.5 percent for block grants for emergency medical services at the county level, determined by population, and the remaining 42.5 percent as competitive grants distributed to applicants based on the rules established by the Emergency Medical Services Committee.

EMT Certification

Emergency Medical Technicians (EMT) must be certified to meet a statewide standard for emergency medical service provision. The following two charts show the number of certifications and re-certifications and examinations given from 2000 to 2006. The number of EMT certifications has grown fairly steadily from 1997 when there were 1,501 certifications to 2,366 in FY 2006. This is a 57.6 percent increase over the ten years or an average of 5.76 percent per year.

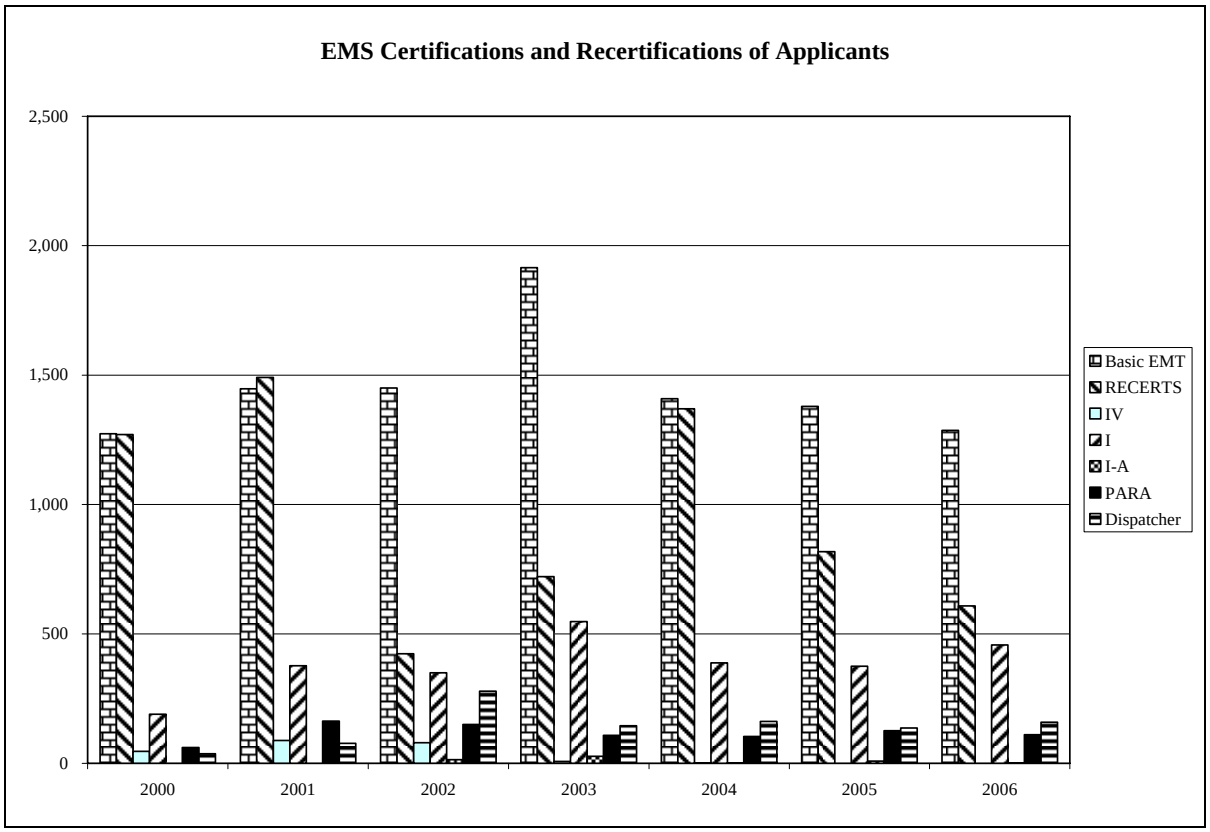


Figure 3-2

To assist EMTs in gaining certification or recertification, courses are available. The following chart shows the number of those course offerings. In 2000, there were 135 course offerings; in 2006, there were 188.

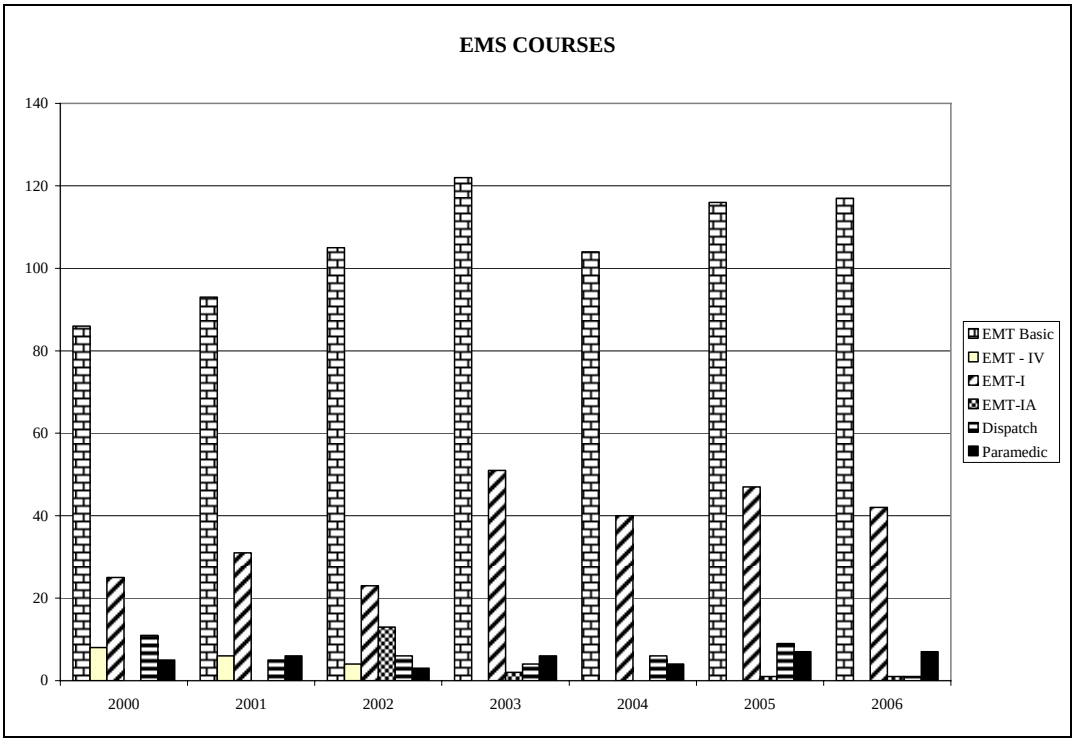


Figure 3-3

* The EMT IV program was dropped during FY 2003.

Funding Detail

Funding for the Emergency Management Services is primarily self-generated from Dedicated Credit Revenue. The General Fund to Dedicated Credit ratio is more than 3 to 1.

Budget History - Health - Health Systems Improvement - Emergency Medical Services

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	901,500	886,000	1,070,000	1,103,900	1,091,800
General Fund, One-time	0	8,300	0	0	(2,800)
Federal Funds	1,094,758	1,012,864	445,900	286,800	49,300
Dedicated Credits Revenue	2,501,661	2,752,489	2,985,000	2,911,900	3,498,600
Transfers	156,280	222,183	0	0	0
Transfers - Public Safety	0	0	134,200	131,400	145,400
Beginning Nonlapsing	1,015,817	471,965	357,100	1,074,000	575,600
Closing Nonlapsing	(471,965)	(357,095)	(1,074,000)	(1,324,000)	(597,600)
Lapsing Balance	47,932	(43,429)	0	0	0
Total	$5,245,983	$4,953,277	$3,918,200	$4,184,000	$4,760,300
Categories of Expenditure					
Personal Services	1,341,452	1,187,672	1,235,900	1,418,300	1,428,700
In-State Travel	89,784	61,884	72,900	97,200	85,600
Out of State Travel	32,919	32,365	36,000	52,600	37,000
Current Expense	1,543,021	1,504,435	1,041,100	677,500	614,000
DP Current Expense	53,574	74,906	191,400	144,800	86,000
DP Capital Outlay	0	0	0	14,000	0
Capital Outlay	5,874	0	0	0	0
Other Charges/Pass Thru	2,179,359	2,092,015	1,340,900	1,779,600	2,509,000
Total	$5,245,983	$4,953,277	$3,918,200	$4,184,000	$4,760,300
Other Data					
Budgeted FTE	30.1	26.8	27.0	27.3	27.3
Vehicles	6	6	6	6	6

Table 3-3

CHILD CARE LICENSING

Function

The Bureau of Child Care Licensing is responsible for ensuring and protecting the health and safety of children through inspection of child care facilities, enforcing rules governing child care facilities and providing education and information to the public. The Bureau of Child Care implements this mission by inspecting child care facilities to ensure compliance to state rules.

The categories with the largest numbers of facilities include Residential Certificate (1,266), Licensed Family Child Care Providers (810), Child Care Centers (272), Licensed Family Group Child Care providers (260) and Hourly Child Care Centers (83).

A provider/facility may be issued a deficiency if it is found to be in violation of state rules. Enforcement activities and sanctions follow adjudicative proceedings. A major activity of rule writing and rule revision is completed under the direction of the Child Care Licensing Advisory Committee.

As a result of legislation passed during the 1997 Legislative General Session, the responsibility of licensing child care providers was added to the Bureau of Child Care Licensing. In addition, Licensing also was given the responsibility of licensing hourly care providers. To accommodate this additional responsibility, Licensing has updated the state rules with input from the Child Care Licensing Advisory Committee, and has centralized the licensing function and redistributed personnel to address case load equity. In 2003, licensing adopted the issuance of two-year licenses to reduce paperwork submission from licensed child care providers. The following chart shows the number and types of child care facilities. It should be noted that a significant driver of the workload in the child care licensing area is the turnover. Over the course of 2006, there were 552 facilities which closed, while another 528 new facilities were opened. In January 2006, the Office of Child Care was changed to the Bureau of Child Care Licensing and a new director was hired. On July 1, 2006, the Bureau of Child Care Licensing reverted back to the one year license so that all providers will have a background check annually. Also, the Bureau regionalized their initial license and renewal process to create better customer service.

Accountability

The Child Care Licensing performance measures are more measures of activity though they are factors related to improving the quality of child care throughout the state. Completing the child care licensing procedures, along with the required and unannounced visits both increases and improves child care in Utah. The chart on the next page lists the number of visits to child care facilities. These numbers include licensing inspections as well as both announced and unannounced visits.

The Bureau regularly increases their targets, but actual workload continues to outpace the estimated efforts.

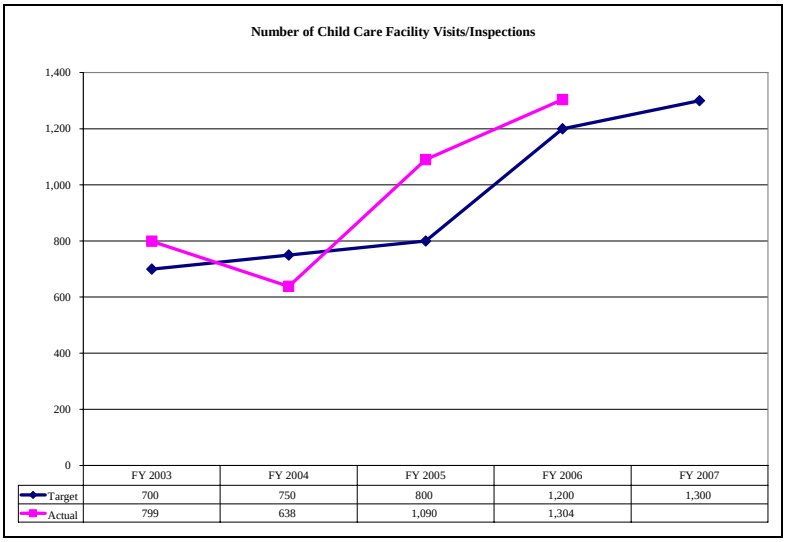


Figure 3-4

In 2006, Licensing processed more than 9,900 MIS and Background Criminal Investigation (BCI) checks on child care providers with 195 hits. This is an effort to improve the safety of the children that receive child care services.

The chart below details the number of facilities. Each facility receives at least two visits annually, one announced and the other unannounced. More visits may be required if violations are discovered. Follow-up visits are then required.

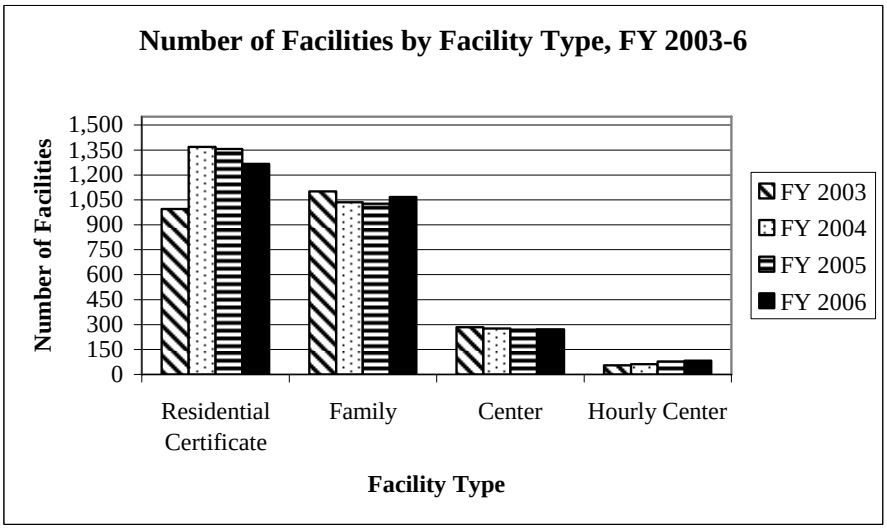


Figure 3-5

Funding Detail

The Bureau of Child Care Licensing is funded approximately 50 percent from General Fund and the remainder from Dedicated Credit Revenue generated by licensing and training fees collected throughout the year.

Budget History - Health - Health Systems Improvement - Child Care Licensing

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,849,200	995,000	1,133,200	1,163,000	1,365,200
General Fund, One-time	0	0	0	0	(3,500)
Dedicated Credits Revenue	1,189,717	965,007	1,231,900	1,131,800	1,200,900
Transfers	(253)	0	0	0	0
Transfers - Public Safety	0	0	2,400	0	0
Transfers - Within Agency	0	0	0	2,100	0
Beginning Nonlapsing	81,441	0	13,200	0	0
Closing Nonlapsing	(77,596)	0	0	(11,400)	0
Lapsing Balance	(38,330)	83,607	(6,200)	(3,600)	0
Total	$3,004,179	$2,043,614	$2,374,500	$2,281,900	$2,562,600
Categories of Expenditure					
Personal Services	2,658,513	1,738,334	1,893,300	1,900,800	2,180,700
In-State Travel	49,007	36,062	27,800	48,300	43,500
Out of State Travel	204	778	(900)	0	3,500
Current Expense	266,148	228,402	310,300	273,100	262,700
DP Current Expense	30,307	40,038	100,300	59,700	72,200
DP Capital Outlay	0	0	42,200	0	0
Other Charges/Pass Thru	0	0	1,500	0	0
Total	$3,004,179	$2,043,614	$2,374,500	$2,281,900	$2,562,600
Other Data					
Budgeted FTE	52.8	49.9	37.5	37.5	37.5
Vehicles	10	10	10	9	10

Table 3-4

HEALTH FACILITY LICENSURE, CERTIFICATION AND RESIDENT ASSESSMENT

Function

Effective July 1, 2004 the Division of Health Systems Improvement implemented a merger between the Bureau of Licensing and the Bureau of Program Certification and Resident Assessment to form a single organizational unit. This unit has the responsibility for both licensing and certification activities for all health care providers within the State of Utah. The name of the newly combined organization is the Bureau of Health Facility Licensing, Certification and Resident Assessment; this title provides a more accurate description of the Bureau's overall duties and responsibilities.

The merger will allow for more coordinated oversight of all health care providers and allow for greater State presence to ensure continued compliance for all Medicare/Medicaid certified entities. Along with an increased coordination within the provider community the bureau also increases its ability of implementing state authorized sanctions against a specific provider identified as being out of compliance with Medicare/Medicaid program requirements.

Rulemaking

The bureau licenses over 700 health care providers, and certified over 350 providers for Medicare/Medicaid participation. These include hospitals, nursing homes, institutions for the mentally retarded and the mentally ill, home health agencies, and many other provider types. In addition to survey inspections, follow-up inspections and complaint investigations are performed. The bureau performs pre-admission/continued stay reviews for over 4,700 Medicaid recipients in Utah nursing homes and institutions for the mentally retarded and the mentally ill.

The bureau is responsible for managing two federal grants: Title 18 (Medicare) Certification Grant, and Title 19 (Medicaid) Certification. These grants are funded at different matching rates. Title 18 Certification is matched at 100 percent and Title 19 is matched at either 75 percent or 50 percent Federal Financial Participation (FFP). In addition, the bureau participates in the regular Title 19, general Medicaid administration program. This program is matched at 75 percent or 50 percent FFP. Overall, the average match rate is 87.5 percent federal and 12.5 percent state.

The bureau manages reviews building plans for new construction and remodeling of health care facilities. Due to the fact that construction and reviews often span multiple fiscal years, the Legislature has approved the designation of plan review fees as non-lapsing.

Background Screening

The Bureau performs background screening for all direct care staff of all nursing homes; small health care facilities; assisted living; home health agencies; hospice agencies; and end stage renal disease facilities. The Bureau performs approximately 23,600 screenings annually.

The Bureau works with the Health Facility Committee, whose members are appointed by the Governor, to develop and revise state regulations to govern the building, operation and quality of care in licensed facilities.

Accountability

The HCFLC&RA established a Medicare/Medicaid Provider Report Card. This is to report the inspections that are done at least every 15 months. It is a federal requirement to conduct and report these inspections. The performance target is that 100 percent of the facilities receive an inspection and report care an "average" of every 15 months. The Bureau has been successful in meeting these targets for nursing home facilities.

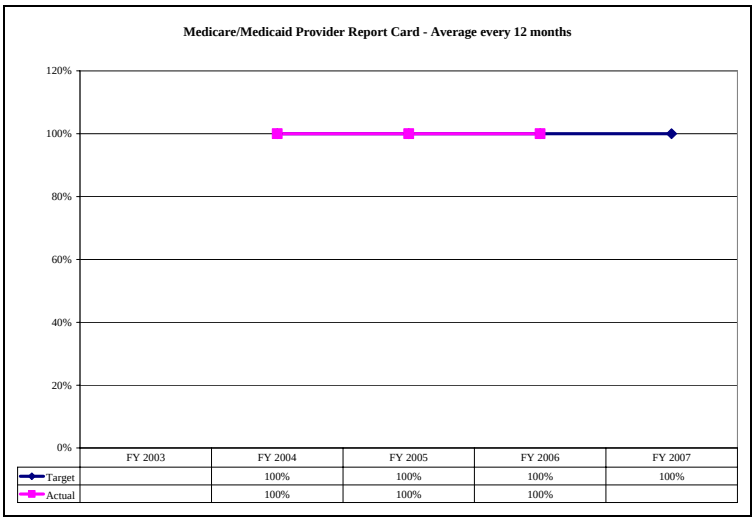


Figure 3-6

The Bureau had planned to implement a similar program and report card for Assisted Living Facilities during FY 2006. This has not yet been done.

Funding Detail

A significant portion of the budget comes from the federal government to address the needs of the Medicare and Medicaid programs. Dedicated Credit Revenue is generated from civil penalties. These are nonlapsing.

Budget History - Health Systems Improvement - Health Facility Licensure, Certification, and Resident Assessment

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	496,000	1,318,800	1,256,800	1,165,000	1,198,400
General Fund, One-time	0	0	0	0	(3,500)
Federal Funds	2,483,764	2,736,027	2,588,300	2,730,900	3,905,700
Dedicated Credits Revenue	121,078	243,430	161,400	267,900	155,400
Transfers - Within Agency	0	0	0	50,000	0
Beginning Nonlapsing	70,616	263,197	272,000	390,900	370,800
Closing Nonlapsing	(185,601)	(285,222)	(390,800)	(488,400)	(351,800)
Lapsing Balance	(70,915)	3,024	(188,000)	0	0
Total	$2,914,942	$4,279,256	$3,699,700	$4,116,300	$5,275,000
Categories of Expenditure					
Personal Services	2,577,800	3,763,349	3,213,700	3,544,400	4,405,700
In-State Travel	75,676	91,761	60,900	88,000	103,700
Out of State Travel	38,091	41,957	28,500	40,200	59,400
Current Expense	146,385	245,531	291,500	382,100	600,300
DP Current Expense	76,990	136,658	97,300	61,600	105,900
Capital Outlay	0	0	7,800	0	0
Total	$2,914,942	$4,279,256	$3,699,700	$4,116,300	$5,275,000
Other Data					
Budgeted FTE	46.0	47.0	59.6	63.6	63.6
Vehicles	6	6	6	8	8

Table 3-5

PRIMARY CARE AND RURAL HEALTH

Function

The Office of Primary Care and Rural Health is an office within the Division of Health Systems Improvement. The office continues to be a resource for Utah's rural, multi-cultural, and underserved communities. The office works with communities that need assistance conducting needs assessments, recruiting health care professionals, grant writing, identifying sources of funding, and implementing other projects related to decreasing disparity and increasing access to primary health care.

The office also serves as the federally-funded State Office of Rural Health; the Primary Care Office is the lead agency in working with the federal National Health Service Corps and the Conrad State 30 J-1 Visa Waiver Program recruiting and retaining health care professionals to work in medically underserved areas of Utah; the Rural Hospital Flexibility Grant Program that assists in strengthening rural health by: 1) allowing small hospitals the flexibility to reconfigure operations and be licensed as critical access hospitals, 2) offering cost-based reimbursement for Medicare acute inpatient and outpatient services, 3) encouraging the development of rural-centric health networks, and 4) offering grants to help implement a critical access hospital program in the context of broader initiatives to strengthen the rural health care infrastructure; and the Small Rural Hospital Improvement Grant Program, which assists small rural hospitals to help them: 1) pay for costs related to the implementation of Medicare Prospective Payment Systems (PPS), 2) comply with provisions of Health Insurance Portability and Accountability Act (HIPAA) and 3) reduce medical errors and support quality improvement.

Primary Care Grants Program

The State Primary Care Grants Program for Medically Underserved Populations makes grants to public and nonprofit entities for the cost of operation of providing primary health care services to medically underserved populations. The program strives to decrease the number of individuals without access to appropriate, high quality, post-effective primary health care by making these grants to qualified provider organizations. The program targets Utah's low-income populations, who have no health insurance, or whose health insurance does not cover primary health care services and do not qualify for Medicare, Medicaid, CHIP, or other government insurance programs. The scope of this program includes populations in medically underserved areas, including the working poor, individuals with chronic diseases, children of low income families, the homeless, Native Americans, seasonal and migrant farm workers, and other disadvantaged groups.

The 1996 and 1997 Legislatures approved $350,000 from Mineral Lease Funds for a State Primary Care Grants Program. The 1998 Legislature increased the funding to $500,000. This amount was also appropriated in 1999 for FY 2000 and FY 2001, but the source of the funding switched in FY 2001 to the Medicaid Restricted Account. Since FY 2002, the funding for the State Primary Care Grants Program has been from the General Fund. Intent language has been included each year with the funding, designating it as nonlapsing.

Assistance to Persons with Bleeding Disorders

The Assistance to Persons with Bleeding Disorders Program makes grants available to assist persons with bleeding disorders with the cost of obtaining hemophilia services. The program assists persons 1) who are medically diagnosed with hemophilia or a bleeding disorder, 2) who are not eligible for Medicaid or Children's Health Insurance Program; and 3) who has either a) insurance coverage that exclude coverage for hemophilia services; b) who has exceeded their insurance plan's annual maximum benefits, c) who has exceeded their annual or lifetime maximum benefits payable under the Comprehensive Health Insurance Pool Act (UCA 31A-29); or d) whose insurance coverage available under either private health insurance, Comprehensive Health Insurance Pool Act, Utah mini COBRA coverage, or federal COBRA coverage, but the premiums for that coverage are at or greater than 7.5 of a person's annual adjusted gross income.

The 2005 and 2006 Legislature appropriated $250,000 each year in State General Fund as part of the Health Care Assistance Act (UCA 26-47-101) to create the Assistance to Persons with Bleeding Disorders program. Intent language has been included with this funding designating it as nonlapsing.

During FY 2006, thirteen persons with bleeding disorders were awarded funding in two rural counties, (Millard and Washington) and two urban counties, (Utah and Weber). During FY 2007 it is estimated that up to fifty persons with bleeding disorders will be awarded funding through the program.

Intent Language

The Legislature included intent language for the Primary Care Grants Program in the FY 2006 New Fiscal Year Supplemental Appropriations Act (S.B. 4).

Item 84, S.B. 4, 2006 General Session, the Legislature stated that all funding for the State Primary Care Grants Program be considered nonlapsing.

Item 84, S.B. 4, 2006 General Session, the Legislature stated that funds appropriated for assistance for people with bleeding disorders be nonlapsing.

Accountability

The performance measures in this program area monitor both the efficiency of the office and the funding available from the Legislature. Processing the awards is an important aspect of the program to assure funding to serve targeted populations.

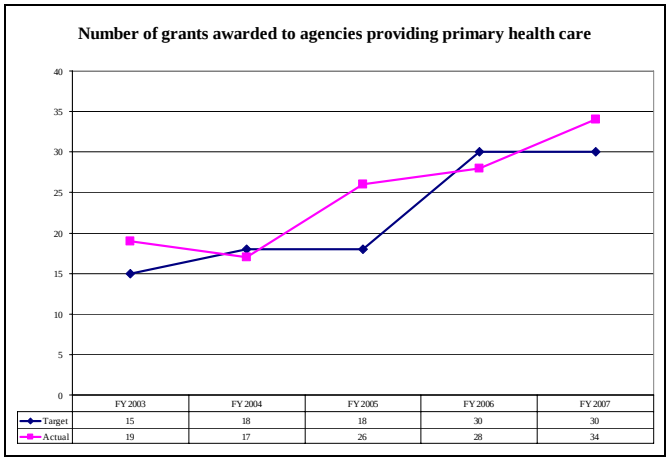


Figure 3-7

The ultimate number of awards is based on the amount of funds available and the purposes for which they are allocated. The chart lists a history of awards.

The following table details the number of awards and the funding allocated according to the type of project.

PRIMARY CARE GRANTS PROGRAM HISTORY									
	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Rural Projects									
New	0	3	5	3	2	0	7	6	11
Continuation	2	5	3	5	6	9	6	11	9
Individuals Served	861	1,699	3,093	1,932	2,503	2,652	1,778	5,511	5,720
Funds	$71,940	$191,798	$218,700	$228,700	$223,850	$205,700	$232,200	$449,360	$687,758
Urban Projects									
New	3	0	0	0	5	1	6	0	5
Continuation	4	4	4	6	6	7	7	11	9
Individiuals Served	3,352	3,117	3,298	1,768	3,178	3,693	5,923	8,215	7,308
Funds	$404,218	$304,594	$251,300	$251,300	$346,300	$363,599	$453,500	$517,340	$729,979
Total Projects									
Rural	2	8	8	8	8	9	13	17	20
Urban	7	4	4	6	11	8	13	11	14
Individuals Served	4,213	4,816	6,391	3,700	5,681	6,345	7,701	13,726	13,028
Funds	$476,158	$496,392	$470,000	$480,000	$570,150	$569,299	$685,700	$966,700	$1,417,737

Table 3-6

Funding Detail

Funding for the Primary Care and Rural Health Programs is from the General Fund. This program is granted nonlapsing status since many of the financial awards will be granted to carry over from one fiscal year to the next.

Budget History - Health - Health Systems Improvement - Primary Care and Rural Health					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	568,500	598,900	699,700	996,700	1,363,200
General Fund, One-time	0	100	0	0	356,800
Federal Funds	0	0	561,000	521,400	834,700
Beginning Nonlapsing	107,109	110,269	82,600	251,700	250,000
Closing Nonlapsing	(110,269)	(82,612)	(251,800)	(517,300)	(250,000)
Total	$565,340	$626,657	$1,091,500	$1,252,500	$2,554,700
Categories of Expenditure					
Personal Services	12,392	10,388	186,300	185,600	246,600
In-State Travel	55	54	1,400	1,500	1,600
Out of State Travel	0	0	5,900	3,300	6,700
Current Expense	487,701	493,453	800,600	958,800	1,848,900
DP Current Expense	1,154	712	11,700	10,100	3,900
Other Charges/Pass Thru	64,038	122,050	85,600	93,200	447,000
Total	$565,340	$626,657	$1,091,500	$1,252,500	$2,554,700
Other Data					
Budgeted FTE	0.5	0.6	0.2	4.4	4.8

Table 3-7

CHAPTER 4 WORKFORCE FINANCIAL ASSISTANCE PROGRAM

Function

The Legislature established the Utah Health Care Workforce Financial Assistance Program during the 2002 Legislative General Session by consolidating the Rural Physicians and Physician Assistants Grant and Scholarship Program, the Nurse Education Financial Assistance Program, and the Urban Special Population Health Care Provider Financial Assistance Program. The purpose of the combined Health Care Workforce Financial Assistance Program is to increase the number of health care professionals (physicians, physician assistants, nurses, dentists, mental health therapists, or other health care professionals) to provide primary health care services in medically underserved areas in the State through educational loan repayment grants and scholarships in return for providing primary health care services for an obligated period of time. Funding for this program is designated as nonlapsing and is appropriated as a separate line item, in accordance with UCA 26-46-102(4).

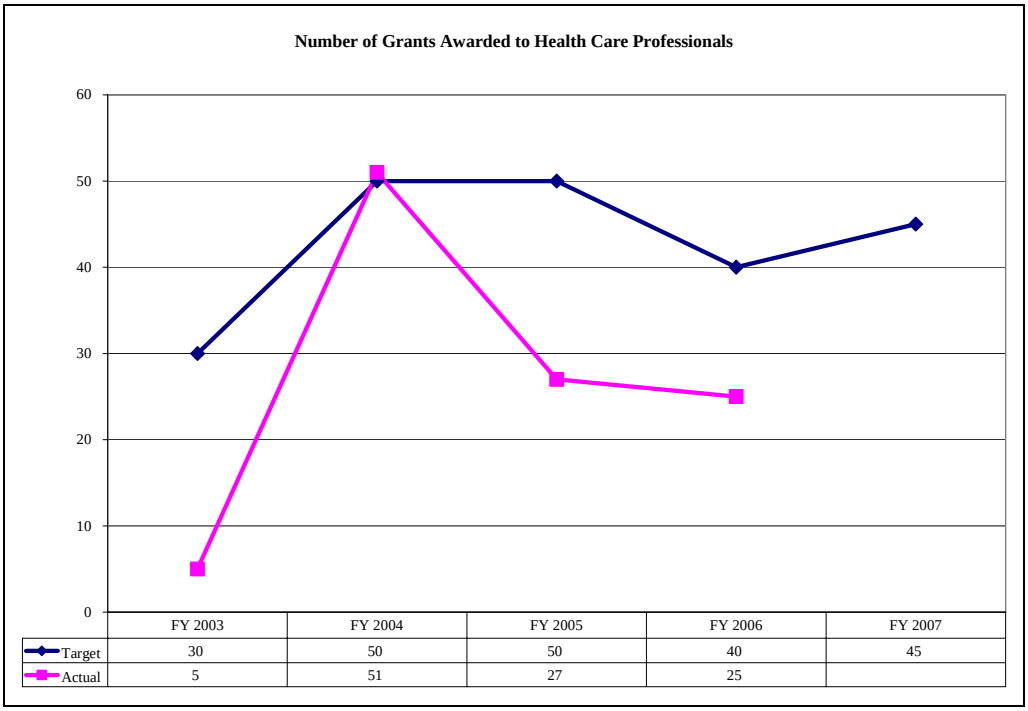
Statutory Authority

The Workforce Financial Assistance Program is governed by Title 26, Chapter 46 of the Utah Code.

- UCA 26-46 creates the Utah Health Care Workforce Financial Assistance Program Advisory Committee and establishes the department's authority to administer the program.

Accountability

The Health Care Workforce Financial Assistance Program has outlined the following performance measure listing the awards presented. The chart on the next page displays more detail on the awards.



	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Target	30	50	50	40	45
Actual	5	51	27	25	

Figure 4-1

Of those individuals that have completed their service obligation, 83 percent have either remained in their original service areas or within the same county where their service obligation began. Placements have been made in 26 of Utah's 29 counties, allowing those communities the opportunity for more comprehensive primary health care services. Over the course of its existence, the program has provided funding to secure the obligation of a total of 862 years of service.

The following table represents the number of grants awarded classified by the health care profession.

HEALTH CARE WORKFORCE FINANCIAL ASSISTANCE PROGRAM HISTORY

Health Care Professional	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007*
Dentist	1	2	1	1	0	1	1	2	3
Mental Health Therpaist	1	3	4	1	1	16	6	6	4
Nurse	25	13	23	14	0	19	10	14	12
Physician	4	3	11	10	3	13	10	3	5
Physician Assistant	1	1	3	0	1	2	0	0	6
Total Number of Grants	32	22	42	26	5	51	27	25	30
Funds	$659,500	$585,000	$568,000	$530,500	$528,800	$510,300	$419,700	$419,900	$422,900

Table 4-1

* 2007 Workforce Program History as of 10/27/2006

Funding Detail

The Utah Health Care Workforce Financial Assistance Program's funding comes from the state General Fund, including nonlapsing General Fund appropriations.

Budget History - Health - Workforce Financial Assistance

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	528,800	419,300	419,900	421,400	423,000
General Fund, One-time	0	100	0	0	(100)
Federal Funds	63,071	43,676	140,300	171,000	0
Beginning Nonlapsing	1,152,361	1,177,932	1,210,700	976,000	500,000
Closing Nonlapsing	(1,177,933)	(1,210,709)	(976,000)	(628,100)	(350,000)
Total	$566,299	$430,299	$794,900	$940,300	$572,900
Programs					
Workforce Financial Assistance	566,299	430,299	794,900	940,300	572,900
Total	$566,299	$430,299	$794,900	$940,300	$572,900
Categories of Expenditure					
Personal Services	21,440	19,357	16,300	15,100	18,200
In-State Travel	2,864	516	1,100	1,400	1,100
Current Expense	541,060	409,897	777,400	922,500	553,200
DP Current Expense	935	529	100	1,300	400
Total	$566,299	$430,299	$794,900	$940,300	$572,900
Other Data					
Budgeted FTE	0.4	0.3	0.3	0.3	0.3

Table 4-2

CHAPTER 5 EPIDEMIOLOGY AND LABORATORY SERVICES

Function

The Division of Epidemiology and Laboratory Services encompasses a director's office, four programs within the State Health Laboratory and three programs associated with communicable disease investigation and control.

Statutory Authority

The Division of Epidemiology and Laboratory Services is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-6 and 26-6b are established to define, control, and treat various communicable diseases.
- UCA 26-15 outlines the Department's efforts, in conjunction with those of local health departments, in relation to general sanitation, including those dealing with the Indoor Clean Air Act.
- UCA 26-15a outlines the Department's efforts, in conjunction with those of local health departments, in relation to food safety.
- UCA 26-23b outlines the procedures to be taken during a public health emergency.

Intent Language

The Legislature has regularly included intent language for the line item of Epidemiology and Laboratory Services for the supplemental year (FY 2006) authorizing the use of nonlapsing balances. This year, the Division received a direct supplemental appropriation for additional equipment as well. House Bill 1 "Current Fiscal Year Supplemental Appropriations Act" Item 32 includes the following intent language:

It is the intent of the Legislature that additional funds appropriated for FY 2006 to Epidemiology and Laboratory Services for equipment be nonlapsing.

Under the terms of UCA 63-38-8.1, the Legislature intends to make nonlapsing, item 92, Chapter 8, Laws of Utah 2005. Expenditure of these funds is limited to $200,000 for laboratory equipment, computer equipment and/or software, and building improvements

Accountability

The Division has outlined a number of performance measures. The key measures of the Division are listed with the specific programs.

Funding Detail

The Division's funding comes from three main sources - the state General Fund, Federal Funds, and Dedicated Credit Revenue. The Dedicated Credit Revenue comes primarily from laboratory fees.

Budget History - Health - Epidemiology & Lab Services

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	4,218,000	4,037,800	4,366,700	4,423,300	5,049,300
General Fund, One-time	0	9,200	0	499,900	169,100
Federal Funds	7,822,114	7,981,803	8,127,500	7,339,900	7,791,300
Dedicated Credits Revenue	2,680,984	2,456,542	2,436,100	3,646,300	4,142,600
GFR - State Lab Drug Testing Account	270,800	277,600	293,600	293,600	293,300
Transfers	41,495	503,473	0	0	0
Transfers - Environmental Quality	0	0	30,800	22,500	31,900
Transfers - Workforce Services	0	0	641,000	639,900	676,300
Beginning Nonlapsing	313,800	313,800	313,800	194,500	0
Closing Nonlapsing	(313,800)	(313,800)	(194,500)	(425,100)	0
Lapsing Balance	(332,305)	(6,748)	(149,600)	0	0
Total	$14,701,088	$15,259,670	$15,865,400	$16,634,800	$18,153,800
Programs					
Director's Office	1,029,687	555,076	640,600	964,900	534,300
Chemical and Environmental Services	2,405,496	1,727,781	1,780,100	1,665,700	1,610,100
Forensic Toxicology	0	880,802	903,700	963,200	1,016,600
Laboratory Improvement	911,711	847,787	909,900	1,005,000	1,044,100
Microbiology	1,519,046	1,696,549	1,990,300	2,743,200	3,866,800
Communicable Disease Control	6,840,978	6,899,855	7,280,400	7,151,300	7,377,200
Epidemiology	1,994,170	2,651,820	2,360,400	2,141,500	2,704,700
Total	$14,701,088	$15,259,670	$15,865,400	$16,634,800	$18,153,800
Categories of Expenditure					
Personal Services	6,895,631	7,169,310	7,628,800	7,818,900	8,794,800
In-State Travel	23,566	25,021	21,200	26,500	36,300
Out of State Travel	98,345	120,266	120,500	83,400	102,300
Current Expense	5,644,501	5,637,598	5,663,500	6,665,300	7,368,100
DP Current Expense	211,192	359,698	243,600	231,100	237,200
DP Capital Outlay	0	291,961	42,100	82,100	0
Capital Outlay	134,465	225,430	398,200	285,700	177,800
Other Charges/Pass Thru	1,693,388	1,430,386	1,747,500	1,441,800	1,437,300
Total	$14,701,088	$15,259,670	$15,865,400	$16,634,800	$18,153,800
Other Data					
Budgeted FTE	129.3	142.7	137.1	132.9	134.8
Vehicles	3	3	3	3	3

Table 5-1

Special Funding

As shown in Table 5-2, a portion of the funding for this division comes from the State Laboratory Drug Testing Account, as detailed in the following table.

Restricted Funds Summary - Epidemiology and Laboratory Services

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
GFR-State Laboratory Drug Testing Account	26-1-34	Portion of fees generated from the reinstatement of certain licenses. See 53-3-106(5)	To perform drug and alcohol analysis tests for state and local law enforcement agencies.	$37,114

Table 5-2

DIRECTOR'S OFFICE

Function

The Division of Epidemiology and Laboratory Services was formed during FY 1996 with the consolidation of other divisions within the Department. This program provides administration of public health and environmental health programs. These programs include environmental testing and toxicology, laboratory licensure, microbiology, communicable disease control, and epidemiology.

Funding Detail

Budget History - Health - Epidemiology & Lab Services - Director's Office

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	481,300	469,700	521,300	851,700	535,900
General Fund, One-time	0	1,200	0	319,900	(1,600)
Federal Funds	470,840	0	0	0	0
Dedicated Credits Revenue	9,445	0	0	23,900	0
Beginning Nonlapsing	313,800	313,800	313,800	194,500	0
Closing Nonlapsing	(313,800)	(313,800)	(194,500)	(425,100)	0
Lapsing Balance	68,102	84,176	0	0	0
Total	$1,029,687	$555,076	$640,600	$964,900	$534,300
Categories of Expenditure					
Personal Services	334,894	299,454	307,100	467,500	417,800
In-State Travel	238	559	500	1,400	500
Out of State Travel	2,223	(410)	900	3,900	900
Current Expense	87,117	102,092	101,200	210,500	95,900
DP Current Expense	18,470	34,516	19,200	30,900	19,200
DP Capital Outlay	0	0	0	20,000	0
Capital Outlay	115,905	118,865	211,700	230,700	0
Other Charges/Pass Thru	470,840	0	0	0	0
Total	$1,029,687	$555,076	$640,600	$964,900	$534,300
Other Data					
Budgeted FTE	6.3	6.3	6.3	6.6	6.8
Vehicles	3	3	3	3	3

Table 5-3

CHEMICAL AND ENVIRONMENTAL SERVICES

Function

The Bureau of Chemical and Environmental Services provides testing of water, soil, and air to monitor the environment to assure compliance with health and safety standards, and to respond to emergencies such as chemical spills and contaminated drinking water. The tests, requested primarily by the Department of Environmental Quality and the Department of Natural Resources, assist those departments in assessing the safety of the environment.

New capacity has been developed to test for chemical agents in clinical samples in response to chemical terrorism incidents as a result of federal funding from the Center for Disease Control and Prevention (CDC). The laboratory is now able to analyze for heavy metals and cyanide in samples to

determine exposure of these chemicals to humans. The bureau has been reorganized to combine chemical terrorism and metals testing.

The bureau is also working on a BioMonitoring project funded by CDC in collaboration with epidemiologists in the Environmental Epidemiology program. The goal of this study is to provide the Office of Epidemiology with test results to assess human exposure to environmental chemicals.

During FY 2004, the division reorganized by moving the drug and alcohol analysis and testing functions from this program to a new "Forensic Toxicology" program. The FY 2004 expenditure data reflects this change.

Accountability

The measures reported by the Bureau are output measures. The Division receives a large number of samples to be tested each year. These must be done accurately and in a timely manner. The performance measure here is a combination of the Divisions of Chemical and Environmental Services and Microbiology.

Figure 5-1

The following table details the laboratory workload for this division for the fiscal years 2001 through 2006.

LABORATORY WORKLOAD (Tests)

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Inorganic Chemistry Section & Metals	121,520	102,867	112,886	85,397	109,141	95,592
Radiation/Organic Chemistry	325	333	251	350	250	14,574
Organic Chemistry	3,917	4,112	3,534	20,376	2,193	0
Environmental Microbiology		4,562	4,079	16,312	4,842	18,032
Chemical Preparedness Terrorism					200	2,000
Totals	**125,762**	**111,874**	**120,750**	**122,435**	**116,626**	**130,198**

Table 5-4

Funding Detail

The primary sources of revenue are General Fund to subsidize services to other state and local agencies and Dedicated Credit Revenue from lab fees charged for specific tests.

Budget History - Health - Epidemiology & Lab Services - Chemical and Environmental Services

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,517,300	1,459,900	1,303,200	1,109,300	1,206,000
General Fund, One-time	0	4,000	0	0	(3,500)
Dedicated Credits Revenue	586,667	694,941	476,900	556,400	407,600
GFR - State Lab Drug Testing Account	270,800	0	0	0	0
Lapsing Balance	30,729	(431,060)	0	0	0
Total	$2,405,496	$1,727,781	$1,780,100	$1,665,700	$1,610,100
Categories of Expenditure					
Personal Services	1,852,590	1,290,182	1,463,100	1,359,100	1,320,900
In-State Travel	851	123	100	500	0
Out of State Travel	9,561	12,926	3,000	5,300	1,400
Current Expense	502,419	345,751	261,600	317,500	268,300
DP Current Expense	28,837	42,034	19,500	12,500	19,500
Capital Outlay	11,238	36,765	32,800	(29,200)	0
Total	$2,405,496	$1,727,781	$1,780,100	$1,665,700	$1,610,100
Other Data					
Budgeted FTE	31.5	23.4	23.4	23.0	22.0

Table 5-5

FORENSIC TOXICOLOGY

Function

During FY 2004, the division created this program by moving the drug and alcohol analysis and testing functions from the Environmental Testing and Toxicology program. The Funding Detail reflects the beginning of expenditures in FY 2004.

The Bureau of Forensic Toxicology provides drug and alcohol analysis needed by law enforcement agencies to support driving under the influence violations, including automobile homicide. In addition, the bureau provided testing for drug, alcohol, and other poisons in autopsy specimens to assist the Office of the Medical Examiner in determining the cause and manner of death.

Accountability

The Forensic Toxicology identified an output measure to address the issue of timeliness. This is important for the law enforcement and medical examiner related cases.

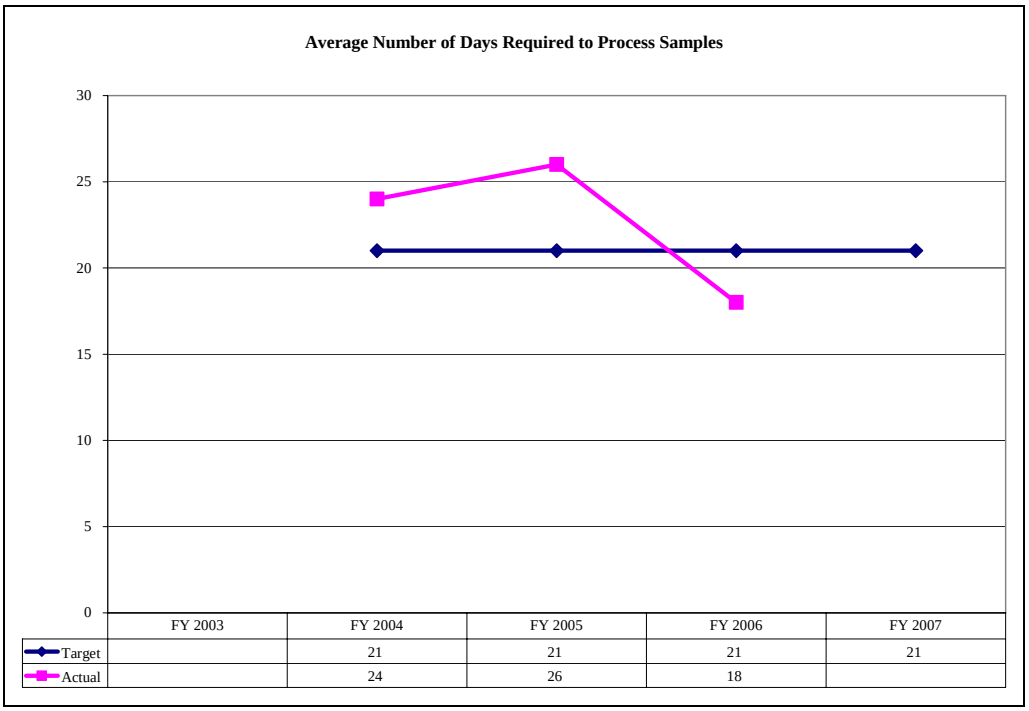


Figure 5-2

The number of tests for the Medical Examiner show continued increases in FY 2006. This is due to the increase in samples from this agency in addition to changes in laboratory analytical methods, such as screening multiple tissues for drugs. Drug related deaths contribute significantly to the workload of both this program and the medical examiner. The following table details the breakdown between law enforcement requested tests and those requested by the State Medical Examiner.

LABORATORY WORKLOAD (Tests)	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Law Enforcement Toxicology	15,476	17,103	15,938	25,058	19,639	26,521
Medical Examiner Toxicology	6,903	8,198	8,171	9,079	16,803	17,812
Totals	**22,379**	**25,301**	**24,109**	**34,137**	**36,442**	**44,333**
Court Testimony Hours	N/A	264	319	376	431	419

Table 5-6

Funding Detail

The primary source of funding is from the State General Fund. Approximately one-third of this budget is from a General Fund Restricted Account – State Lab Drug Testing. This revenue is to fund tests performed for state and local law enforcement.

Budget History - Health - Epidemiology & Lab Services - Forensic Toxicology

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	0	0	634,000	669,700	723,300
General Fund, One-time	0	0	0	0	(1,800)
Dedicated Credits Revenue	0	1,814	1,800	(100)	1,800
GFR - State Lab Drug Testing Account	0	277,600	293,600	293,600	293,300
Lapsing Balance	0	601,388	(25,700)	0	0
Total	$0	$880,802	$903,700	$963,200	$1,016,600
Categories of Expenditure					
Personal Services	0	618,379	667,500	744,500	787,500
In-State Travel	0	219	700	600	700
Out of State Travel	0	1,096	3,300	1,700	3,300
Current Expense	0	183,961	167,100	133,700	167,100
DP Current Expense	0	7,347	5,200	7,000	5,200
Capital Outlay	0	69,800	59,900	75,700	52,800
Total	$0	$880,802	$903,700	$963,200	$1,016,600
Other Data					
Budgeted FTE	0.0	11.6	11.6	11.6	11.6

Table 5-7

LABORATORY IMPROVEMENT

Function

The Bureau of Laboratory Improvement sets and enforces standards for those laboratories that perform tests that impact public health.

The following table shows the total number of laboratory service units (certifications and inspections, safety, training, internal quality assurances, and other support functions for the laboratory) accomplished during the past six years. These are important functions to maintain certification and accreditation of labs throughout the state.

Though no performance measures have been listed for this program, the table below lists the workload indicators.

LABORATORY WORKLOAD (Tests)

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Service Units						
Sample receiving	7,802	8,049	9,697	9,621	9,098	9,565
Environ. Labs drinking water	48	58	64	65	65	71
Environ. Labs water quality	60	68	70	75	73	82
Environ. Labs solid & haz. waste	56	97	65	66	67	67
Clinical Accreditation labs	103	106	112	110	106	107
Clinical Certification labs	217	215	199	200	204	200
Clinical PPM labs	252	270	278	273	270	277
Clinical Waived labs	425	440	470	521	580	655
Training Hours	2,092	672	1,275	756	1,993	888
Totals	**11,055**	**9,975**	**12,230**	**11,687**	**12,456**	**11,912**

Table 5-8

Funding Detail

Funding for these services is a mix of the Bureau's funding, including State General Fund, Federal Funds and Dedicated Credit Revenue.

Budget History - Health - Epidemiology & Lab Services - Laboratory Improvement

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	353,200	346,600	355,800	392,700	428,400
General Fund, One-time	0	1,000	0	0	(1,300)
Federal Funds	92,606	119,651	75,900	138,400	104,800
Dedicated Credits Revenue	395,171	451,626	478,200	473,900	512,200
Lapsing Balance	70,734	(71,090)	0	0	0
Total	$911,711	$847,787	$909,900	$1,005,000	$1,044,100
Categories of Expenditure					
Personal Services	808,763	740,248	800,800	918,500	935,200
In-State Travel	3,576	3,745	4,000	4,400	4,000
Out of State Travel	25,384	18,048	29,000	15,200	29,000
Current Expense	66,789	65,140	66,200	50,800	66,500
DP Current Expense	7,199	20,606	9,900	16,100	9,400
Total	$911,711	$847,787	$909,900	$1,005,000	$1,044,100
Other Data					
Budgeted FTE	19.0	19.0	17.0	17.0	17.0

Table 5-9

MICROBIOLOGY

Function

The Bureau of Microbiology provides laboratory support services for local health departments; hospitals, clinics, labs, and physicians throughout Utah; the Utah Department of Agriculture; State Mosquito Abatement; the Department of Environmental Quality; the Division of Community and Family Health Services; and the State Medical Examiner. The areas of support include newborn screening, HIV, sexually-transmitted diseases, agents of bioterrorism surveillance, arbovirus surveillance, virology, rabies testing, bacteriology, mycology, mycobacteriology, parasitology, as well as outbreak control (food and waterborne), and communicable disease outbreak support, i.e., influenza, pertussis.

The bureau works in close support with state epidemiology to provide test data for disease surveillance and statistics across the entire state.

The FTE count increased from FY 2003 to FY 2004 by two, as a result of a new federal grant from the CDC. This increase in staff has allowed the lab to prepare for West Nile, influenza, and other diseases.

Accountability

The measures reported by the Bureau are primarily output measures. The Division receives a large number of samples to be tested each year. These must be done accurately and in a timely manner. The performance measure here is a combination of the Divisions of Microbiology and Chemical and Environmental Services.

Figure 5-3

The following table details the Microbiology programs' workload for the past several years.

LABORATORY WORKLOAD (Tests)						
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Bacteriology Section	39,637	9,946	7,088	7,469	5,603	8,132
Virology Section	66,195	67,300	48,236	43,412	36,268	42,957
Immunology Section	52,975	55,545	24,020	21,618	16,787	18,053
Newborn Screening	493,617	540,750	520,655	468,598	404,592	427,063
Molecular Biology	469	4,064	4,349	9,916	11,987	19,869
Totals	**652,893**	**677,605**	**604,348**	**551,013**	**475,237**	**516,074**

Table 5-10

The drop in the number of tests from FY 2002 to FY 2005 reflects the loss of General Funds from the 2003 General Session. These have not been replaced. The number of tests completed continues to drop. Selected services were either reduced or eliminated if those services were available from other laboratories. The lab has shifted to providing more complex (and more costly and time-consuming) tests that are required for epidemiological investigations and disease prevention efforts. Lab fees were increased this past year.

The bureau also works closely with state partners such as health care workers, local public health, fire, law enforcement, military and Indian tribes to provide training on safe handling and shipping of specimens for testing, interpreting microbiology results, and emergency preparedness functions that the microbiology laboratory provides.

Funding Detail

The increase in lab fees is expected to increase the Dedicated Credit Revenue significantly in this program area.

Budget History - Health - Epidemiology & Lab Services - Microbiology					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	447,200	432,700	179,500	0	325,500
General Fund, One-time	0	700	0	0	(300)
Federal Funds	89,457	233,455	442,100	254,200	373,600
Dedicated Credits Revenue	1,316,736	1,221,416	1,368,700	2,489,000	3,168,000
Lapsing Balance	(334,347)	(191,722)	0	0	0
Total	$1,519,046	$1,696,549	$1,990,300	$2,743,200	$3,866,800
Categories of Expenditure					
Personal Services	835,823	836,166	946,800	1,028,600	1,188,300
In-State Travel	47	0	100	100	100
Out of State Travel	1,658	3,235	2,300	5,100	5,000
Current Expense	644,782	803,028	888,200	1,598,200	2,526,500
DP Current Expense	36,736	54,120	59,100	40,600	21,900
DP Capital Outlay	0	0	0	62,100	0
Capital Outlay	0	0	93,800	8,500	125,000
Total	$1,519,046	$1,696,549	$1,990,300	$2,743,200	$3,866,800
Other Data					
Budgeted FTE	16.6	17.6	18.2	18.2	19.0

Table 5-11

COMMUNICABLE DISEASE CONTROL

Function

The Bureau of Communicable Disease Control focuses its efforts on providing technical assistance and capacity building expertise to the community and to local health departments in the areas of HIV disease prevention, counseling/testing services, surveillance, treatment and care; tuberculosis (TB); hepatitis C; sexually transmitted disease (STD) control and elimination; and refugee health assessment. Services include consultation, direct client programs and contract monitoring provided by bureau staff and through contracts with other governmental agencies, local health departments and community-based organizations. Funding sources include the Centers for Disease Control and Prevention (CDC), Health Resources Services Administration (HRSA), the Utah Department of Workforce Services, and the Office of Refugee Resettlement (ORR).

The mission of the bureau is to protect the public health by:

- documenting and analyzing the incidence and prevalence of HIV disease, Hepatitis C, TB, STDs, and refugee health concerns;
- assessing community-based needs for prevention and care services in refugee and high-risk populations;
- developing policies and implementing strategies to prevent, control, and treat individuals with HIV disease, Hepatitis C, TB, and STDs, and;
- assuring that policies and strategies are implemented to ensure the improved health of affected populations.

Accountability

The Bureau of Communicable Disease has numerous programs. Two key performance measures have been submitted by the Department as indicators of the overall program activity. More detailed information has been included with the specific programs.

The first deals with Chlamydia incidence and the second HIV Drug Assistance Program Tracking.

In the first measure, it appears that the Department is not making progress based on the statistics. STD's of all kinds seem to be increasing throughout the state of Utah.

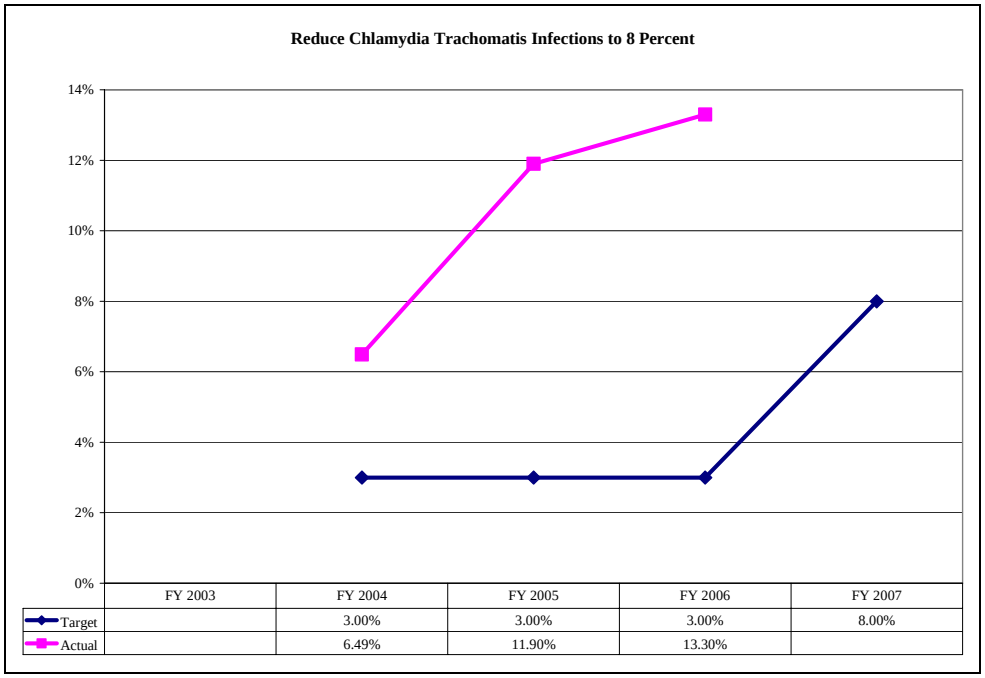


Figure 5-4

In the second measure, the Department is tracking individuals receiving HIV/AIDS medication and treatment. This, too, seems to be increasing at a significant rate.

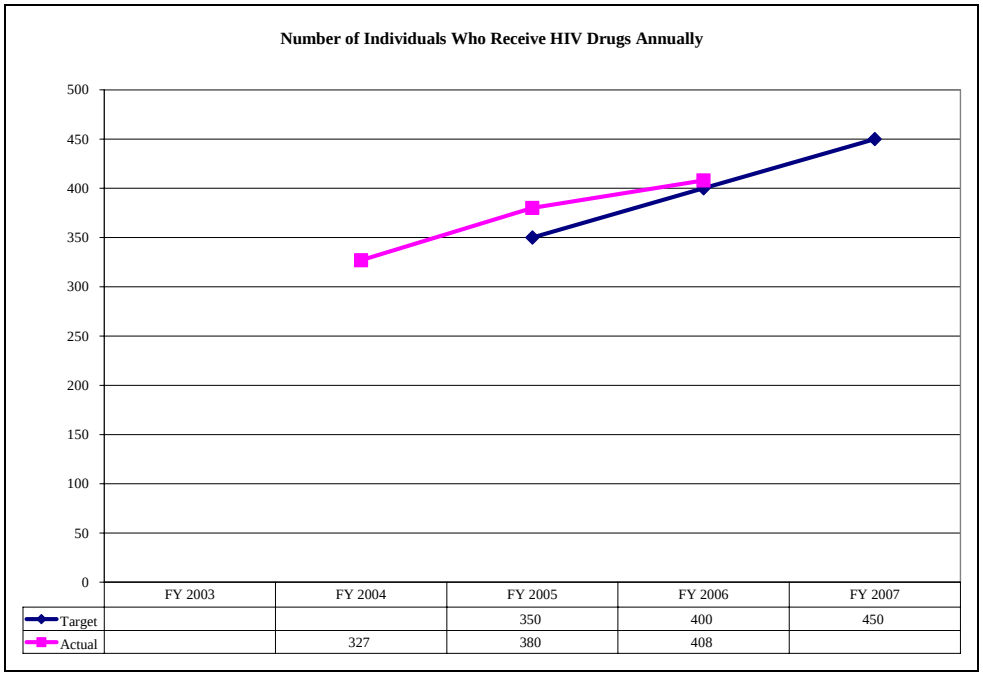


Figure 5-5

HIV Prevention

The goals of the HIV Prevention Program are to provide education and training programs which emphasize reduction and prevention for diverse populations, including individuals at high risk (men who have sex with men, youth, women, injecting drug users, and ethnic populations), and to provide confidential or anonymous HIV pre- and post-test counseling, testing and referral services to approximately 6,211 individuals at publicly-funded sites (local health departments). Counseling and testing efforts attempt to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV through "client-centered" pre-and post test counseling, and partner counseling and referral services. The program also provides information on services available in the community to those who test positive or to those that might be considered "high-risk" and have tested negative including those individuals in occupational exposures.

Table 5-13 shows the number of tests administered and individuals receiving counseling.

Service Provided	2001	2002	2003	2004	FY 2005	FY 2006
Confidential Tests	5,221	4,800	5,920	6,357	7,277	6,211
Anonymous Tests	379	328	306	251	237	190
EMS Reports	44	49	76	41	50	Not Req.
Partner Counseling						
Client	53	57	40	33	68	103
Partner	97	86	75	40	63	169

Table 5-12

HIV/AIDS Surveillance Program

Surveillance program activities include public health efforts to study HIV/AIDS incidence and prevalence within the state. HIV/AIDS data are analyzed by demographic factors, i.e. race, risk, age, and gender in order to determine infection trends and to formulate prevention strategies.

The incidence rate of new cases is shown in the Table 5-14.

New AIDS Cases	2000	2001	2002	2003	2004	FY 2005	FY 2006 *
HIV	47	41	60	101	101	98	73
AIDS	142	116	70	72	76	63	32
Total	189	157	130	173	177	161	105

*** Calender Year through October 2006**

Table 5-13

The Surveillance Program also documents tuberculosis infection and disease in Utah. The program works closely with laboratories and health providers in order to encourage disease reporting to the department.

HIV/AIDS Treatment and Care Program

The goal of the Title II program is to provide for the development, organization, coordination, and operation of a more effective and cost-effective system for the delivery of essential services to individuals and families with HIV disease. Individuals and their families affected by HIV are provided essential health and support services if they are not covered or are under-insured by private health insurance and do not qualify for Medicaid, Medicare, or other state or local programs. These activities are accomplished

primarily through supportive services, a home and community based care program, and an AIDS drug assistance program.

The home health program, established in 1990, provides the following services: homemaker, health aide, personal care, routine diagnostic tests administered in the home, and durable medical equipment.

The AIDS Drug Assistance Program (ADAP), established in 1987, assists people living with HIV/AIDS to access AIDS-related medications.

The Health Insurance Continuation Program pays all or part of a person's health insurance premium if the person has HIV disease and is eligible to COBRA their health benefits. A premium payment program assists individuals with HIV disease who are not eligible for other insurance coverage, to obtain insurance through the Utah Comprehensive Health Insurance Pool (HIP), by providing monthly premium payments, co pays, and deductibles.

Supportive services provide individuals with HIV the following services: ambulatory care, dental services, food vouchers, mental health counseling, eye exams and glasses, legal advocacy, emergency funding, transportation, substance abuse services, and case management.

Table 5-15 reflects the use of services by individuals who have been diagnosed with HIV. (Note: Supportive Services were formerly administered by a contractor. They are now administered directly by the Treatment and Care Program.)

Services Received	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
ADAP	209	228	295	225	332	380	487
Home Health	11	14	13	21	22	17	0
Insurance Continuation	51	148	166	177	180	155	128
Supportive Services				778	777	693	450

Table 5-14

Tuberculosis (TB) Control Program

The goal of the Tuberculosis (TB) Control Program is to reduce the incidence of TB in Utah through prompt identification and treatment of active TB cases, and the investigation and treatment of those who may have been in contact with someone with active TB. Medications, medical expertise, and public health nursing are provided at no charge to the client. The program also provides preventive treatment to those with TB infection that has not progressed to the disease.

TB Cases	2000	2001	2002	2003	2004	2005	2006
TB Cases	49	35	31	39	36	29	25
Drug-resistant cases	12	8	5	3	6	1	5

* Calendar Year through September 2006

Table 5-15

Refugee Health Program

The federally-funded Refugee Health Program provides health screening and follow-up to newly arriving refugees in the State. Health screening is

essential to protect Utah's resident population from exposure to communicable diseases and related problems.

Refugees	2000	2001	2002	2003	2004	2005	2006
Total Refugees	1,085	861	374	491	946	827	496
Refugees with TB	4	5	4	1	8	5	6
Refugees receiving health screen	96.0%	80.0%	97.0%	92.0%	96.0%	98.0%	98.0%

* Calendar Year through September 2006

Table 5-16

STD Program

Utah's Sexually Transmitted Disease (STD) Control Program is responsible for the detection, treatment, and control of sexually transmitted diseases throughout the state. The STD Control Program coordinates with local health departments, tribal governments, federal government, as well as dealing with other states that have similar issues, and concerns. STDs can cause harmful, often irreversible health complications such as reproductive health problems, fetal and perinatal health problems, and cancer. Women are biologically more susceptible to infection and suffer more frequently than men. They also suffer from more serious complications as a result of a STD infection than men do. Pelvic inflammatory disease (PID), ectopic pregnancy, infertility, and chronic pelvic pain are among the more serious of STD complications. Program efforts include screening, examination, diagnosis, education, case management, data management, treatment, partner notification, technical assistance, and epidemiological studies, analysis, and research. Community wide outbreaks can occur without appropriate investigation and control. Currently, Utah's STD Control Program has expanded screening, treatment and education into high-risk youth detention centers, homeless youth populations, and substance abuse youth treatment centers. The majority of STD infections occur among persons 15 - 24 years of age.

In FY 2006, over 5,600 cases of STDs in Utah have been reported to the Bureau of Communicable Disease Control. Chlamydia, the most common reportable STD, increased by 126% between FY 2001 and FY 2006. Gonorrhea increased by 323% during the same time period. While female's accounted for approximately 70% of all Chlamydia infections during FY 2006, the need to test males is of significant importance to control the spread of this disease.

Number of Cases Identified	2001	2002	2003	2004	2005	2006
Syphilis (Primary & Secondary)	8	7	9	15	15	7
Gonorrhea	197	268	438	487	674	834
Chlamydia	2,114	3,351	4,208	3,745	4,295	4,778

Table 5-17

Hepatitis C Program

The Hepatitis C Program activities include efforts to prevent and control hepatitis C virus (HCV) that are integrated with HIV Prevention, STD Control and Substance Abuse Programs. The focus is on managing, networking, and building technical expertise and capacity within the programs to control the spread of HCV.

HCV is a reportable disease. The following table shows the number of reported infections from private physicians and labs.

	2001	2002	2003	2004	2005	2006 Est.
HCV reported	1,888	1,917	1,868	1,660	1,551	1,429

* Calendar Year through October 2006

Table 5-18

Funding Detail

Almost 80 percent of this program budget is from Federal Funds. The remainder of the funding is split about evenly between State General Fund and Transfers from other State Agencies.

Budget History - Health - Epidemiology & Lab Services - Communicable Disease Control

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	671,100	594,400	613,700	635,900	680,900
General Fund, One-time	0	500	0	180,000	178,800
Federal Funds	5,895,647	5,705,983	5,979,200	5,643,000	5,841,200
Dedicated Credits Revenue	292,447	5,180	60,400	52,500	0
Transfers	0	501,604	0	0	0
Transfers - Workforce Services	0	0	641,000	639,900	676,300
Lapsing Balance	(18,216)	92,188	(13,900)	0	0
Total	$6,840,978	$6,899,855	$7,280,400	$7,151,300	$7,377,200
Categories of Expenditure					
Personal Services	1,557,993	1,701,419	1,831,200	1,810,700	2,149,800
In-State Travel	10,144	13,573	11,200	11,200	15,000
Out of State Travel	23,588	43,610	47,300	30,400	31,900
Current Expense	4,115,521	3,910,873	4,006,200	4,066,800	3,993,800
DP Current Expense	48,102	81,989	59,800	42,900	50,100
Capital Outlay	7,322	0	0	0	0
Other Charges/Pass Thru	1,078,308	1,148,391	1,324,700	1,189,300	1,136,600
Total	$6,840,978	$6,899,855	$7,280,400	$7,151,300	$7,377,200
Other Data					
Budgeted FTE	29.0	33.5	33.9	32.2	32.2

Table 5-19

EPIDEMIOLOGY

Function

The Bureau of Epidemiology is responsible for the detection, investigation, and control of communicable and infectious diseases and for surveillance and investigation of health effects associated with environmental hazards. The Bureau operates two programs: the Communicable Disease Epidemiology Program and the Environmental Epidemiology Program. The programs have adapted the *U.S. Healthy People 2010 Goals and Objectives*, and activities are established to meet the UDOH goals of protecting the public health, improving quality of life, preventing disease and premature death, and promoting healthy lifestyles for the residents of the State.

The Bureau is responsible for developing and operating surveillance systems to detect bioterrorism and for assuring epidemiological preparedness to respond to an incident of bioterrorism or the similar threat of pandemic disease.

State Epidemiologist

The 2006 Legislature approved ongoing funding of $210,000 General Fund to hire a State epidemiologist. The State epidemiologist had been paid by the federal government previously and was a federal position, but federal funding for the position was eliminated.

Accountability

A major responsibility of Epidemiology is to track the incidence of communicable diseases in an effort to alert the public and expedite measures to prevent the spread of harmful pathogens and manage their control. One key indicator is the inspection of commercial food establishments. This is primarily done by local health departments but tracked through epidemiology when a problem is discovered.

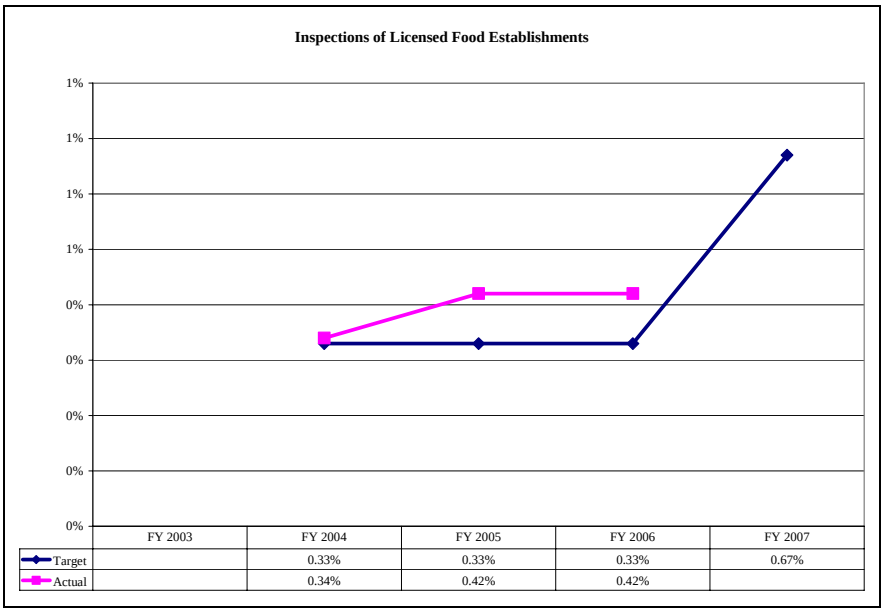


Figure 5-6

Communicable Disease Epidemiology Program

The Communicable Disease Epidemiology Program (CDEP) conducts communicable disease surveillance and management. The responsibilities of CDEP include assisting with the identification, investigation, and management of communicable diseases and outbreaks. Epidemiological investigations are

conducted in conjunction with local health departments to identify risk factors and implement appropriate control measures and prevention strategies. The program also responds rapidly to suspect and confirmed cases of diseases of public health significance, aiding local health departments, healthcare workers, and the public in implementing control and prevention measures. In addition, the program provides consultation regarding communicable diseases to healthcare professionals, healthcare facilities, and a variety of local, state, and federal agencies, and acts as a liaison to the Centers for Disease Control and Prevention (CDC) for disease investigations in Utah.

The program conducts routine analyses of surveillance data, generating and evaluating daily reports. These reports incorporate statistical methods to interpret disease trends over time to identify clusters of disease that may indicate an outbreak. The program also develops surveillance reports that provide communicable disease trend data to the public, healthcare professionals, and local, state, and federal partners on a regular basis and as requested.

The program is responsible for maintaining the current National Electronic Telecommunication System for Surveillance (NETSS) and providing support to local health departments in using this system to store and manage communicable disease data. The program is also responsible for building, implementing, and maintaining the National Electronic Disease Surveillance System (NEDSS) in Utah as part of a national effort to improve mechanisms for disease reporting, public health surveillance, and disease control practices. NEDSS will replace NETSS, providing a web-based system for storing and managing communicable disease data, as well as a mechanism for allowing case management functions to be monitored and evaluated by local and state health department staff simultaneously. The program utilizes technology for statewide surveillance systems that will improve public health's ability to detect bioterrorism and other large-scale events and enhance preparedness for responding to such events in coordination with local and federal agencies such as CDC.

As CDEP is a newly reorganized program, there is a mixture of measures which includes historical values, as well as new goals that will demonstrate success for the program in their initiation this year and measurement in subsequent years. Illustration of CDEP's work to prevent, manage, and control communicable diseases, in collaboration with other programs and agencies as appropriate, is included in Table 5-21.

Activities	2000	2001	2002	2003	2004	2005	2006
Hepatitis A infections	66	66	55	39	36	21	11
Salmonellosis	482	225	181	228	234	310	165
E. Coli infections	84	58	95	99	68	66	36
WNV (human)				1	11	54	2
WNV (mosquito poolshuman)				2	181	80	88
WNV (horses)				35	5	68	1
WNV (sentinel chickenshuman)				9	32	79	12
WNV (birds)				4	8	22	6

* Calendar Year through July 2006

Table 5-20

Environmental Epidemiology Program

The Environmental Epidemiology Program (EEP) addresses environmental hazards and diseases in Utah. The mission of the program is to develop and support, in partnership with other public and private agencies nationally and in Utah, programs to prevent or reduce the potential for acute and chronic morbidity and mortality associated with environmental and occupational factors, including exposure to toxic substances, reproductive hazards, unsafe work environments, and agents responsible for debilitating diseases. The program conducts epidemiological investigations, cooperates with local, state, and federal agencies in problems related to hazardous substance exposure, and researches environmental and occupational health problems.

During calendar year 2004, 903 consultations and 1,385 investigations were conducted, and 3,532 person-hours of training were provided by EEP staff. For the first half of 2005, 540 consultations and 1,361 investigations were conducted and 1,327 person hours of training were provided. Investigations conducted include: burn injuries, releases of hazardous chemicals, comprehensive public health assessments of superfund hazardous waste sites, cancer cluster investigations in communities concerned about high cancer rates, sources of lead poisonings in children and adults, and exposure investigations of communities exposed to hazardous chemical releases.

The food safety and environmental health programs' goal is to reduce premature death and disability due to the effects of secondhand smoke, contaminated food, and poor sanitation at public swimming pools, public lodging, schools, and many other public places. With the focus to decrease premature death and disability due to contaminated food served to the public, this program provides consultation to food and restaurant inspectors. This program also seeks to establish and maintain a consistent approach to environmental health regulation across the 12 local health districts in Utah.

The Utah Indoor Clean Air Act (UICAA) program is conducted jointly with the staff in the Bureau of Health Promotion. This program helps reduce morbidity and mortality attributable to one of the most preventable causes of premature death and disability – secondhand tobacco smoke.

The following table shows some of the functions performed by the Environmental Epidemiology Program.

Activities	2000	2001	2002	2003	2004	2005	2006
Ratio of restaurant inspectors to licensed food establishme	1:292	1:229	1:220	1:277	1:293	1:293	1:281
Prevalance of children with Blood Lead levels >= 10 ug/dl	1.7%	1.3%	1.2%	1.7%	1.4%	1.8%	2.2%
Incidence of work-related burns per 100,000 workfo	8.1	18.8	26.4	14.3	21.5	No longer Tracking	No longer Tracking

Table 5-21

Funding Detail The final program in this line item is funded approximately two-thirds with Federal Funds and one-third State General Fund.

Budget History - Health - Epidemiology & Lab Services - Epidemiology

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	747,900	734,500	759,200	764,000	1,149,300
General Fund, One-time	0	1,800	0	0	(1,200)
Federal Funds	1,273,564	1,922,714	1,630,300	1,304,300	1,471,700
Dedicated Credits Revenue	80,518	81,565	50,100	50,700	53,000
Transfers	41,495	1,869	0	0	0
Transfers - Environmental Quality	0	0	30,800	22,500	31,900
Lapsing Balance	(149,307)	(90,628)	(110,000)	0	0
Total	$1,994,170	$2,651,820	$2,360,400	$2,141,500	$2,704,700
Categories of Expenditure					
Personal Services	1,505,568	1,683,462	1,612,300	1,490,000	1,995,300
In-State Travel	8,710	6,802	4,600	8,300	16,000
Out of State Travel	35,931	41,761	34,700	21,800	30,800
Current Expense	227,873	226,753	173,000	287,800	250,000
DP Current Expense	71,848	119,086	70,900	81,100	111,900
DP Capital Outlay	0	291,961	42,100	0	0
Other Charges/Pass Thru	144,240	281,995	422,800	252,500	300,700
Total	$1,994,170	$2,651,820	$2,360,400	$2,141,500	$2,704,700
Other Data					
Budgeted FTE	26.9	31.4	26.8	24.3	26.3

Table 5-22

CHAPTER 6 COMMUNITY AND FAMILY HEALTH SERVICES

Function

The Division of Community and Family Health Services assures that women, infants, children, and their families have access to comprehensive, coordinated, affordable, community-based quality health care. Division services are available to all citizens of the State according to their ability to pay, but primary clients are women, infants, and children who have special health care needs and are low income. The division coordinates efforts, identifies needs, prioritizes programs, and develops resources necessary to reduce illness, disability and death from:

- Adverse Pregnancy Outcomes
- Chronic Diseases
- Disabling Conditions
- Injury and Violence
- Vaccine-Preventable Infections

The division is organized into a Director's Office and three functional bureaus. These bureaus are: Health Promotion; Maternal and Child Health; and Children with Special Health Care Needs

Statutory Authority

The Division of Community and Family Health is governed by various chapters of the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-5 defines chronic diseases and requires the department to establish programs to prevent, delay, and detect the onset of such.
- UCA 26-7 authorizes the department to create programs to promote good health practices and reduce major risk factors that contribute to injury, sickness, death, and disability.
- UCA 26-9f creates the Utah Digital Health Services Commission which deals with telehealth issues.
- UCA 26-10 establishes "Family Health Services" including the metabolic testing of newborns.
- UCA 26-15 requires the department to adopt rules to implement the Utah Indoor Clean Air Act, a function carried out by the Tobacco Prevention Program in the area of Health Promotion.
- UCA 26-21a requires the department to create a program to reduce breast cancer mortality.
- UCA 26-38 is the Utah Indoor Clean Air Act, which restricts smoking in indoor public places, and establishes enforcement authority and penalties for noncompliance.
- UCA 26-42 establishes civil penalties for individuals and/or licensees that sell tobacco products to underage minors.

- UCA 26-43 requires the department to obtain information regarding tobacco products and the level of detectable compounds in them.

Intent Language

The 2006 Legislature included intent language in SB 4, "New Fiscal Year Supplemental Appropriations Act", Item 86, for the Division of Community and Family Health Services authorizing funding for alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs as nonlasping.

Accountability

The Division of Community and Family Health Services has few bureau or program categories but numerous program activities. Each of these activities identifies performance, output and outcome measures.

A few key measures are highlighted and reported for the purpose of this report to help the reader understand the type of measures used and the overall success of the Division. They are detailed and charted throughout this section of the report with a graph showing the program trends. The five key measures are:

- Decrease Tobacco use among Utah youth
- Increase immunization rates among Utah children
- Increase early prenatal care among Utah women
- Increase early detection of hearing loss
- Increase early identification and treatment of developmental problems among Utah children.

Special Funding

As shown in Table 6-1, a portion of the funding for this division comes from two restricted accounts, as detailed in Table 6-3.

Restricted Funds Summary - Community and Family Health Services

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
Tobacco Settlement Restricted Account	63-97-201	70% of all funds received by the state relative to the settlement agreement with the tobacco manufacturers. (The allocation drops to 60% on July 1, 2007 - see UCA 63-97-201(d))	Alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs . . . with a preference in funding given to tobacco-related programs.	$3,190,296 (balance listed is total amount in account for all designated purposes)
Cigarette Tax Restricted Account	59-14-204(5)	$250,000 from the increase in the cigarette tax effective July 1, 1998, and 58% of the revenue generated from the increase in the cigarette tax imposed during the 2002 General Session.	The share to the Department of Health is for tobacco prevention, reduction, cessation, and control programs.	$4,498,268

Table 6-1

Funding Detail

The Community and Family Health Services Division's primary source of revenue is Federal Funds – due to the significant federal funding for the Women, Infants, and Children (WIC) program. Other significant funding sources include the state General Fund, Dedicated Credit Revenue, transfers, and two restricted funds.

Budget History - Health - Community & Family Health

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	7,590,000	8,391,900	8,560,400	8,761,600	9,791,100
General Fund, One-time	0	9,900	0	0	(12,400)
Federal Funds	57,163,606	56,391,818	59,113,900	59,099,200	63,515,000
Dedicated Credits Revenue	15,907,105	18,270,659	18,638,700	19,007,500	17,161,300
GFR - Cigarette Tax Rest	2,868,400	3,131,500	3,131,500	3,131,500	3,131,700
GFR - Tobacco Settlement	6,061,700	6,061,700	6,149,000	6,219,600	6,303,400
Transfers	3,985,889	1,537,953	0	0	0
Transfers - H - Medical Assistance	0	0	2,012,100	10,000	20,100
Transfers - Human Services	0	0	640,300	(1,321,500)	10,000
Transfers - Intergovernmental	0	0	(1,083,100)	(1,406,800)	(145,100)
Transfers - Other Agencies	0	0	(1,341,400)	864,900	(131,600)
Transfers - Public Safety	0	0	0	93,400	91,200
Transfers - State Office of Education	0	0	175,200	0	8,400
Transfers - Within Agency	0	0	2,848,000	5,552,000	5,562,700
Beginning Nonlapsing	319,934	663,766	393,800	447,100	0
Closing Nonlapsing	(663,766)	(393,762)	(447,100)	(447,500)	0
Lapsing Balance	(95,901)	(1,000)	(1,000)	(1,000)	0
Total	$93,136,967	$94,064,434	$98,790,300	$100,010,000	$105,305,800
Programs					
Director's Office	2,199,358	2,179,136	2,279,600	2,254,300	2,324,700
Health Promotion	18,879,781	19,067,324	20,320,800	20,364,500	20,696,300
Maternal and Child Health	50,612,187	49,842,465	52,558,700	53,320,800	56,563,500
Children with Special Health Care Needs	21,445,641	22,975,509	23,631,200	24,070,400	25,721,300
Total	$93,136,967	$94,064,434	$98,790,300	$100,010,000	$105,305,800
Categories of Expenditure					
Personal Services	15,191,957	16,107,945	17,074,000	18,151,800	19,363,700
In-State Travel	239,195	218,358	234,100	256,300	229,800
Out of State Travel	211,299	202,066	220,100	200,900	187,600
Current Expense	19,369,568	23,388,581	20,185,200	20,274,800	20,751,900
DP Current Expense	922,023	1,082,990	1,287,000	624,700	662,900
DP Capital Outlay	6,373	17,922	0	62,100	0
Capital Outlay	0	0	6,800	9,700	0
Other Charges/Pass Thru	57,196,552	53,046,572	59,783,100	60,429,700	64,109,900
Total	$93,136,967	$94,064,434	$98,790,300	$100,010,000	$105,305,800
Other Data					
Budgeted FTE	285.6	301.1	301.6	302.6	299.0
Vehicles	8	8	8	8	8

Table 6-2

DIRECTOR'S OFFICE

Function

The Office of the Director of the Division of Community and Family Health Services (CFHS) leads and manages all the resources and programs of the division. The office consists of the Director, the administrative secretary, the Center for Multi-Cultural Health and the Financial Resources Program. The director oversees three bureaus, including Health Promotion, Maternal and Child Health, and Children with Special Health Care Needs.

The Center for Multicultural Health addresses health disparities among ethnic groups through health programs in the department and in the community. The Center aims to foster accessible and high-quality programs and policies that help all racial and ethnic minorities in Utah achieve optimal health, dignity, and independence. The center will accomplish this by increasing public and health professional awareness of persistent racial/ethnic disparities and developing effective health policies and culturally competent programs that lead to better access to quality health care services and improved health status. The Center for Multicultural Health is funded with state General Funds.

The Financial Resources program provides financial management for the division by managing budgets, contracts and grants; ensuring compliance with financial policies and regulations; ensuring the accuracy of all financial transactions; and providing billing services for public services.

Funding Detail

Budget History - Health - Community & Family Health - Director's Office

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	559,500	549,100	636,400	722,100	825,000
General Fund, One-time	0	1,600	0	0	(2,200)
Federal Funds	1,646,156	1,615,936	1,644,200	1,530,600	1,501,900
Dedicated Credits Revenue	503	0	0	2,600	0
Lapsing Balance	(6,801)	12,500	(1,000)	(1,000)	0
Total	$2,199,358	$2,179,136	$2,279,600	$2,254,300	$2,324,700
Categories of Expenditure					
Personal Services	738,394	595,167	655,100	756,700	796,300
In-State Travel	1,007	971	1,600	2,400	2,500
Out of State Travel	2,895	410	1,200	3,700	1,100
Current Expense	56,914	59,737	61,400	75,600	119,400
DP Current Expense	13,670	12,291	26,900	18,300	8,900
Other Charges/Pass Thru	1,386,478	1,510,560	1,533,400	1,397,600	1,396,500
Total	$2,199,358	$2,179,136	$2,279,600	$2,254,300	$2,324,700
Other Data					
Budgeted FTE	12.6	8.7	9.5	10.1	11.1

Table 6-3

HEALTH PROMOTION

Function

The Bureau of Health Promotion includes more than 90 public health professionals focused on reducing premature death and disability due to heart disease, stroke, cancer, diabetes, arthritis, asthma, tobacco, injuries and violence, and lack of prenatal care. The bureau's programs systematically coordinate around common functions such as surveillance and information management, local health departments and other partner relations, media campaigns and related outreach, consumer research, and education of health care providers. Comprehensive population-based interventions are provided at the school, work, community and health care sites, and include primary, secondary, and tertiary prevention strategies.

Cancer Control Program

Cancer places a significant burden on the lives of many Utahns. The mission of the Utah Cancer Control Program is to reduce cancer incidence and mortality in Utah through collaborative efforts that provide services and programs directed toward comprehensive cancer prevention and control through the following:

1. Implementation of the strategies of the 2006-2011 Utah Comprehensive Cancer Control Plan and initiate priority strategies annually along with the members, work groups, and committees of the Utah Cancer Action Network (UCAN).
2. Maintain UCAN, a group of over 75 people from 50 organizations including hospitals, private clinics, government and community agencies, nonprofit organizations and other groups who are working together to reduce cancer incidence and mortality for all Utahns.
3. Implement breast and cervical cancer media campaigns.
4. Sponsor and co-sponsor meetings for health care providers, practitioners and professionals.
5. Work closely with Local Health Departments and other community providers statewide.

Program Activity Measurement

Breast cancer is the leading cause of cancer death for Utah women. In 2004, 220 Utah women died of breast cancer and in 2003, 1,005 new cases of breast cancer were diagnosed. Late stage diagnosis is the primary predictor of poor survival and subsequent mortality. Cervical cancer is also a cause of morbidity and mortality for Utah women. In Utah during 2003, there were 49 new cases of cervical cancer detected and 13 deaths due to cervical cancer in 2004. Cervical cancer develops slowly and is highly curable if detected at an early stage.

The program plans, during FY 2007, to reduce morbidity and mortality from breast and cervical cancers by working with LHD's and other community providers statewide to:

- Provide 7,487 low cost or free breast and cervical cancer screenings (including mammograms) to women with limited or no health insurance at or below 250 percent of the Federal Poverty Level;
- Provide public and professional education about the need for early detection and availability of screening services;
- Develop and use a statewide surveillance system to plan and evaluate screening and education efforts.
- Make these services accessible to Utah women (rural and urban areas).
- Target specifically low-income underserved women 50 and older (higher risk for breast cancer) for breast cancer and the never and rarely screened for cervical cancer.
- Decrease the unnecessary cervical cancer over screening of women who had three consecutive normal Pap smears and hysterectomies not related to cervical neoplasia.

Heart Disease and Stroke Prevention Program (HDSPP)

The goal of the Heart Disease and Stroke Prevention Program (HDSPP) is to decrease premature death and disability due to heart disease and stroke through the following:

- Develop and Coordinate State Partnerships: The Alliance for Cardiovascular Health in Utah (with over 100 partners) has been organized to strengthen health systems for the primary, secondary, and tertiary prevention of heart disease and stroke by advocating principles that are designed to promote, influence and assist the public in developing skills and making decisions for healthier choices.
- Assist communities, work-sites, schools and health care sites to develop effective polices, environment supports and practices that are effective in promoting heart health and preventing heart disease and stroke, such as enhancing infrastructures to make communities more physically active, and promoting the 5 A Day message to eat at least five servings of fruits and vegetables/day.
- Increase school participation in the Gold Medal School Program, implementing healthier policies and environments in the schools to promote healthier nutrition and physical activity choices for students and faculty.
- Increase the knowledge and awareness base of Utahns about the importance of preventing heart disease and stroke for every age group, and the signs of heart attack and stroke. Maintain a surveillance and evaluation program to monitor heart health and risk status of Utahns, and evaluate effectiveness of program interventions and strategies.
- Provide training and technical assistance to enhance knowledge, skills and resources of community partners to affect and sustain policy and environmental changes.

Activity Measures Table 6-5 shows some of the outcome measurements of the program.

Service	FY 2004 Outcomes	FY 2005 Outcomes	FY 2006 Outcomes
Gold Medal School Initiative (Schools/Students)	138/65,669	168/104,744	205/100,892
Walk Your Child to School Day (Schools/Students)	110/42,000	130/50,000	122/65,621
Students participating in 5 a Day activities	73,140	80,000	88,000
Utahns receiving prevention messages from events or campaigns			
Direct prevention messages	154,492	318,869	-----
Number of impressions from public education & media campaign			19,000,000
Website education	89,000	141,870	135,601
Newsletters	138,950	125,000	128,000
Health professionals receiving education	1,037	1,021	325
Teachers, principals, superintendents, and school food service staff receiving school health information and/or training	1,631	500	392
Utahns taking action to decrease high levels			
Blood Pressure	89.8%	89.8%	69.3%
Cholesterol	91.3%	91.3%	52.8%
Percent increase of adults eating 5-A-Day	19.5%	19.5%	22.9%
Percent increase of adolescents eating 5-A-Day	20.3%	20.3%	20.0%
Increase in adults getting adequate physical activity	53.3%	53.3%	53.8%

Table 6-4

Diabetes Prevention and Control Program (DPCP)

The Diabetes Prevention and Control Program (DPCP) is funded solely through federal monies. Its mission is to work in partnerships to improve the quality of life of all Utahns at risk for, or affected by, diabetes. More than four percent (4.1%) of Utahns, or about 106,000 residents, including children, have been diagnosed with diabetes (Utah Health Status Survey 2005). Among adults, an estimated one in 20 have been diagnosed (BRFSS 2005). An estimated additional 40,000 residents have diabetes but are unaware of it. Indirectly, diabetes affects the entire population as it is a major cause of morbidity and mortality, placing a huge economic burden on the health care system. Diabetes accounts for over 9% of Utah hospital discharges. In 2005, there were more than 22,000 discharges for people with diabetes (more than any other listed diagnosis), with charges amounting to over $325 million. There are also costs related to outpatient treatment, lost productivity, disability, and family resources.

The changing demographics in Utah continue to lead to an increasing percentage of the population at risk. While Utah retains its position as one of the youngest states in the U.S., over one-fourth (27.3%) of the population is age 45 or older (2005 Population Estimates: Governor's Office of Planning and Budget). The population is predominantly white, with nine out of ten (90.8%) residents(claiming one race only) reported to be white (http://factfinder.census.gov [2004]). There has been a particularly strong growth in the Hispanic/Latino population. An estimated one of 10 Utahns (10.6%) is of Hispanic/Latino ethnicity (http://factfinder.census.gov [2004]). Over half (56.4%) of Utah adults are overweight or obese (BRFSS 2004). The DPCP strives to improve awareness of the risks and treatment of diabetes and its complications (heart disease, end-stage kidney disease, blindness, amputations, hospitalizations and disability). The DPCP recognizes that access to quality care, up-to-date information, and education are important components of diabetes management.

Program Activity

The Diabetes Prevention and Control Program accomplished the following in FY 2006:

Health Communications: The Utah Diabetes Prevention and Control Program (DPCP) conducted the seventh phase of its public awareness campaign. The FY05 campaign focused on increasing awareness of the diabetes risk factors and symptoms; prevention and delay of type 2 diabetes; and diabetes care and control methods by Utahns with diabetes. Public Service Announcements (PSAs) were aired on English and Spanish television and radio stations. Diabetes messages were distributed on posters, brochures, and a bus wrap. The bus wrap targeted Hispanics and Utahns with diabetes displaying the message “You are the Heart of Your Family, Control Your Diabetes, For Life”.

As a result of its media buy, the Utah DPCP was given match for three surveys that were conducted by an outside vendor. Surveys were used to evaluate the impact of the bus wrap, the general diabetes awareness, and “Get Real” campaigns. For FY06 the program focused on increased awareness of the clinical measure A1C.

Utah Diabetes Practice Recommendations (UDPR): Practice recommendations for treatment of adults with diabetes were completed by an expert panel and endorsed by every medical association in Utah with an interest in or focus on diabetes. These were published on the program website and provided hard copy to those requesting the information in that format. An update on "early and aggressive treatment" was added to the UDPR.

Community-based Activities: The Utah Diabetes Prevention and Control Program contracted with six local health departments (Bear River, Southwest, Tooele, Davis, Utah and Weber-Morgan) and five Community Based Organizations (Nevada Health Systems in Wendover, East Carbon Community Health Center, Monument Valley, Midvale City and Mountainlands Community Health Center) to implement awareness activities in these counties/districts. Diabetes coordinators distributed information to physicians, clinics, grocery stores, schools, pharmacies, libraries, worksites and many other locations and individuals. In addition, media messages were displayed in print and through the radio. Two of the Community Based Organizations are developing a lay-health worker program to educate Hispanics/Latinos with diabetes about self-management and risk reduction techniques.

The Program contracted with AUCH (Association for Utah Community Health) to benefit all eleven of Utah's Community Health Centers (CHCs) involved in the Breakthrough Collaborative. The goal is to improve diabetes care for high risk/low-income populations through continuing implementation of a chronic care model.

Training Programs: - The Utah DPCP provided two days of training for support staff from around the state. The content covered intermediate level diabetes topics such as foot screening, type 2 diabetes in children, carbohydrate counting, and insulin dosing. Participants included medical assistants, AmeriCorps workers from Community Health Centers, local health department educators, and Native American clinics and programs. Provided eight statewide professional training updates to primary care providers, community health centers, and other health care professionals involved in care of patients with diabetes using telemedicine. Diabetes Updates (professional education for clinicians who care for patients with diabetes) were held in person in three locations. Managed the Utah Certification Program for Diabetes Self-Management Training Programs including the provision of continuing education opportunities. Technical assistance was also provided to those sites seeking American Diabetes Association Recognition. There are currently sixteen state programs. Updates and re-certification of certified programs were provided. Conducted twelve monthly telehealth distance learning diabetes education sessions for programs in state as well as for a few out-of-state participants. Participation in these sessions continues to grow. Provided a one-day training in Spanish for lay health workers and Americorps workers who are monolingual or who provide services in Spanish.

Monitoring Activities: The DPCP contracts with six health plans to collect hybrid HEDIS information (claims and chart reviews) for seven enhanced

comprehensive diabetes care measures: A1C testing, A1C levels, eye exams, LDL testing, LDL levels, and monitoring for nephropathy. The DPCP, through its health plan partnership, developed enhancements in the required HEDIS data by requiring that specific A1C and LCL levels be reported rather than just those meeting or exceeding the HEDIS benchmarks. Data are reported using specified reporting formats to make comparisons. The data are used to measure progress in and among the health plans and results are weighted to reflect the total membership with diabetes in participating health plans.

Healthy Utah Program

Healthy Utah is a work-site-based employee health promotion and prevention program available to more than 70,000 state and other public employees and spouses covered by Public Employees Health Program. Healthy Utah's mission is providing resources, incentives and skills: empowering people to achieve healthy lifestyles. Healthy Utah works in state agencies and with other public entities (local governments) to create healthy work environments that support healthy lifestyle behaviors. Healthy Utah offers physical assessments, personal health sessions, weight management and stress prevention classes. Seminars on a variety of health topics and group health promotion programs are also available free of charge. Healthy Utah also provides technical assistance to work-sites interested in establishing wellness councils and integrating employee health promotion and prevention into daily business activities. Healthy Utah strives to increase employee productivity, decrease employee absenteeism and reduce the rapid escalation of health care costs.

Program Activity

The following table demonstrates some of the program's accomplishments for FY 2005:

Healthy Utah

Service	FY 2004 Outcomes	FY 2005 Outcomes	FY 2006 Outcomes
State/Public employees and spouses who are registered members	23,940	28,100	---
New Accounts - My Healthy Utah			4,884
Participants in assessment sessions	6,143	5,600	5,456
Participants in wellness seminars	5,565	4,500	4,727
Participants in personal health couseling sessions	380	350	313
Participants in health enhancement programs	2,617	2,157	2,346
Weight Management Class	198	240	107
Smoking cessation rebates completed	5	30	92
Physical activity rebates completed	7,040	7,740	8,831
Diabetes rebate participants	71	23	29
Average number of visits to the web site per day	7,221	9,200	9,800
Number of agencies with Wellness Council	6	17	27

Table 6-5

Arthritis Program

According to the Utah Department of Health, arthritis affects one of every five Americans (21%) and is the leading cause of disability. In 1997, direct costs due to medical expenditures were 51.1 billion, and an additional 35.1 billion were due to indirect costs such as work loss. Costs will increase by the year

2020, when it is estimated that at least 60 million individuals will be affected. Almost one of every four Utah adults, 18 and older (23% or 404,309) reported arthritis during 2005.

In Utah arthritis is a leading cause of disability, activity limitation, and poor health. Among adults with doctor-diagnosed arthritis, 36% (131,400) report activity limitation due to their arthritis and 30% (109,500) report their arthritis affected their work for pay. Adults with doctor-diagnosed arthritis were more than four times more likely to report fair or poor health (24%) when compared to those without arthritis (6%). Self-management programs, such as physical activity and self-management education, can reduce the pain and disability associated with arthritis, yet less than 15% of people with arthritis reported participating in such programs.

Considering these facts, the Utah Department of Health, Bureau of Health Promotion, Utah Arthritis Program (UAP) is focused on 1) increasing community awareness; 2) measuring arthritis trends; 3) improving clinical practice; and 4) promoting supportive health systems and policies.

The mission of the Utah Arthritis Program is to improve the quality of life for people affected by arthritis. The Program is fully funded by the Centers for Disease Control and Prevention.

Program Activity

Significant progress has been made towards each of these areas. Examples of this progress, and the "per unit/person cost" follows:

Increasing Community Awareness: In May/June/July 2006 an evidence-based media campaign with radio and print was implemented along the Wasatch Front and rural Washington County. The radio segment of the campaign reached 32,783 women 35+ and 43,344 individuals in the general population who were 45+ on KBEE 13 times and 15,629 women 35+ and 20,644 individuals in the general population 45+ on KKAT over 11 times. Print materials were provided to all senior centers, rheumatologists, libraries, and primary care provided who indicated a willingness to partner with the UAP. Based on calls generated and web hits, which have increased from 21 hits for the four month period January-April 2006 to 589 hits for May-August 2006, this effort has been effective. Additionally, the reports developed by UAP continue to be downloaded from our website and have been utilized to educate professionals and others about these conditions. Free community arthritis seminars were held at The Orthopedic Specialty Hospital. In May 2006, over 230 people attended the week-long seminar series. Importantly, many of these participants enrolled in more intensive, evidence based arthritis self-management programs (see improving clinical practice below).

Measuring Arthritis Trends: The Utah Arthritis Program is constantly collecting and reviewing data. We have completed many reports to inform and assist key partners, constituents and decision makers. These reports include:

- Small Area Analysis Report 2006
- Local Health Department Reports-2005

- Prevalence and Impact of Arthritis on Hispanics and Latinos in Utah 2005-The first comprehensive report on the burden of arthritis on Hispanic Utahns
- The Burden of Arthritis in Utah-2005
- Health Status Update-2004
- Utah BRFSS Brief: Arthritis and Coexisting Health Conditions-2003
- Doctors' Knowledge, Attitudes & Awareness Report-2003
- Local Health District Report
- Utah's BRFSS Arthritis Follow-up Survey Report-2003
- Utah's Arthritis Plan
- Utah's Arthritis Report

All reports are available on the UAP website. http://health.utah.gov/arthritis/

Improving Clinical Practice: Effective interventions have been identified and partnerships with medical providers, health plans, and clinics have been established. One important partnership is with The Orthopedic Specialty Hospital and is described in the awareness section above. Also, partial funding is provided for a position at the Arthritis Foundation, Utah/Idaho Chapter. In addition to working on community awareness issues, this individual coordinates arthritis self management programs and trains instructors for those classes. During the past year approximately 6,500 individuals have received training, information, or services related to these efforts.

Importantly, between 1999 (when the Utah Arthritis Program was established) to 2006, participation in evidence-based arthritis programs (EBP) led to: 45 active Arthritis Foundation Self Management Program (AFSMP) leaders, AFSMP taught annually increased from zero to 20. Arthritis Foundation Exercise Program (AFEP) leaders increased from zero to 36, sites delivering AFEP increased from zero to 7. Arthritis Foundation Aquatics Program (AFAP) leaders have increased to 135. Participation in these three programs have grown to over 2,000 per year. Growth of these programs is projected at 10% for 2007. Also, The Utah Arthritis Program has successfully partnered with clinics to establish and deliver successful community-wide, free arthritis education seminars (see awareness above). Currently the UAP is entering into a partnership with Utah State University Extension Service to increase the reach of programs to rural areas of the State.

Promoting Supportive Health System and Policies: As noted above, the partnership with Select Health, through TOSH, has provided free arthritis seminars to persons in the Salt Lake City area. This partnership has further supported referrals into more intensive, evidence-based arthritis management programs. It has accomplished this through the Select Health network and through partnership with the Arthritis Foundation, Utah/Idaho Chapter.

Asthma Program

Asthma is one of the most common chronic illnesses overall in the United States. In Utah, children ages 17 and under who report that they have asthma increased from 4.97% in 2001 to 8.2% in 2005. There are currently over 228,000 Utahns of all ages suffering from asthma, approximately 9% of the population. In 2005, there were more than 1,600 hospitalizations for asthma, with children under the age of 18 accounting for 48%. Costs for Utah hospitalization in 2005 amounted to almost $10,700,000.

Although medical management is at the forefront of treatment for asthma, public health has an important role to play in assessment of the problem, assurance that adequate and appropriate health care systems are in place and promoting appropriate public policy. The Utah Asthma Program was developed in 2002 with funding from CDC to begin efforts to address asthma from a public health perspective.

Program Activity

The Utah Asthma Program:

- Developed and maintains an asthma surveillance system.
- Established and staffs the Utah Asthma Task Force, comprised of public and private organizations, that has assessed the state of asthma prevention and care in Utah and has designed a strategic plan to provide direction for future program interventions.

The Utah Asthma Task Force is divided into 5 action groups that include:

- Providers –currently has a resource guide for pediatricians on the Medical Home Project and is developing a print and PDA version to market to family practice physicians and pediatricians statewide.
- School Issues –Developed an Asthma School Resource Manual and trained faculty and staff in over 148 schools. Parent education packets were also created and distributed through schools.
- Public Awareness – Provided awareness of the asthma inhaler law when it was passed in 2004 and are now airing radio spots to increase asthma awareness in adults aged 18-64.
- Risk Factors – Works on occupational asthma and environmental air quality issues, including development of the "Indoor Air Quality Guidance" for schools and conducted research to determine if indoor air quality in schools is better during winter inversions than outdoor air quality.
- Data and Monitoring – Analyzing the various data sets associated with asthma and provides the data to various stakeholders, conducted a gap analysis that showed that Utah needed more information about asthma in the school setting and conducted a study to collect additional data from faculty and staff.

Resources are provided to the public such as:

- A website used to facilitate partner communications and education about programs and policies affecting those with asthma.
- The average number of asthma educational encounters per month via program website: 1,668

Chronic Disease Genomics Program

The study of genes and their functions has led to recent advances in genetics and the understanding of the molecular mechanisms of disease, including the complex interplay of genetic and environmental factors or genomics. It is necessary to integrate genomics and family history assessments into ongoing and new population-based strategies for identifying and reducing the burden of chronic, infectious and other diseases. Of particular importance is enhanced planning and coordination to integrate genomics into core State public health specialties (such as epidemiology, laboratory activities, and environmental health), and particularly into chronic disease prevention efforts. This program, which began in July 2003 with funding from the Centers from Disease and Control and Prevention, is developing public health leadership capacity and infrastructure to better integrate genomics into public health practice, with a focus on chronic diseases. The major activities underway include:

- Working with external and internal partners to plan and implement strategies in public health programs. An external Chronic Disease Standing Committee formed under the aegis of the Genetics Advisory Committee is reviewing and revising the chronic disease section of the state genetics plan. Internally, genomics activities have been incorporated into several chronic disease funding applications. In addition, the UDOH Genomics Workgroup receives training on a quarterly basis on topics of interest to public health professionals.
- Assessing existing data sources for possible applications in public health genomics. For example, the Cancer Control and Diabetes Prevention Programs collect information on family history of disease but have not analyzed it. Additionally, the Utah Population Database (UPDB), a unique Utah resource, has been used extensively for research purposes but not for public health programs. The Program is working with the University of Utah staff to determine the state genetic disease load for specific diseases that are applicable to chronic disease programs.
- Education of various target audiences, including training sessions, ranging from Genomics 101 to pharmacogenetics, for public health professionals. The Program is assessing and training physicians in regards to family history use in their training and practice settings.
- Working to re-establish a population-based family history assessment for multiple chronic diseases and intervene with high-risk families. The Program has conducted an in-depth analysis of the highly successful Family High Risk Program and developed recommendations for a future intervention. In partnership with the University of Utah Cardiovascular Genetics Research Clinic, the

Program is working with multiple partners to revise and pilot test a 'new-and-improved' family history intervention.

Violence and Injury Prevention Program (VIPP)

The mission of the Violence and Injury Prevention Program (VIPP) is to promote the health of all Utah citizens by working to reduce the incidence and severity of fatal and non-fatal injuries. Injury is a significant public health problem and a leading cause of premature death and disability. During the five-year period 2000 through 2004, injuries resulted in 6,290 deaths (53.3 per 100,000 persons). For that same period there were 50,669 injury-related hospitalizations (429.6 per 100,000 persons) with charges totaling $676 million, and 917,246 Emergency Department visits (7,777.6 per 100,000 persons) costing over $468 million. In addition, there were thousands more injuries treated in doctor's offices, clinics, schools, worksites, etc.

To accomplish its mission, VIPP collaborates with many partners, including other UDOH programs, state and local agencies, local health departments, private businesses, non-profit community organizations, health care providers, and others.

The VIPP conducts and/or provides significant support to the following projects and activities: Motor Vehicle Seat Belt and Child Booster Seat Campaigns; Youth Suicide Study; Suicide Prevention Task Force; Child Fatality Review Committee; Intimate Partner Violent Death Review Team; Rape and Sexual Assault Prevention Project; Domestic Violence Prevention Project; Traumatic Brain Injury Surveillance Project; Pedestrian Safety Project; Safe Kids Utah; and others. The VIPP contracts with all local health departments, providing funding and technical support for local injury prevention programs that address adult seat belt and child car seat use, bicycle safety and helmet use, pedestrian safety, school playground safety, fall prevention, community and family violence prevention, etc.

FY 2006 Program Service Information

Activities promoting the use of child safety seats:

- 479 activities reaching 31,366 individuals
- 2,791 child safety seats distributed
- 95 media activities such as PSA's, press conferences and news releases.

Activities promoting bicycle safety:

- 123 events reaching 16,564 individuals
- 5,042 bike helmets distributed
- 15 media activities such as PSA's, press conferences and news releases.

Activities promoting pedestrian safety:

- 77 events reaching 87,762 individuals

- 22 media activities such as PSA's, press conferences and news releases.

Activities promoting domestic violence prevention:

- 14 events reaching 603 individuals
- 14 media activities such as PSA's, press conferences and news releases.

Activities promoting sexual assault prevention:

- 1,026 events reaching 29,309 individuals
- 1,343 rape crisis and information line calls answered by rape recovery program staff statewide.

Activities promoting other injury prevention areas:

- 408 events reaching 82,660 individuals
- 122 media activities such as PSA's, press conferences and news releases.

Baby Your Baby Program (BYB)

The Baby Your Baby (BYB) Outreach Program strives to improve the health of families in Utah through outreach programs, telephone hotlines and education services. The Baby Your Baby Program provides a vehicle through which the Health Department can target audiences throughout the state with important health messages. The outreach program establishes public-private partnerships to promote healthy lifestyles, reduce health risks, and increase access to health care. This is accomplished through public service announcements and other television programs, radio and printed materials which address Department goals dealing with early prenatal care, folic acid, vaccine-preventable infections, injury, dental disease, obesity, and other important health issues.

Program Activity

Since 2001, Utah has ranked number 49 in the nation for pregnant women receiving early and adequate prenatal care. More than 22 percent of pregnant women do not begin prenatal care in the first trimester. This prevents Utah from meeting the Year 2010 objective of 90 percent. Approximately 23 percent of Utah women do not receive adequate prenatal care, defined as having one's first prenatal visit with a health professional within the first trimester of pregnancy and receiving a minimum number of visits during pregnancy. The United Health Foundation reported that from 2001 to 2004 access to adequate prenatal care increased from 60.9 percent to 76.9 percent of pregnant women receiving adequate prenatal care. Financial assistance and access to prenatal care continue to be a need in Utah.

The Check Your Health (CYH) Program, under the BYB umbrella, encourages all Utahns to eat healthy and be active. In Utah during 2002, an estimated 25.5 percent of kindergarten-eighth grade students were overweight or at risk of becoming overweight. Studies show that overweight children are at greater risk for chronic diseases, like diabetes and heart disease, both during

childhood and adulthood. Women at normal weight at the start of pregnancy have significantly better birth outcomes than obese women.

The Baby Your Baby Program started with the hotline service and now provides answering service to a number of other program including the Asthma Program, the Diabetes Program, the Immunization Program, among others. The number of callers served is a combination of increased usage as well as additional programs being served by the hotline service.

Total Hotline Calls

Service	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Number of hotline callers served	73,648	62,800	68,380	81,785	82,631

Table 6-6

Accountability

One of the performance measures is getting the information out to the public. This is measured by activity of calls coming in to center. Figure 6-2 identifies the performance measure of calls specifically for the Baby Your Baby Program as reported by the Department of Health.

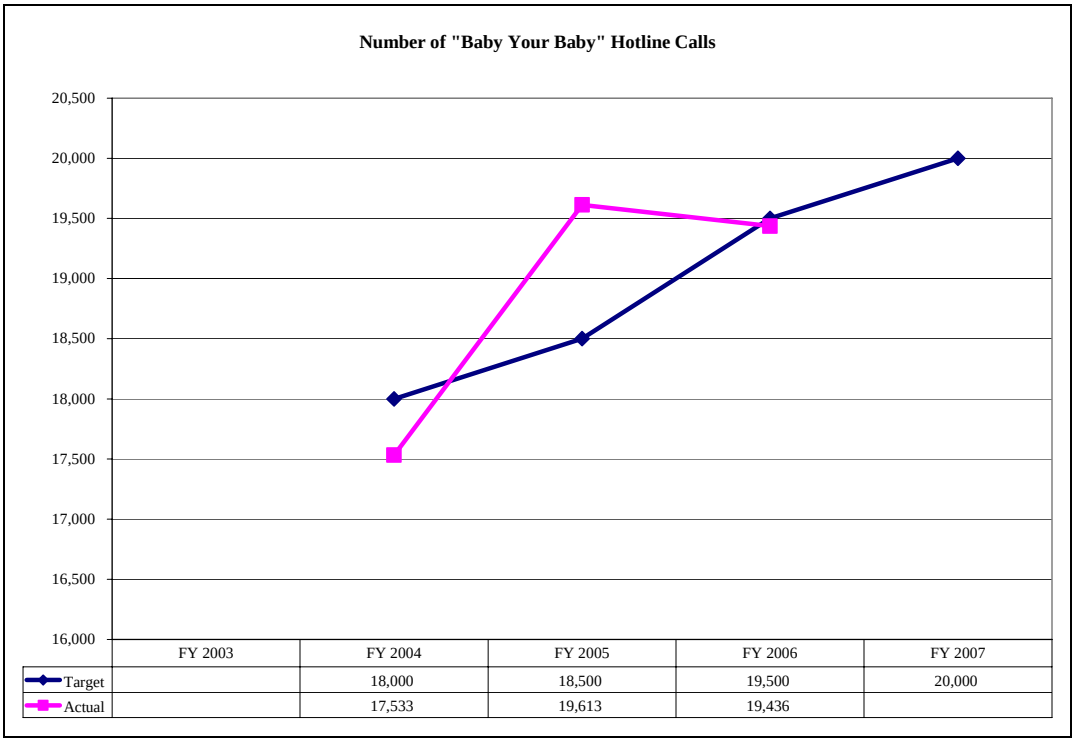


Figure 6-1

Tobacco Prevention and Control Program (TPCP)

The TPCP provides technical expertise and coordination at state and community levels to prevent and reduce tobacco use in Utah. Utah's comprehensive approach to preventing and controlling tobacco use seems to be making an impact:

- In 2004, Utah's adult smoking rate reached its lowest level since health surveys started to measure smoking behaviors. With a 2005 smoking rate of 11.5 percent, Utah continues to be the only state that

meets the Health People 2010 Objective of reducing cigarette smoking to 12 percent. Since 1999, adult smoking decreased by 18 percent.

- In 2005, the percentage of Utah high school students who reported that they had ever tried cigarettes reached a historic low of 25.0 percent. 7.4 percent of students reported that they had smoked in the past 30 days.
- Smoking among pregnant women decreased by 23 percent (from 8.2 percent in 1999 to 6.3 percent in 2004).

Despite these successes, the need to address tobacco use in Utah remains great. More than 200,000 Utahns continue to use tobacco. Smoking rates remain high among Utahns with low education and income levels and among some racial and ethnic communities. Each year, more than 1,100 Utah adults die as a result of their own smoking, and an estimated 140 to 250 adults, children, and babies die due to secondhand smoke exposure. The Utah economy loses a staggering $530 million annually to smoking-attributable medical and productivity costs. To entice people to use tobacco, major tobacco companies spend more than $60 million each year marketing tobacco products in Utah—several times more than what Utah spends on anti-tobacco programming. Our joint efforts in fighting tobacco are yielding results, but there is more to be done to protect our citizens from the disability, disease, and death caused by tobacco use.

- *Program Activity* The goals of the TPCP are to promote quitting among young people and adults, prevent initiation of tobacco use among young people, eliminate nonsmokers' exposure to secondhand smoke and identify and eliminate disparities in tobacco use among populations groups. The program receives state dedicated, federal, and private funds. More than 95 percent of state funds are passed through to Local Health Departments (LHDs), community prevention and cessation programs, The TRUTH media campaign, and other services. An independent evaluation contractor assists in measuring the impact of funded programs.

Anti-Tobacco Projects Funded by Senate Bill 15, 2000 General Session

The TPCP and its partners attack the problem of tobacco use with proven program components. Anti tobacco programs and services include:

Statewide and Community Based Services to Help Smokers Quit

Tobacco cessation counseling is one of the most effective interventions in preventive medicine. Quitting smoking at any age provides health benefits and increases life expectancy for former smokers. More than 78% of Utah smokers report that they want to quit. To help them quit successfully, the TPCP offers the following quit services:

- The Utah Tobacco Quit Line (1 888 567 TRUTH) and Utah QuitNet (www.utahquitnet.com)
- Medicaid coverage of tobacco cessation services for pregnant women and for the cessation medication Zyban.

- Local Health Department tobacco quitting programs for pregnant women.
- Local school and community based teen cessation programs and community based adult cessation programs.

FY 2006 Outcomes

Utahns utilized quit smoking services:

- Demand for Utah Tobacco Quit Line services remained high. Since it's inception in 2001, the Quit Line has provided assistance to more than 30,000 Utahns.
- More than 12,000 tobacco users received quitting services from the Quit Line, QuitNet, and local cessation programs.
- More than 1,000 youth participated in the court mandated teen tobacco cessation program, Ending Nicotine Dependence (END).
- Quit rates were high for all services.

<u>"The TRUTH" Public Awareness Campaign</u>

The TRUTH media campaign is multi-pronged, targeting prevention and quitting among mainstream and high risk youth, adults, pregnant women, Native Americans, Hispanics and Latinos, college students, rural populations, and work sites through a mix of media including radio, TV, and outdoor advertising. Most Utah residents are directly or indirectly impacted by the campaign. The TPCP evaluates the reach and impact of the media campaign with annual surveys of 1,200 randomly selected Utah teens, and adult smokers and non smokers. Some campaign components include:

- "I Did It" quit smoking TV campaign to promote Utah Quit Line and QuitNet services.
- "Truth About Tobacco" youth ads.
- Advertisements addressing pregnant women and secondhand smoke.
- Events promoting tobacco free communities.

FY 2006 Outcomes

The Baby Your Baby Outcomes for FY 2006.

- The TRUTH campaign is highly recognizable:
- 97% of adult smokers and 98% of teens recall seeing anti tobacco ads during the past month.
- 89% of adult smokers and 82% of teens report knowing about the Utah Tobacco Quit Line.
- 51% of adult smokers thought about quitting after seeing the ads.

<u>Prevention Partnerships with Local Health Districts, Schools, and Communities</u>

Evidence based school programs promote strong "no tobacco use" attitudes among students, increase students' knowledge of the dangers of tobacco, and teach students skills to resist peer influences. School programs are most effective when they are part of comprehensive school tobacco policies that include enforcement of rules against tobacco use, tobacco prevention education for students in all grades, access to cessation services, and involvement of families and communities in tobacco prevention. TPCP prevention services included:

- Collaboration with select school districts to strengthen and better enforce school tobacco policies.
- Evidence based anti tobacco curricula for students in grades 4 to 8.
- Truth from Youth Anti Tobacco Advertising Contest for fourth and fifth grades, and School Jamz Contest for Middle and High schools.
- Anti tobacco activities and presentations in schools and communities across Utah.
- Working with Utah's statewide youth anti-tobacco movement, the Phoenix Alliance, to ensure that youth play an important role in developing and spreading anti-tobacco messages.

FY 2006 Outcomes Approximately 120,000 students were impacted by enhanced school policies on tobacco use.

Approximately 7,000 students in grades 4 to 8 participated in proven anti tobacco curricula, provided or coordinated by Local Health Departments.

1,200 active Phoenix Alliance coalition members from 25 counties engaged 2,000 peers in anti-tobacco education.

Efforts to Reduce Exposure to Secondhand Smoke

Secondhand smoke (SHS) kills over 50,000 Americans annually by causing fatal diseases such as heart disease and cancer. Children exposed to SHS suffer from low birth weight, sudden infant death syndrome, asthma, pneumonia, ear infections, and bronchitis. To reduce Utahns' exposure to SHS, the TPCP and its partners work to enforce the provisions of the Utah Indoor Clean Air Act (UICAA), and encourage voluntary smoke-free policies in homes, worksites not covered by the UICAA, and outdoor venues.

FY 2006 Outcomes Since 2001, child exposure to second-hand smoke in the home declined by 53% (from 6.0% in 2001 to 2.8% in 2005).

Youth Access to Tobacco

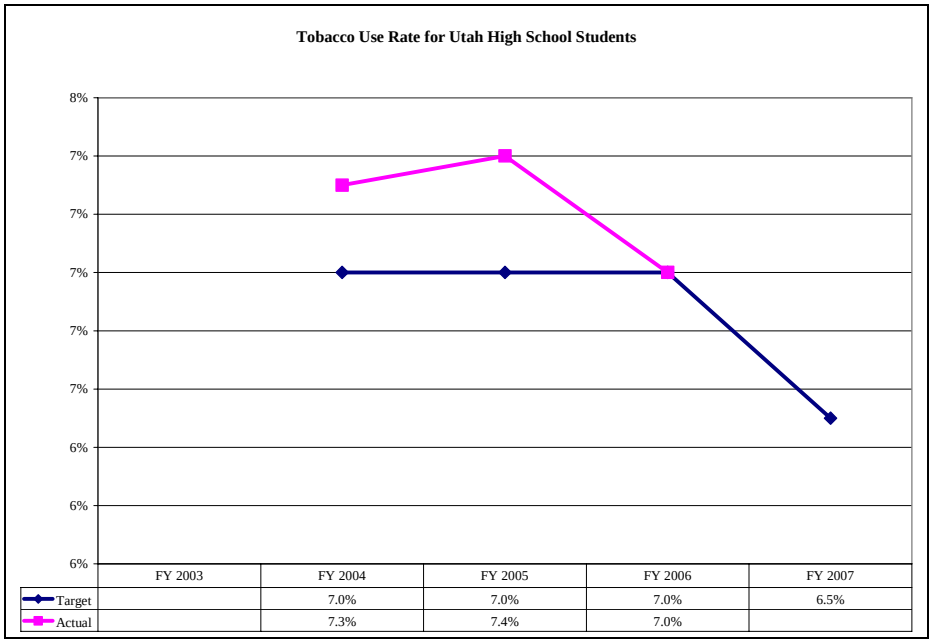
Utah law prohibits tobacco sales to minors under the age of 19. Local health departments collaborate with retailers and law enforcement to ensure compliance with youth access laws through retailer education, retailer recognition, and compliance checks.

FY 2006 Outcomes Since 2001, illegal tobacco sales to underage youth declined by 50%.

Accountability

The Tobacco Prevention and Control Program has established clearly defined goals which are used to monitor the program and some goals are used to determine Utah's eligibility for continued Tobacco Settlement Funds. Each program has a variety of goals and objectives. The primary focus of the program is the youth of the state.

The figure below shows the trends in smoking in high school students. This is one of the five key performance measures of the Division for review purposes.



	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Target		7.0%	7.0%	7.0%	6.5%
Actual		7.3%	7.4%	7.0%	

Figure 6-2

Other Funding through Senate Bill 15, 2000 General Session

Originally, Senate Bill 15 allocated $4.0 million to the Health Department for programs addressing tobacco education, prevention, and cessation. The bill's language also provided additional funding ($2 million) in the event that the lawsuit from the outside law firm was settled. That suit was settled and the Legislature approved increasing the funding from the Tobacco Settlement Account to $6 million, but reduced the division's General Fund appropriation by a corresponding $2 million.

TOBACCO SETTLEMENT
General Fund Restricted - Tobacco Settlement Account

		Split	Beg. Balance	Restricted Gen. Fund	Gen. Approp Restricted Acco	Rstrcted Acct Earned Interest	CHIP Approp.	DOH Approp.	Drug Courts/ I	UU Health Sci	End. Balance
FY 2000	27,736,565		0	13,868,282							13,868,282
FY 2001	27,898,359	50.0%	13,868,282	13,949,180		63,994	(5,500,000)	(4,000,000)	(2,000,000)	(4,000,000)	12,381,456
FY 2002	32,551,700	50.0%	12,381,456	16,275,850		69,834	(5,500,000)	(6,000,000)	(2,000,000)	(4,000,000)	11,227,141
FY 2003	32,642,900	50.0%	11,227,141	16,321,450		67,083	(5,500,000)	(6,000,000)	(2,000,000)	(4,000,000)	10,115,674
FY 2004	27,936,000	80.0%	10,115,674	22,348,800	(9,821,500)	23,722	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	3,666,696
FY 2005	28,353,400	70.0%	3,666,696	19,847,380		13,494	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	4,527,570
FY 2006	26,028,633	70.0%	4,527,570	18,220,043		(1,285)	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	3,746,328
FY 2007	30,390,400	55.0%	3,746,328	16,714,720		10,284	(7,000,000)	(6,000,000)	(2,000,000)	(916,839)	4,554,493
FY 2008	58,499,028	55.0%	4,554,493	32,174,466		0	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	17,728,958
FY 2009	37,276,209	55.0%	17,728,958	20,501,915		0	(7,000,000)	(8,756,593)	(2,000,000)	(4,000,000)	16,474,280
FY 2010	36,581,742	55.0%	16,474,280	20,119,958		0	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	17,594,238
FY 2011	35,765,910	55.0%	17,594,238	19,671,250		(0)	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	18,265,489
FY 2012	34,819,984	55.0%	18,265,489	19,150,991		(0)	(7,000,000)	(6,000,000)	(2,000,000)	(4,000,000)	18,416,480

State statute ((63-97-201(4)) allocates the funding in the order listed above "to the extent funds will be available for appropriation in a given fiscal year". Funding through FY 2006 appears to be adequate to fund each of the entities. However, in FY 2007, there is not enough money in the restricted account to fully fund all of the programs. The problem is resolved beginning in FY 2008, when the State is scheduled to receive "Strategic Payments", which will last for 10 years.

* During the 2003 General Session, $9.8 million was transferred to the General Fund from the Restricted Account for FY 2004 (SB 3, Item 63).
** In FY 2002, the Department of Health's GFR-Tobacco Settlement appropriation was increased by $2 million, replacing $2 million of General Fund, which was reduced due to the budget shortfalls. The $2 million is used in core public health programs, including immunizations, cancer control, etc.

Table 6-7

In addition to the Tobacco Settlement Account's funding for the TPCP, other allocations include $7 million to cover the State's share of the costs for the Children's Health Insurance Program (CHIP); $1.49 million to the Courts and the Department of Human Services to expand the drug court program; $510,000 to the Board of Pardons, the Department of Corrections, and the Department of Human Services for a drug board pilot program; and $4 million to the University of Utah Health Sciences Center. Utah Code requires that each of the state agencies that receive funding from the Tobacco Settlement funds shall provide an annual report on the program and activities funded to both the Health and Human Services Interim Committee and the Health and Human Services Joint Appropriations Subcommittee (63-97-201(6)).

Funding Detail

The primary source of funding is Federal Funds which constitutes over 40 percent of the budget. Another forty percent comes from General Fund Restricted accounts with the remainder split between General Fund, Dedicated Credit Revenue and Transfers.

Budget History - Health - Community & Family Health - Health Promotion

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	325,200	(664,500)	313,500	332,300	359,800
General Fund, One-time	0	900	0	0	(1,000)
Federal Funds	8,349,347	7,545,833	8,786,000	8,662,500	9,180,900
Dedicated Credits Revenue	1,234,893	1,497,979	1,418,600	1,447,400	1,366,400
GFR - Cigarette Tax Rest	2,868,400	3,131,500	3,131,500	3,131,500	3,131,700
GFR - Tobacco Settlement	5,066,500	5,066,500	5,153,800	5,224,400	5,308,200
Transfers	1,397,273	1,255,008	0	0	0
Transfers - H - Medical Assistance	0	0	1,320,500	10,000	17,100
Transfers - Human Services	0	0	0	7,500	10,000
Transfers - Public Safety	0	0	0	93,400	91,200
Transfers - State Office of Education	0	0	175,200	0	8,400
Transfers - Within Agency	0	0	0	1,530,900	1,223,600
Beginning Nonlapsing	319,934	663,766	393,800	372,100	0
Closing Nonlapsing	(663,766)	(393,762)	(372,100)	(447,500)	0
Lapsing Balance	(18,000)	964,100	0	0	0
Total	$18,879,781	$19,067,324	$20,320,800	$20,364,500	$20,696,300
Categories of Expenditure					
Personal Services	4,558,030	4,778,145	5,032,100	5,314,200	5,845,900
In-State Travel	82,847	77,916	73,900	78,800	72,500
Out of State Travel	87,529	103,779	86,000	80,300	77,800
Current Expense	8,449,880	9,431,202	10,199,300	9,853,300	9,588,800
DP Current Expense	166,252	158,146	154,400	138,800	114,000
DP Capital Outlay	0	7,089	0	0	0
Other Charges/Pass Thru	5,535,243	4,511,047	4,775,100	4,899,100	4,997,300
Total	$18,879,781	$19,067,324	$20,320,800	$20,364,500	$20,696,300
Other Data					
Budgeted FTE	96.0	99.9	100.8	99.7	99.4
Vehicles	3	3	3	3	3

Table 6-8

MATERNAL AND CHILD HEALTH

Function

Maternal and Child Health Administration - The Bureau of Maternal and Child Health supports the Department mission to reduce illness, disability and death among women of childbearing ages, children, and youth in the state. The Bureau identifies needs, prioritizes strategies to address needs, develops programs, coordinates efforts, and develops resources to address health issues for mothers and children.

The Maternal and Child Health Bureau provides leadership for many maternal and child health efforts in the state through its programs, contracts with local health departments and other entities, federal grant opportunities and involvement at a national level to learn from other states' programs to apply in Utah. The Bureau is responsible for most maternal and child health issues,

such as promotion of healthy women of childbearing ages, including planning for a healthy pregnancy before pregnancy, access to health care before pregnancy and during pregnancy, healthy weight and nutrition, mental health, oral health, and immunization status; and, promotion of healthy children and adolescents, including immunizations, oral health, mental health, healthy weight and nutrition. The Bureau includes a staff or more than 60 highly skilled public health professionals who work to improve the health of Utah mothers, children and their families in Utah through a variety of public health functions. The Bureau conducts surveillance and analysis of data related to pregnancy and factors associated with poor pregnancy outcomes, such as prematurity; review of maternal, fetal and infant deaths to identify factors that are related to prevention of future deaths; surveillance and analysis of data related to children's health, such as dental screenings for young school-aged children to determine the degree of dental disease, or parents' experiences with health care for their children; promotion of access to health care services, such as family planning, prenatal and well child care; outreach to disadvantaged populations; education of the general public and health care providers; collaborative efforts with local health departments, community health centers and the private provider community, as well as community-based organizations, health care professional organizations, hospitals, and schools. The Bureau includes six programs that work to achieve the Bureau's goal of healthy mothers and children: Reproductive Health; Child, Adolescent and School Health; Data Resources; Immunizations; Oral Health; and the Women, Infants and Children (WIC) Programs. The Bureau is responsible for the state Title V Maternal and Child Health Block Grant Application and Annual Report, the CDC-funded Immunization Program, and the USDA funded WIC Program. The Bureau reviews and analyses numerous data sources to determine priorities and to establish program plans to improve the health of mothers and children. The Bureau is responsible for oversight of the funding sources, including Title V, CDC Immunization, USDA WIC and a small amount of state general funds that meet the federal match requirements.

Reproductive Health Program (RHP)

The mission of the Reproductive Health Program (RHP) is to improve the health of women of childbearing age and their infants by reducing preventable illness, disability and death related to pregnancy, birth and infancy through the promotion of healthy lifestyles and optimal health care. The various components of the RHP include the Prenatal/Family Planning, the WeeCare, the Pregnancy Risk Assessment Monitoring System (PRAMS), the Baby Your Baby (BYB) by Phone and the Perinatal Mortality Review (PMR) component. The program creates and disseminates pertinent health education messages that are identified through the program's various data collection resources. These messages are distributed via presentations at schools, churches, health fairs, etc. as well as their Internet website (www.health.utah.gov/rhp), brochures, radio messages and poster displays.

The Prenatal Component of the program improves access to prenatal care through expedited eligibility to Medicaid, enhanced prenatal and delivery services within Medicaid, and by covering prenatal care for uninsured women. The family planning component assures access to family planning services in

under served areas of the state, and also assures reproductive health services through technical assistance to local health departments, community health centers, and other providers. Contracts are maintained with these agencies for prenatal and family planning services.

The Wee Care Component offers nurse case management of moderate and high-risk PEHP pregnant participants throughout the state via telephone. Women are provided information that can help them reduce the risk of premature delivery and other pregnancy complications. They also enjoy follow-up contact throughout the pregnancy to assure that everything is going well, and that mother and infant have optimal healthy outcomes

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based surveillance system that queries a sample of Utah mothers about their experiences before, during and after pregnancy. PRAMS is intended to help answer questions that birth certificate data alone cannot answer. Data are used to provide important information that can guide policy interventions, and other efforts to improve care and outcomes for pregnant women and infants in Utah. An example of how PRAMS data are being used is to educate prenatal care providers about the effects of overweight/obesity on pregnancy outcomes.

The Baby-Your-Baby by Phone Component of the program has been implemented to provide a quick and easy Presumptive Eligibility determination by enrolling women who reside in Salt Lake County into Presumptive Eligibility via telephone. This program expedites early access to prenatal care for women who participate. This component is paid for with state general funding.

The program has also partnered this year with other UDOH programs in a contract with Utah State University's Early Intervention Research Institute to develop an online web-based application program to enable low income families to be screened for presumptive eligibility for Medicaid and other services. The program was implemented in early FY 2006. RHP covers a portion of the contract costs to help facilitate easier enrollment into presumptive eligibility for prenatal Medicaid.

The Perinatal Mortality Review (PMR) Component of the program is a process aimed at identifying and examining the factors that contribute to perinatal deaths (fetal, infant, and maternal) through the systematic evaluation of individual cases. Through individual case review, the PMR coordinator, in conjunction with a committee of perinatal professionals, identifies contributing factors that may have led to the death. Information is obtained through medical records, public health records, autopsy reports, birth/death certificates and health care provider records. Committee members make recommendations based on findings that may lead to public health recommendations for changes that could improve the outcome of future cases.

The PMR committee completed the review of 85 infant deaths and 8 maternal deaths this calendar year.

Program Activity

One of the performance measures is getting the information out to the public. Table 6-9 details the calls related to this program area as reported by the Health Department. The numbers are based on calendar year. The 2006 numbers are not the complete year, but only as of September 2006. It is estimated that it will continue to increase.

Client Type	Numbers Served 2005	2006
Prenatal/Family Planning	11,020	9,760
WeeCare	2,215	1,449
Baby Your Baby by phone	1,765	1,439

Table 6-9

Child, Adolescent and School Health (CASH) Program

The CASH Program provides a broad range of services related to child health and development, from birth through adolescence. The CASH Program administers several grants that seek to improve the system of services for children and promote health behaviors.

The CASH Program provides oversight, training and technical assistance for two home visiting nurse programs provided by public health nurses through the twelve local health departments. The CASH Program oversees the Title V-funded Prenatal-5 Nurse Home Visiting Program that provides nurse home visiting for pregnant women and at-risk children from birth to five years of age. The program provides coordination, oversight and technical assistance for the Title V-funded Sudden Infant Death Syndrome (SIDS) Program for families that need grief and local services support after the unexpected loss of an infant. SIDS prevention materials and training are provided to local hospitals, community organizations, child care providers, and professional preparation programs.

The program administers the State Early Childhood Comprehensive Systems grant, funded with federal Title V funds, to improve the system of services for children from birth to age eight by coordinating efforts of statewide agencies and organizations to ensure children are ready to enter school healthy and ready to learn.

The Head Start-State Collaboration Office grant is designed to meet the increasingly complex and difficult challenges of improving long-term health outcomes for low-income children and their families and is funded with federal and state-match funds. The overall goal of this grant is to create and promote a statewide focus of interagency partnerships and linkages between Head Start and other early childhood service providers.

The CASH Program provides oversight, with federal Title V funds, for the Abstinence Education Grant, Section 510 of Title V, to provide technical assistance, training, and consultation to the agencies that implement the Abstinence Education Only programs for youth from ages nine to fourteen. The goal of this grant is to promote abstinence from sexual activity before marriage.

Service	FY 2003	FY 2004	FY 2005
Child Health Services			
(well child care, care coordination, screening, school health)	12,277	46,055	27,298
Prenatal - 5 Nurse Home Visit	7,954	7,238	5,246
Prenatal - 5 Nurse Home Visit # of children	3,986	3,049	2,893
Abstinence-only Education - adolescents and parents	37,930	42,375	45,221

Table 6-10

Immunization Program (IMM)

IMM promotes immunization as part of comprehensive health care across the life span – infants, children, adolescent, and adult. It provides services through technical assistance to local health departments (LHD), community health centers (CHC), managed care organizations (MCO), schools (public and private) and licensed day cares, and private providers. The program contracts with LHDs and CHCs to support infrastructure for outreach activities to at-risk and eligible populations. Special emphasis is placed on efforts to improve the immunization coverage for pre school-age children, especially those under two years of age.

The Vaccines for Children (VFC) component provides vaccine at no cost to eligible children ages 0-18 years who are uninsured, covered by Medicaid, under-insured, or American Indian. The vaccine is provided to 325 enrolled public and private medical providers statewide. An essential part of this program is technical assistance for vaccine management and accountability including doses administered and quality assurance, assessment, and audits. The VFC distribution system is now used, through an MOA with CHIP, to provide vaccine to children enrolled in CHIP which provides a substantial cost savings to the CHIP program and also provides the same provider services related to vaccine management and accountability.

The Disease Surveillance and Outbreak Control activities monitor the incidence of vaccine-preventable diseases and assist in addressing disease outbreaks. A full time employee is supported in the Division of Epidemiology and Laboratory Services to monitor morbidity and mortality data.

The Population Based Assessment component provides technical assistance to school staff, school nurses, and school administrators. It further provides retrospective school entrance surveys and validation audits of all schools and licensed day care/Head Start centers. It also monitors second MMR levels of all school children through grade 12. There is a strong collaboration with Utah State Office of Education.

The Vaccine Adverse Event Reports System (VARES) component provides for a reporting system for adverse events following receipt of any U.S. licensed vaccine.

The Public and Professional Information and Education component involves activities and efforts to provide current immunization information, education, and training to the public and providers. It also supports the Every Child by Two public/private partnership and four local coalitions and media campaign working to increase immunization rates for children under two. This

component maintains the Immunization Hotline and mobile immunization services through Care-A-Van.

The Immunization Registry component pertains to the Immunization program support of aspects of the development and maintenance of a population based immunization registry. This includes support of provider enrollment and technical assistance to increase provider utilization of Utah Statewide Immunization Information System (USIIS).

The Perinatal Hepatitis B Prevention program promotes Hepatitis B immunization to prevent perinatal transmission. The program offers technical assistance and oversight of case management provided through local health departments, as well as Hepatitis B immunization for infants and household contacts. It also provides technical assistance, information and education resources on all forms of hepatitis: A, B, and C.

The Adolescent Immunization component supports activities to prevent vaccine preventable diseases in adolescents ages 11-21. This is accomplished through providing technical assistance, current information and education to the public and providers. College entrance immunization recommendations are also in place and collaboration with Youth Corrections.

The Adult Immunization component promotes the prevention of vaccine preventable diseases among adults with an emphasis on influenza and pneumococcal disease. It also supports the Utah Adult Immunization Coalition working to increase immunization rates for adults.

The WIC Linkage component promotes increased rates of immunization and the prevention of vaccine preventable diseases among WIC participants.

The Preparedness component provides support for Utah to achieve appropriate pandemic preparedness and response to bioterriorism agents statewide. Technical assistance and vaccine management are provided to local health departments and communities statewide.

The IMM Program provides vaccine to eligible children through a federal grant awarded credit line at the Centers of Disease Control. It also provides educational information and technical assistance to the entire population through grant awarded CDC funds.

Accountability

The program lists numerous vaccines available to the public. The major focus is on early vaccines for those up to two years of age. The following performance measures were reported by the Division.

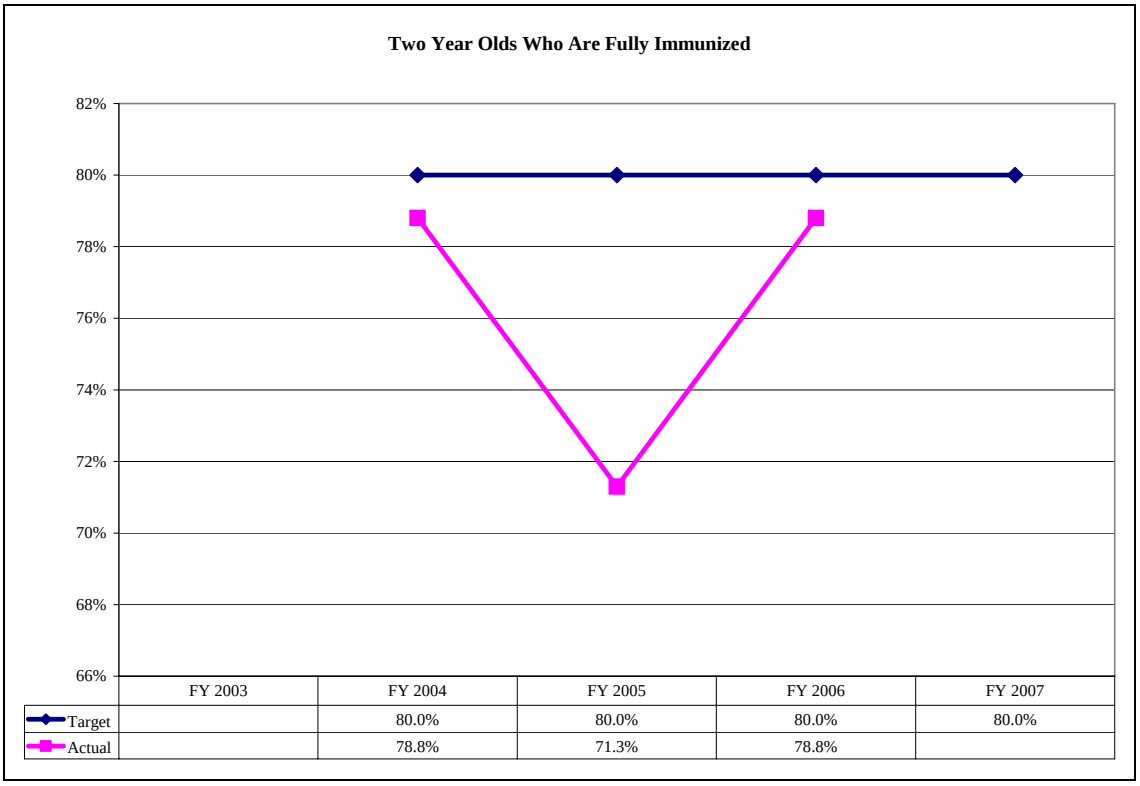


Figure 6-3

Data Resources Program

The Data Resources Program (DRP) provides health data and information support to staff within MCH and CSHCN programs, local health departments, community-based health organizations, and citizens. The program is two-pronged in its approach as it aims to 1) increase access to health information and data, and 2) provide analytic consultation, data training, and web services.

DRP acts as a resource for MCH programs in identifying data sources and status of certain health indicators. The program also facilitates the coordination of multi-program projects and reports. The program also plays an active role in designing web site and web-based applications for CFHS and ensures that they are in compliance with department and state web standards.

DRP provides the necessary activities related to all the MCH Bureau programs which deal with the documentation of data reporting by local health departments as part of the contract process. The DRP serves as the data resource component for all MCH Bureau and CSHCN Bureau programs since it is not feasible to hire an epidemiologist or data analyst for each individual program.

Women, Infants and Children (WIC)

Women, Infants, and Children (WIC) is a federally funded program designed to provide supplemental food and nutritional education to pregnant, breast-feeding or postpartum women, infants and children up to five years of age. Included are individuals from low income families who are determined to be at nutritional risk because of inadequate nutrition, health care, or both. WIC is specifically designed to serve as an adjunct to good health care during critical periods of human growth and development.

Applicants must meet the following criteria to be certified and eligible for WIC Authorized foods:

- A resident of the area or member of the population served by the 52 local clinics.
- Income at or below 185 percent of the poverty guidelines established by the federal government.
- Certified to be at nutritional need through a medical and/or nutritional assessment.

In FY 2006, the average monthly participation was 67,029. This is a monthly average decrease of 1.5 percent from the previous year.

Oral Health Program (OHP)

Tooth decay is the most common chronic childhood disease in Utah and the United States. Preventable oral diseases afflict many Utah children, in particular, children from families with low incomes and children with special health care needs. According to the 2005 Statewide Oral Health Survey, 55 percent of six through eight year olds in Utah have experienced dental caries compared to only 52 percent nationally. Furthermore, 21 percent of Utah's six to eight year olds have untreated dental caries, an important measure of dental care access. An additional factor that contributes to high rates of dental caries in children is the lack of water fluoridation. In Utah, approximately 52 percent of Utahns have adequate fluoride in their water systems.

The Health Program (OHP) improves the oral health status of Utah residents by developing, implementing, and promoting effective prevention and dental access programs at both the state and local health department levels. OHP dental caries prevention methods such as community water fluoridation, fluoride mouth rinse programs, tooth sealant programs, and early childhood interventions help reduce rates of dental caries among all populations. The evaluation and dissemination of statewide dental health surveys, Head Start data and other Utah specific dental health information by OHP provide important needs assessment information for state and local health departments. OHP activities which improve systems of outreach to and treatment care for Medicaid, CHIP, and low-income uninsured populations help to assure access to appropriate oral health care services for these targeted populations.

In collaboration with the Utah Oral Health Coalition, the OHP has developed and maintains the Utah Oral Health Action Plan which emphasizes implementation of appropriate prevention and access strategies for target populations and promotes development of policies for better oral health and improved oral health systems statewide. Additionally, the OHP encourages and facilitates the formation of local oral health coalitions by conducting needs assessments and oral health surveys, providing technical consultation and reporting progress toward Healthy People (HP) 2010 oral health objectives. The OHP collaborates with local health departments and community health centers and partners with many community public health and private practice dental and health professionals, stakeholders, and

advocates to effectively implement programs which best serve the needs of local communities. The OHP has developed and maintains an oral health website that provides educational and resource information for public and private partners as well as the general population of the State.

Funding Detail

Almost seventy-three percent of this budget is from Federal Funds. Over twenty percent of the remainder is from Dedicated Credit Revenue.

Budget History - Health - Community & Family Health - Maternal and Child Health

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	244,400	1,158,100	219,100	228,100	247,700
General Fund, One-time	0	200	0	0	(800)
Federal Funds	37,741,238	37,306,240	38,674,900	38,849,300	42,019,100
Dedicated Credits Revenue	10,000,111	11,234,938	12,052,900	12,162,800	12,268,900
GFR - Tobacco Settlement	995,200	995,200	995,200	995,200	995,200
Transfers	1,670,438	96,787	0	0	0
Transfers - H - Medical Assistance	0	0	691,600	0	3,000
Transfers - Within Agency	0	0	0	1,010,400	1,030,400
Beginning Nonlapsing	0	0	0	75,000	0
Closing Nonlapsing	0	0	(75,000)	0	0
Lapsing Balance	(39,200)	(949,000)	0	0	0
Total	$50,612,187	$49,842,465	$52,558,700	$53,320,800	$56,563,500
Categories of Expenditure					
Personal Services	2,897,344	3,351,238	3,587,300	3,980,300	4,209,700
In-State Travel	22,215	20,371	35,200	42,500	39,100
Out of State Travel	59,779	55,625	70,600	60,700	64,900
Current Expense	4,812,130	3,400,463	3,858,900	4,527,200	4,338,000
DP Current Expense	356,494	546,599	621,200	301,700	427,400
DP Capital Outlay	0	10,752	0	0	0
Capital Outlay	0	0	0	9,700	0
Other Charges/Pass Thru	42,464,225	42,457,417	44,385,500	44,398,700	47,484,400
Total	$50,612,187	$49,842,465	$52,558,700	$53,320,800	$56,563,500
Other Data					
Budgeted FTE	57.8	65.1	67.3	67.2	67.1
Vehicles	1	1	1	1	1

Table 6-11

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Function

The Bureau of Children with Special Health Care Needs (CSHCN) encompasses ten programs serving special needs children. CSHCN programs reduce preventable death, disability, and illness due to chronic and disabling conditions by providing access to affordable high-quality health screening, specialty health care, and case management. Bureau programs provide "direct services" or "population based services". These services are provided by bureau staff or through contractual agreement with community providers.

Hearing, Speech, and Vision Services (HSVS)

HSVS provides statewide screening, evaluation, and referral of infants and children with hearing, speech, and/or vision problems. Target populations are newborns, infants and preschoolers, children at risk, children in areas lacking alternative care, children whose parents request financial assistance, and children with special health care needs. Pediatric hearing, speech, and vision services are provided throughout the state, from the main clinic in Salt Lake City, regional clinical facilities in Ogden, Cedar City, Vernal, Price, and Montezuma Creek, and 26 traveling clinic sites. HSVS works with local resources to provide referral to appropriate intervention services. Children

identified with these disorders in early life have a much lower rate of subsequent chronic disability. In FY 2006, 3,397 clinical visits were provided in addition to over 2,000 educational encounters.

HSVS Clinical Direct Services	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007 est
# patient encounters	3,023	3,514	3,305	3,650	3,397	3,400
# public health education efforts	3,455	2,200	3,935	3,512	2,072	3,000
# photo screens provided statewide	814	879	803	562	513	700
# recycled hearing aids provided	15	32	44	14	25	30

Table 6-12

Newborn Hearing Screening (population based services)

Hearing, Speech and Vision Services (HSVS) oversees legislatively mandated hearing screening of all Utah newborns and provides technical assistance to hospital programs. HSVS manages the Early Hearing Detection and Intervention (EHDI) centralized database, and works with hospitals and audiologists for tracking and follow up of infants that require additional testing.

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007 est
# / % hospitals providing newborn hearing screening	43/100%	43/100%	43/100%	42/100%	42/100%
% live births receiving hearing screenings *	96.6%	98.6%	98.5%	98.5%	98.5%
% passing at initial screening	90.6%	92.6%	93.0%	93.7%	94.5%
# confirmed hearing losses	59	52	60	72	70
# recommended for diagnostic evaluation	462	406	402	346	<1% of all newborns

* reported on calendar year. % calculated on data reported from hospitals to the State HI*TRACK data system

Table 6-13

Of 51,839 births for 2005, 51,239 had screening reported. (Birth frequency counts from Vital Records as of 8/23/06).

Accountability

Though there are many activities, early screening for hearing is a key item to assist both parents and the child. It is also representative of the efforts made within the program.

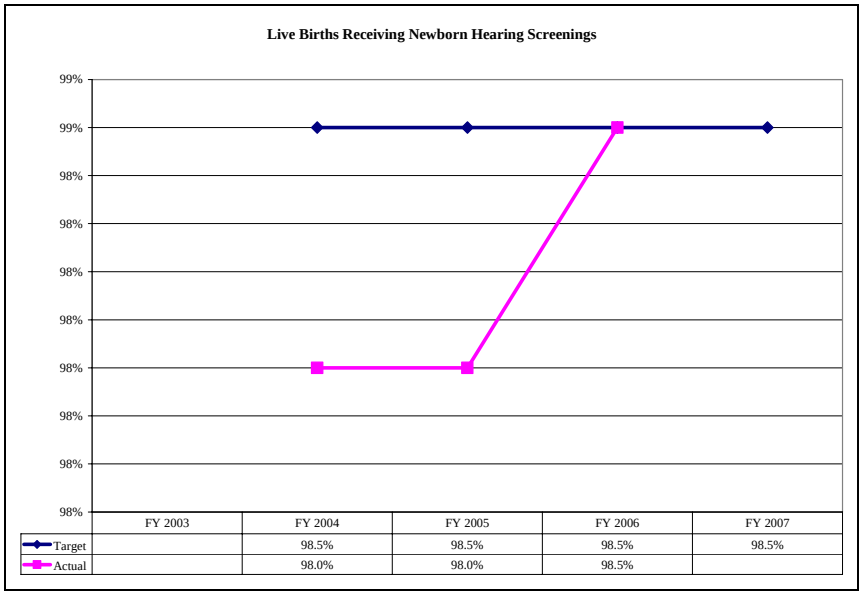


Figure 6-4

Neonatal Follow-up Program (NFP)

The Neonatal Follow-up Program provides statewide multi-disciplinary screening services for the very low birth weight graduates of Utah newborn intensive care units. The services are offered through three satellites in Salt Lake City, Ogden, and Provo.

Expanded availability of prenatal care, early recognition of labor and available pharmaceuticals failed to decrease the rate of babies born preterm. In fact, there is an increase in the number of babies born too early and too small. The rise is attributed, at least in part, to improved survival of the most fragile babies and a sharp increase in multiple births.

Undesirable long term outcome remains high in spite of advances in technology, pharmacology and better understanding of fetal and newborn physiology. Risk for poor outcome rises as birth weight and gestational age decrease. Of the extremely low birth weight babies, 20 percent will have cerebral palsy, 25-30% will test in mentally retarded range, and 45% will need special education resources.

The cost of low birth weight is felt by all citizens. The cost of prematurity exceeds the cost of other major health problems.

The Neonatal Follow up Program provides:

- two and one half (2½) year follow-up for the very low birth weight babies;
- four and one half (4½) year follow-up for the extremely low birth weight babies.

The Neonatal Follow-up Program offers:

- periodic screening by multiple providers (neurologist, ophthalmologist, pediatrician, audiologist, speech pathologist,

dietitian, psychologist, occupational/physical therapist, social worker and nurses).

Neonatal Follow-up Program's objectives are:

- To improve long-term outcome by identifying and treating significant findings in a timely fashion;
- To coordinate services with existing resources and partner in long term care;
- To provide feedback to Utah newborn intensive care units and allow for reassessment of treatment practices; and
- To ultimately reduce cost of family stress, health care and educational resources.

Service	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007est
Clinics	156	156	134	124	135	145	140
Patients	2,149	2,408	2,000	1,509	2,093	1,720	1,750
Patient Encounters	12,431	9,382	6,202*	6,258	6,984	7,117	7,200
* New eligibility requirements							

Table 6-14

Child Development Clinic (CDC)

The Child Development Clinic Program provides multi-disciplinary medical and developmental assessment services for children birth to five years of age who have developmental disabilities or chronic illness associated with developmental delay. The program also offers consultative and case management services for children with multiple disabilities up to 18 years of age. Services are designed to:

- Recognize the need for early diagnosis and treatment;
- Provide timely detection of sensory, cognitive, and emotional disorders;
- Assist the family in identifying their child's strengths and weaknesses;
- Develop and monitor a written plan of services;
- Provide parents with support and information;
- Coordinate the delivery of services with local agencies; and
- Promote and develop appropriate community wide services for the prevention of disabilities.

Service	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006 *
# of Clinics	216	246	249	246	246	240	242
# of Children served	384	1,124	837	901	837	773	588
# of Patient encounters including itinerant sites	3,092	4,247	3,167	3,047	4,352	4,757	2,810

Table 6-15

* In calendar year 2005, a major revision regarding how evaluations and staff patient encounters are tracked was initiated. In addition, a reduction of staff was also a factor in changes of overall numbers.

Community Based Specialty Services (CBS)

Community Based Specialty Services (CBS) administers Utah's Medicaid Waiver for Technology Dependent Children, Utah's Integrated Services Project and provides family-to-family support and advocacy for children with special health care needs and their families.

The day-to-day operation and case management for Utah's Medicaid Waiver for Technology Dependent Children is provided by CBS registered nurses. The waiver program targets technology dependent children statewide and provides access to Medicaid without regard to parental income or assets. Medicaid covered services are available to eligible children in addition to "waiver" services including skilled nursing respite and family support services. Waiver case managers assess needs, authorize services and provide resources and referrals to support the entire family.

In collaboration with the University of Utah's Department of Pediatrics, Utah's Integrated Services Project has designed and implemented a community-based system of care for CYSHCN and their families while creating a sustainable infrastructure for all six of the MCH/CYSHCN core system components. Using the Learning Collaborative model, pediatric practices participate in a multi-phase collaborative focusing on the provision of comprehensive care in the Medical Home model. An advisory committee and numerous subcommittees focus on the integration of the 6 MCH core components into community systems. The project's website provides expanded information, resources and services to providers and consumers including an on-line application process for numerous state and local programs. Other project activities include monthly phone conferences, pediatric practice site visits, newsletters and resource information.

Also in collaboration with the University of Utah's Department of Pediatrics, the Medical Home website expanded the number of pages to over 700 and the number of local community resources listed to over 2,000 services. In November 2005, the website changed to a more accurate system of monitoring visits to pages on the information and pictures on a single page. The number of visits to the website has increased 117% since the first full month of monitoring in December 2005 (1749 visits) to July 2006 (3792 visits). Additionally, the website has recorded visitors from 133 countries around the world.

The Bureau's Parent Advocate Coordinator is housed under CBS and is an integral part of all CSHCN programs. The coordinator provides a family perspective and works on numerous state and national committees, including the Integrated Services Project. She provides individual parent-to-parent support for CSHCN families, is the Utah Family Voices Director and Project Manager of Utah Family Voices Health Information Center. Table 6-16 below details the change in counting "hits" on the Medical Home Website verses "visits". A hit is defined as a different page. One person can score

numerous hits while the visit is just the number of persons that visit the entire site each time, no matter how many pages they may peruse at the time.

Service	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007 est.
Waiver Program	116	118	120	120	120
practices given technical	8	8	9	15	21
Number of hits on the Medical Home Website		282,324	450,253		
Number of visits on the Medical Home Website				23,265	30,000

Table 6-16

School Age and Specialty Services Program (SASS)

The goal of the School Age and Specialty Services (SASS) program is to provide Utah's special needs children and their families access to specialty pediatric medical and behavioral providers. Increases in the incidence of certain pediatric conditions including autism spectrum disorders, cerebral palsy and learning disabilities increase the need for specialty services. The program serves children, ages 5 through 18 (on the Wasatch Front) and birth through 18 in itinerant clinic sites. There is particular emphasis in serving special needs children in the underserved, rural areas of the state. Children may be seen by neurology, cardiology, medical genetics and pediatrics through contracts with the University of Utah Department of Pediatrics. The ABLE ("abilities and behavioral resiliency in adaptive learning environments") program provides evaluation and recommendations for children with learning disabilities, behavioral problems and autism spectrum disorders, particularly Aspergers syndrome. Multidisciplinary clinics for condition like cleft lip and palate, spina bifida or osteogenesis imperfecta can be accessed through collaboration with Primary Children's Medical Center or the Shriners Hospital for Children (located in Salt Lake City). Itinerant site clinics, using traveling SASS staff are conducted in collaboration with the local health departments (LHD); these include Price, Moab, Blanding/Montezuma Creek and Provo with general and specialty pediatric services provided by the University of Utah Department of Pediatrics contracts. The Ogden CSHCN statellite clinic also offers pediatric clinics staffed by University of Utah contract providers and CSHCN psychologists. SASS works with community medical providers, school districts, and other agencies to coordinate services. A strong orthopedic program, staffed by pediatric orthopedists from the University of Utah, serves all the previously mentioned sites as well as Logan, Utah.. The SASS program therapy consultants (OT/PT) evaluate children from the ages of birth to twenty-two, coordinating with Early Intervention, local school districts and other state agencies. Additionally, the program includes activities in the areas of young adult transition, medical home, SSI/Medicaid outreach, and cultural awareness.

Service	2003	2004	2005	2006	2007 est.
Total Number of Encounters	6,157	6,357	6,009	6,872	6,900
Number of Itinerant Encounters	3,267	4,096	4,073	4,969	4,990
Number of Salt Lake Area Encounters	2,890	2,261	1,936	1,903	1,930
DDS Transmittal coordination/ Medicaid outreach	551	755	583	158*	400

Table 6-17

* Disability Determination Services (DDS) transmittal reductions were due to loss of examiners, loss of tech support, and increased processing time. Utah's DDS has one of the highest first time denial rates of any state.

Fostering Healthy Children

The mission of the Fostering Health Children Program is to ensure that the health care needs of children in the Utah Child Welfare System are met in a timely manner. The program was implemented in response to the Settlement Agreement the State made with the National Center for Youth Law in 1994. The settlement agreement requires the State to provide health, dental, and mental health care to all children in foster care custody on an on-going basis. DCFS contracts this service with the Department of Health to provide Administrative Case Management of all children entering Foster Care across the state. Registered nurses are utilized to:

- Manage the health, dental, and mental health care needs of children in Foster Care
- Assist the caseworker in addressing physical, dental, and mental health concerns for a child in state custody
- Provide input on the placement of a child with special health care needs
- Provide medical education and training to foster parents, families, and caseworkers
- Provide hospital, home and/or office visits for children with special needs with one on one health care education and training
- Increase the accessibility for health care by identifying providers willing to provide care
- Refer children with developmental delays noted on the Ages and Stages to Early Intervention

Service	2002	2003	2004	2005	2006 est.
Number of Children served in foster care / CPS by FHC staff	3,803	3,778	4,167	4,190	4,000
Number of Nursing Encounters	59,594	63,903	58,931	78,071	76,000
Number of health status outcome measure evaluations	10,357	12,304	13,361	13,838	11,200

Table 6-18

Birth Defects and Genetics Program

This program includes two major efforts: the Pregnancy RiskLine and the Center for Birth Defects Research.

The Pregnancy RiskLine provides information regarding exposure to drugs, chemicals, and infections in pregnancy and lactation and the possible effect on the developing fetus, breast-fed infant and mother that is often not easily accessible to health care practitioners or consumers. It is understandable that during pregnancy there is an increased sensitivity to the possibility of having a child with a birth defect. After an exposure and because of the poor quality of available information about fetal effects, women often feel their risk of having an affected child is higher than the actual risk posed by the exposure. These perceptions of heightened risk have too often led to terminations of otherwise wanted pregnancies, increased anxiety, demands for unnecessary and costly prenatal diagnostic procedures as well as for repeated screening and testing of the in-utero exposed infant and child. Medical, nursing, pharmacy, and other health-related schools usually do not provide courses in human or clinical teratology (the study of causes of birth defects), so practitioners are not prepared to assist their pregnant or lactating patients with these questions and concerns. Since it is common for pregnant and lactating women to be exposed to medications/drugs, chemicals, and infectious agents, misinformation can too often be transmitted. The Pregnancy Riskline was established to provide health care practitioners and consumers with accurate, up-to-date information regarding potential risks to a fetus or breast-fed infant in order to prevent unjustified anxiety leading to unnecessary abortions, costly prenatal and postnatal screening, diagnostics, and testing of an exposed fetus or infant. The program educates more that 9,000 callers each year and more than 1,000 health care practitioners, a total of over 10,000 encounters. Additionally, another 1,000 medical, pharmacy, nursing and health education students are educated each year.

The Utah Birth Defect Network (UBDN) is a statewide surveillance system monitoring the occurrence of major structural birth defects in Utah. The UBDN uses this information to assess the prevalence of birth defects occurring in Utah; conduct epidemiological studies to determine risk factors that may contribute to birth defects; educate women and health care providers about these epidemiologic studies of risk factors in Utah women; evaluate whether education has decreased specific birth defects; and identify whether clusters of birth defects are occurring. Accurate and timely birth defect data collection is essential to public health in Utah. Birth defects are the leading cause of infant mortality. Birth defects also contribute to premature births and are the major reason for hospitalizations during the first year of life. The economic costs for children born with birth defects are tremendous and extend beyond medical and surgical care to behavioral and educational service issues. The cause of most birth defects remains unknown. Due to the high quality of data collected by the UBDN federal grant money has been secured for the epidemiological study of birth defects with no known cause. Utah is one of ten centers selected nationally to participate in this study.

Program Activity

Major goals of these Division of Community and Family Health Services are aimed at prevention of poor pregnancy outcomes and adverse health effects in children. The desired outcomes are intended to prevent low birth weight, infant mortality and birth defects.

By offering accurate and current information about fetal effects of maternal exposure to medications, drugs, chemicals, infections and diseases, the PRL may prevent untoward effects of some of these agents on a developing fetus, resulting in a decreased incidence of low birth weight, infant mortality and birth defects.

PRL Measures: 1) number of Utah clients served; 2) number of educational sessions to Utah health care providers; 3) number of educational session to the Utah public.

The UBDN's efforts are directed toward prevention of birth defects and secondary disabilities by monitoring occurrence, conducting educational outreach, and participating in collaborative epidemiological studies. Evaluation of the UBDN epidemiologic data provides information in order to assess risk factors for birth defects and develop primary prevention activities directed at reducing these risk factors. Implementation of primary prevention activities targeted at high risk populations in the State will reduce the occurrence of birth defects, which must be evaluated through the continuous tracking of all major birth defects statewide.

UBDN Measures: 1) accurate and timely tracking of birth defects statewide; 2) folic acid educational campaign and evaluation of neural tube prevalence over time to evaluate effectiveness of prevention activities; and 3) evaluation of epidemiologic data to determine other prevention activities necessary to reduce birth defects in Utah.

Service	2000	2001	2002	2003	2004	2,005	2006 est
# of clients served by Pregnancy Riskline	10,422	10,503	10,891	10,681	9,990	10,033	12,600
# of births screened by Birth Defects Network	43,331	47,915	49,140	49,834	50,653	52,563	54,000

Table 6-19

Newborn Screening (NS)

The Newborn Screening program provides a statewide system for early identification and referral of newborns with certain metabolic, endocrine, or hematologic disorders that can produce long-term mental or physical disabilities, or death if not treated early. The disorders are: congenital hypothyroidism, galactosemia, and hemoglobinopathy, biotinidase, congenital adrenal hyperplasia, amino acid disorders, fatty acid disorders, and organic acid disorders. The testing kit fee is $65.00. The fee is split between the Lab and CSHCN.

Service	2003	2004	2005	2006 est	2007 proj.
Percent of newborns screened	99.0	99.0	98.3	98.5	98.5
Number of screens performed	374,307	395,547	415,762	703,968	704,000
Number of newborns 'at-risk'	843	2,437	2,005	2601-2926	2601-2926
Number of newborns referred for confirmatory testing	554	410	438	1560-1755	1560-1755
Number of newborns with diagnosis (not normal)	459	346	375	1248-1404	1248-1404
Number of newborns treated	50	33	42	61-76	61-76

Table 6-20

Baby Watch Early Intervention (BW/EI)

BW/EI provides early intervention and developmental interventions statewide for young children with developmental delays and/or disabilities from birth to age three. Services include multi-disciplinary evaluation and assessment; service coordination; specialty and therapy services such as nursing, physical therapy, occupational therapy, speech therapy, special instruction, family support and other related services that build on family strengths and child potential. Services are available statewide through local service delivery personnel.

Service	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006 est
Children served with Individual Family Service Plan	2,463	2,527	2,382	2,524	2,681	2,815
Average number of encounters per child	36	36	36	36	36	36
Total encounters		90,972	85,752	90,864	96,516	101,340

Table 6-21

The 1997 Legislature authorized additional funding for this program to handle the increased number of requests for early intervention services. The amount added to the budget was $1.5 million, with half of that funding coming from the General Fund and the other half coming from fees paid by the recipients, according to the sliding fee schedule which was also approved

The 2000 Legislature allocated $300,000 (General Fund) for growth in the BW/EI Program; the 2001 Legislature approved an additional $600,000. The 2002 Legislature was unable to add any new funding for Early Intervention, however, the division was able to cover the additional growth with carry-forward federal funds. The 2003 Legislature approved an additional $1 million. It now appears that that funding, together with the fee revenue and the division's tightening of eligibility will be sufficient to cover anticipated FY 2006 expenses.

Over the past several years, the BW/EI program has become better known throughout the State and the eligible population has also grown. The caseload in FY 1999 was 2,013, growing in FY 2000 to 2,263 in FY 2001 to 2,463 and in FY 2002 to 2,527. Due to the limited funding levels, eligibility criteria reduced the FY 2003 caseload to 2,382. It has been building since then.

Accountability

The Baby Watch/Early Intervention Program is a major component of the Children with Special Health Care Needs program. Caseloads have been growing.

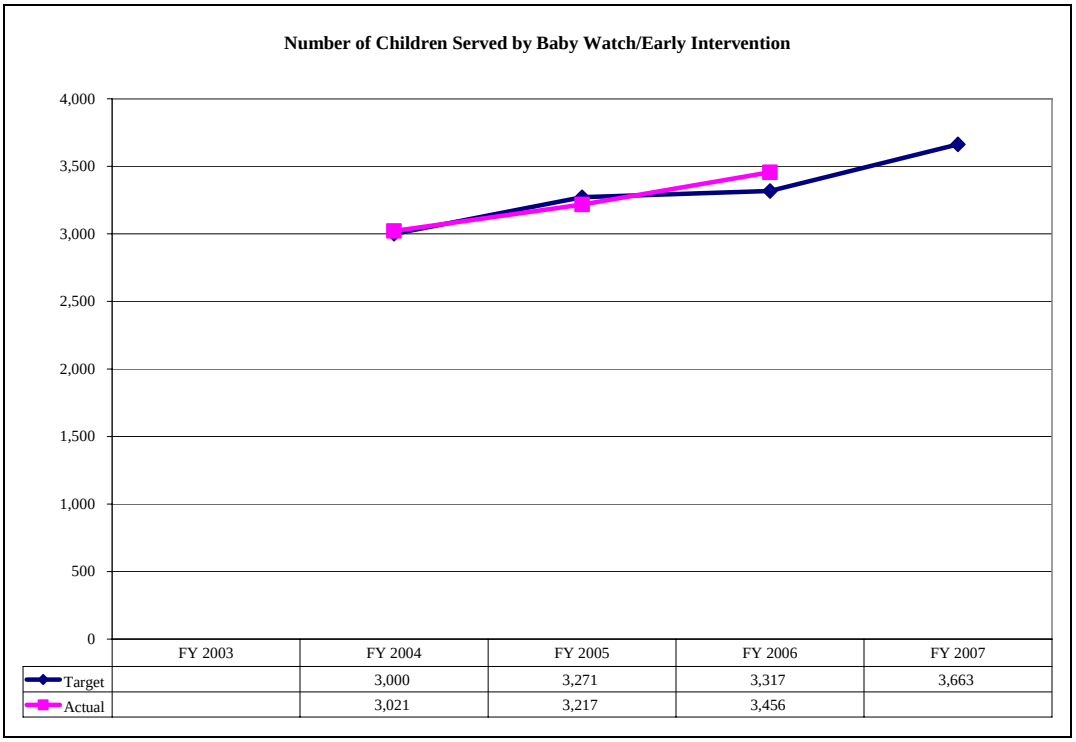


Figure 6-5

Child Health Advanced Records Management (CHARM)

Accurate and timely data are essential for the State of Utah to provide appropriate health services to its citizens. Currently, data exists in an array of public and private health sectors and each database serves its own users and data is not shared across organizations or health programs. Services are often not coordinated and typically do not provide a network of care for families. As a result, many children do not receive critical follow-up. It is estimated that while nearly 95 percent of Utah's children receive newborn screening services, many are lost to follow-up.

The Child-Health Advanced Records Management (CHARM) Project is a coordinated, Department-wide effort to create an electronic virtual health profile for every child in Utah that allows real-time digital access and data sharing among appropriate health care programs and partners. The CHARM Vision is to become a shareable repository of child-specific public health information with secure role-based confidential access to a comprehensive set of integrated public health data accessible by people with a need to know, that promotes timely and efficient access to needed services, and supports program planning and evaluation. Integrating the state's health care databases provides for immediate access to information that is stored in specific databases to track and monitor health status for children and their families.

CHARM integrated the programs targeted for early integration: Vital Records, Newborn Hearing Screening, and Utah's Immunization Registry (August '06).

The Newborn Dried Bloodspot Screening and Baby Watch/Early Intervention Programs, and Birth Defects Registry are also targeted for early integration in July 2007.

Through data-sharing and tracking between integrated programs, CHARM's goal is to reduce the number of children lost to follow up statewide by 50%.

Funding for this project has come from braiding multiple funding streams including HRSA grants, CDC grants, and the MCH Block Grant. Management of the funds is performed by an oversight committee (CHARM Governing Board) to ensure accountability and coordinated use. The CHARM Project is managed by a "hands on" work group consisting of a Program Manager, a Technical Manager, and a Trainer/Evaluator.

Funding Detail

Approximately one-third of the Division's budget is from the General Fund. Federal Funds make up over 40 percent of the total funding. The remainder is from Dedicated Credit Revenue from fees and transfers from within the Department of Health.

Budget History - Health - Community & Family Health - Children with Special Health Care Needs

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	6,460,900	7,349,200	7,391,400	7,479,100	8,358,600
General Fund, One-time	0	7,200	0	0	(8,400)
Federal Funds	9,426,865	9,923,809	10,008,800	10,056,800	10,813,100
Dedicated Credits Revenue	4,671,598	5,537,742	5,167,200	5,394,700	3,526,000
Transfers	918,178	186,158	0	0	0
Transfers - Human Services	0	0	640,300	(1,329,000)	0
Transfers - Intergovernmental	0	0	(1,083,100)	(1,406,800)	(145,100)
Transfers - Other Agencies	0	0	(1,341,400)	864,900	(131,600)
Transfers - Within Agency	0	0	2,848,000	3,010,700	3,308,700
Lapsing Balance	(31,900)	(28,600)	0	0	0
Total	$21,445,641	$22,975,509	$23,631,200	$24,070,400	$25,721,300
Categories of Expenditure					
Personal Services	6,998,189	7,383,395	7,799,500	8,100,600	8,511,800
In-State Travel	133,126	119,100	123,400	132,600	115,700
Out of State Travel	61,096	42,252	62,300	56,200	43,800
Current Expense	6,050,644	10,497,179	6,065,600	5,818,700	6,705,700
DP Current Expense	385,607	365,954	484,500	165,900	112,600
DP Capital Outlay	6,373	81	0	62,100	0
Capital Outlay	0	0	6,800	0	0
Other Charges/Pass Thru	7,810,606	4,567,548	9,089,100	9,734,300	10,231,700
Total	$21,445,641	$22,975,509	$23,631,200	$24,070,400	$25,721,300
Other Data					
Budgeted FTE	119.3	127.5	124.0	125.7	121.4
Vehicles	4	4	4	4	4

Table 6-22

CHAPTER 7 HEALTH CARE FINANCING

Function

The Division of Health Care Financing is the administrative agency for Utah's Medical Assistance Programs. The division administers state and federal funds, and contracts with providers. It also gathers and analyzes data, and pays for the provided services. There are seven bureaus and approximately 464.5 employees.

Federal regulations provide for a wide variety of funding ratios ranging from 50 to 90 percent for different classes of positions and functions for this division. Overall, federal funding makes up approximately 57 percent of the division's budget.

Federal law requires that the Medical Care Advisory Committee (MCAC) serve as an advisory board to the division. This committee consists of providers, Medicaid recipients, representatives from the Department of Human Services and the Department of Workforce Services, and members of the community. The committee advises the division on program content, policy, and priorities. The Committee is advisory and its decisions are not binding on the division.

Medicaid Interim Committee

Legislative management established a Medicaid Interim Committee to look at Medicaid and its relationship to health and human service programs. A thorough review of Medicaid programs was conducted during the 2006 interim period. Recommendations may be discussed at the 2007 Session.

Statutory Authority

The Division of Health Care Financing is governed by several chapters of the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-18 establishes the Medical Assistance Program, commonly referred to as Medicaid and its administrative arm, the Division of Health Care Financing.
- UCA 26-19 authorizes the department to recover Medicaid benefits paid by the division from third parties, including estates and trusts.
- UCA 26-20 prohibits false Medicaid claims and establishes the Medicaid Fraud Unit.
- UCA 26-35a creates the Nursing Care Facilities Account and levies an assessment on the owners of nursing care facilities to generate seed money which draws down additional federal funds for the operation of those facilities.
- UCA 26-47 requires the department to create a Prescription Drug Assistance Program to assist individuals who need help in obtaining prescription drugs at a reduced cost or at no cost.

Intent Language

The Legislature approved intent language in HB 1, the Current Fiscal Year Supplemental Appropriations Act (FY 2006) to make funds appropriated to implement Medicare Part D be nonlapsing. Intent language for FY 2007 (SB 4, Item 87) authorized eREP enhancement funding to be nonlapsing. Additional intent language in SB 4, Item 87 required the "Division of Health

Care Financing within the Department of Health use part of *its* appropriation to: (1) determine the feasibility of developing and submitting a Medicaid waiver to the Secretary of the United States Department of Health and Human Services which would allow the state to match federal Medicaid funds with funds provided by private nonprofit charities for the delivery of optional Medicaid services; and (2) prior to November 30, 2006, report to the Legislature's Executive Appropriations Committee and the Legislature's Interim Health and Human Services Committee regarding the feasibility of the waiver and any proposed amendments to the state Medicaid plan to implement the Medicaid waiver." That report was submitted October 17, 2006 and concluded that it is possible for the State to accept and use private funds as Medicaid match under certain circumstances.

Accountability

The following performance measures have been identified as key measures by the Division of Health Care Financing. Accountability has become an important issue of the Medicaid Interim Committee as well. The Figure below details the performance measure reported for Medicaid Operations. Additional pressures have been placed on this line item as the federal government implemented Medicare Part D. Part of the increased number of phone calls is a result of this.

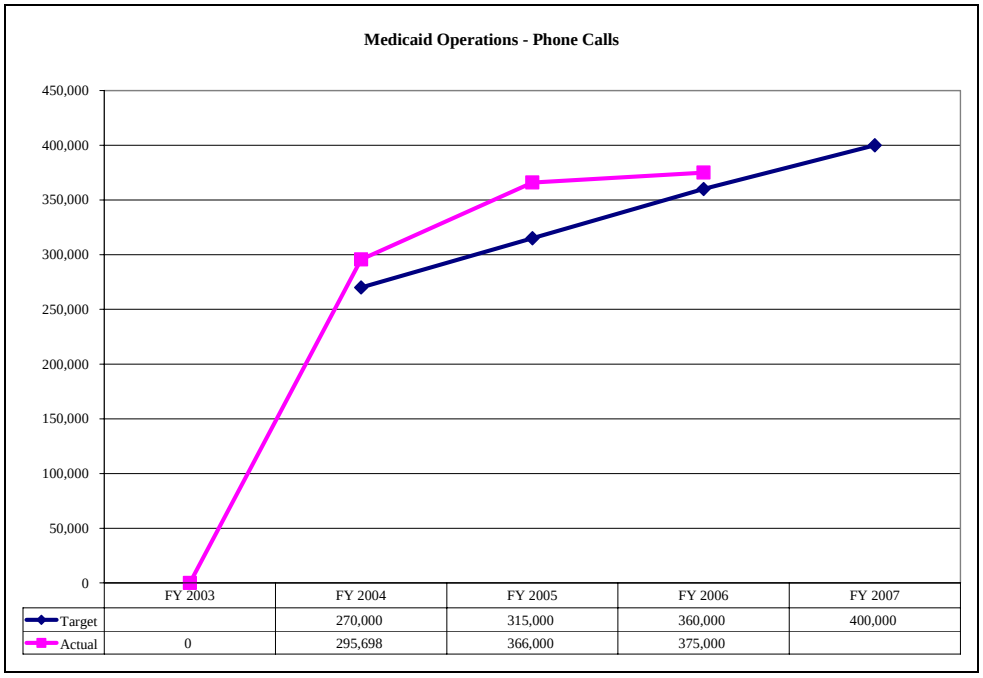


Figure 7-1

As important as the number of calls, is the rate of abandonment of those calls. The Division has been able to maintain quality by tracking this rate and the wait time. It has continued to decrease in spite of the increase in the number of calls.

	FY 2004	FY 2005	FY 2006	FY 2007
Abandonment Rate	8.5%	6.5%	6.5%	6.5%
Wait Time	96 seconds	93 seconds	80 seconds	75 seconds

Table 7-1

The performance measure reported by the Division for Coverage and Reimbursement is to produce a Request for Proposal and award a contract to supplement evidence-based decisions for "out-of-scope" treatments.

Utilizing Utah Medicaid's internal resources and bolstered by outside expertise, the credibility of decisions can be enhanced, thereby reducing the recurring challenges to approving or denying Medicaid coverage decisions. Reducing the number and length of challenges will allow more efficient and effective use of staff time, and will also reduce potential political overtones.

Funding Detail

This division's primary source of revenue is Federal Funds due to the matching monies available for the administration of the Medicaid program. Other significant funding sources include the state General Fund, dedicated credits, transfers, and one restricted funds.

Budget History - Health - Health Care Financing

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	9,454,200	9,452,800	9,561,200	10,307,500	11,058,900
General Fund, One-time	0	396,800	0	0	(42,000)
Federal Funds	41,870,366	36,744,411	38,074,500	42,003,400	39,692,800
Dedicated Credits Revenue	10,500,816	2,810,081	3,562,600	4,337,500	3,620,200
GFR - Nursing Care Facilities Account	0	0	300,000	300,000	350,000
Transfers	11,230,403	15,118,087	0	0	0
Transfers - Human Services	0	0	85,600	82,900	94,300
Transfers - Medicaid	0	0	1,171,500	1,679,000	1,261,000
Transfers - Other Agencies	0	0	8,286,200	7,580,700	8,271,600
Transfers - Within Agency	0	0	6,790,400	10,378,900	6,777,200
Beginning Nonlapsing	0	0	247,300	247,300	0
Closing Nonlapsing	0	(247,275)	(247,300)	(247,300)	0
Lapsing Balance	(114,103)	0	(152,600)	(725,600)	0
Total	$72,941,682	$64,274,904	$67,679,400	$75,944,300	$71,084,000
Programs					
Director's Office	3,712,376	6,924,351	4,311,600	5,027,700	5,073,300
Financial Services	10,794,546	7,796,646	7,869,400	8,319,900	7,199,900
Managed Health Care	2,377,838	2,428,709	2,585,800	2,534,400	3,066,400
Medical Claims	2,812,658	3,508,541	3,560,100	3,711,200	3,936,200
Eligibility Services	15,057,063	16,045,344	17,383,600	18,246,800	18,670,400
Coverage and Reimbursement	3,039,806	3,030,104	3,472,800	3,951,800	4,048,300
Contracts	35,147,395	24,541,209	28,496,100	34,152,500	29,089,500
Total	$72,941,682	$64,274,904	$67,679,400	$75,944,300	$71,084,000
Categories of Expenditure					
Personal Services	24,275,311	25,362,446	27,297,000	29,128,800	30,125,800
In-State Travel	72,618	77,478	81,200	87,500	80,800
Out of State Travel	24,519	43,052	54,100	65,300	55,400
Current Expense	11,077,919	10,684,628	8,714,800	9,161,100	8,316,700
DP Current Expense	4,130,412	4,296,207	4,443,100	5,109,800	4,453,100
DP Capital Outlay	28,300	126,342	792,200	69,400	0
Other Charges/Pass Thru	33,332,603	23,684,751	26,297,000	32,322,400	28,052,200
Total	$72,941,682	$64,274,904	$67,679,400	$75,944,300	$71,084,000
Other Data					
Budgeted FTE	460.3	454.5	463.7	484.5	484.5
Vehicles	14	14	13	13	14

Table 7-2

Special Funding As shown in Table 7-2, a portion of the funding for this division comes from the Nursing Care Facilities Account, as detailed in Table 7-3.

Restricted Funds Summary - Health Care Financing

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
Nursing Care Facilities Account	26-35a-106	Collections from an assessment imposed on nursing facilities determined by the total number of patient days of care to non-Medicare patients.	Funds appropriated may only be used to increase the rates paid to facilities providing care to Medicaid recipients and up to 3 percent for administrative costs.	$0

Table 7-3

DIRECTOR'S OFFICE

Function The Director's Office of the Division of Health Care Financing administers and coordinates Utah's Medicaid program to comply with Titles XIX and XXI of the Social Security Act, other laws of the State, and the appropriated budget. This is accomplished by planning, managing and evaluating activities which authorize payments to qualified providers of approved services who are reimbursed for appropriate and necessary medical assistance rendered to eligible beneficiaries.

Funding Detail Funding, as in all of the programs in Health Care Financing, is primarily Federal Funds. A General Fund match is required and other funds include both restricted accounts and transfers.

Budget History - Health - Health Care Financing - Director's Office

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	1,065,363	305,600	(1,005,200)	800	1,129,800
General Fund, One-time	0	4,300	0	0	(4,300)
Federal Funds	2,175,530	4,031,792	3,019,000	2,340,000	1,258,700
Dedicated Credits Revenue	585,586	1,459,333	1,440,900	1,587,500	1,566,100
Transfers	0	1,395,807	0	0	0
Transfers - Human Services	0	0	85,600	82,900	94,300
Transfers - Medicaid	0	0	775,400	1,645,700	864,900
Transfers - Within Agency	0	0	148,500	96,400	163,800
Beginning Nonlapsing	0	0	0	247,300	0
Closing Nonlapsing	0	0	0	(247,300)	0
Lapsing Balance	(114,103)	(272,481)	(152,600)	(725,600)	0
Total	$3,712,376	$6,924,351	$4,311,600	$5,027,700	$5,073,300
Categories of Expenditure					
Personal Services	2,963,524	3,302,754	3,348,100	3,420,600	3,583,500
In-State Travel	13,339	16,265	14,300	12,800	14,300
Out of State Travel	9,447	18,380	26,000	36,900	26,000
Current Expense	469,042	2,740,910	898,200	1,291,000	933,500
DP Current Expense	133,734	234,596	91,800	116,500	94,300
DP Capital Outlay	0	18,730	0	14,800	0
Other Charges/Pass Thru	123,290	592,716	(66,800)	135,100	421,700
Total	$3,712,376	$6,924,351	$4,311,600	$5,027,700	$5,073,300
Other Data					
Budgeted FTE	53.0	46.5	44.3	49.0	49.0

Table 7-4

FINANCIAL SERVICES

Function

The Bureau of Financial Services is responsible for the following functions within the division:

- Managing the administration and service budgets for both the Medicaid and PCN programs, and assisting with CHIP.
- Monitoring the drug rebate program within the State.
- Performing audits on Medicaid providers within the State to cost settle Medicaid reimbursements. This involves cost studies on reimbursement rates to evaluate if fair rates are being set for provider services.
- Purchasing office equipment and computer hardware and software for the division.

Funding Detail

Budget History - Health - Health Care Financing - Financial Services

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	2,079,126	1,158,700	1,780,600	2,025,000	1,711,100
General Fund, One-time	0	(97,100)	0	0	(4,700)
Federal Funds	8,673,407	5,922,095	5,788,800	5,994,900	5,143,500
Dedicated Credits Revenue	37,000	0	0	0	0
GFR - Nursing Care Facilities Account	0	0	300,000	300,000	350,000
Transfers	5,013	0	0	0	0
Lapsing Balance	0	812,951	0	0	0
Total	$10,794,546	$7,796,646	$7,869,400	$8,319,900	$7,199,900
Categories of Expenditure					
Personal Services	2,559,982	2,938,806	3,037,600	2,979,000	2,999,900
In-State Travel	6,722	8,230	9,200	7,000	9,100
Out of State Travel	6,830	3,526	6,800	3,100	6,800
Current Expense	4,497,253	1,565,027	1,135,000	828,700	503,000
DP Current Expense	3,684,659	3,162,645	3,680,800	4,461,400	3,681,100
DP Capital Outlay	28,300	107,612	0	40,700	0
Other Charges/Pass Thru	10,800	10,800	0	0	0
Total	$10,794,546	$7,796,646	$7,869,400	$8,319,900	$7,199,900
Other Data					
Budgeted FTE	32.8	40.5	38.0	39.0	39.0
Vehicles	1	1	1	1	1

Table 7-5

MANAGED HEALTH CARE

Function

The Bureau of Managed Health Care is responsible for implementing and operating the managed care initiative that includes contracts with managed care plans to serve the medical and mental health needs of Medicaid clients. The bureau is also responsible for the development, implementation, and operation of specialized Medicaid services for special populations in relation to managed care, a home and community-based waiver program, and the Child Health Evaluation and Care (CHEC) program that is Utah's version of the federally-mandated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program covering prevention, outreach, and expanded services for enrolled children.

The current status of clients in fee-for-service and HMOs is detailed in the following table.

Distribution of Medicaid Clients

	FY 2003	FY 2004	FY 2005	FY 2006
Fee for Service Clients (Monthly Average)	149,294	164,336	174,706	177,620
Managed Care Clients (Monthly Average)	95,801	105,625	180,690	182,510
TOTAL	245,095	269,961	355,396	360,130

Note: Almost all managed care clients are also enrolled in fee-for-service for pharmacy claims.

Table 7-6

Funding Detail

Budget History - Health - Health Care Financing - Managed Health Care

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	860,200	802,800	886,400	705,000	796,000
General Fund, One-time	0	2,900	0	0	(3,000)
Federal Funds	1,404,137	1,404,047	1,423,300	1,497,100	2,074,900
Dedicated Credits Revenue	113,501	11,517	148,200	257,300	70,600
Transfers	0	96,801	0	0	0
Transfers - Within Agency	0	0	127,900	75,000	127,900
Lapsing Balance	0	110,644	0	0	0
Total	$2,377,838	$2,428,709	$2,585,800	$2,534,400	$3,066,400
Categories of Expenditure					
Personal Services	1,942,989	1,569,450	1,700,100	1,872,500	2,158,000
In-State Travel	17,015	16,006	19,700	19,000	19,600
Out of State Travel	6,240	9,037	3,100	4,100	4,500
Current Expense	331,634	728,804	790,000	591,600	843,900
DP Current Expense	25,287	76,812	40,500	46,200	40,400
DP Capital Outlay	0	0	0	1,000	0
Other Charges/Pass Thru	54,673	28,600	32,400	0	0
Total	$2,377,838	$2,428,709	$2,585,800	$2,534,400	$3,066,400
Other Data					
Budgeted FTE	34.5	36.0	36.0	33.5	33.5

Table 7-7

MEDICAL CLAIMS

Function

The Bureau of Medical Claims has the following five components:

- Customer Service - The bureau staffs the Medicaid Information Line, providing on-line service to providers and clients regarding Medicaid eligibility, provider payment, and general information regarding all aspects of services provided by the Department of Health. A call management system ensures that calls get routed to the correct area without having to go through numerous transfers.
- Utah Health Information Network (UHIN) Involvement - The UHIN is a statewide cooperative of Medicaid, providers, and other third party medical claims payers. Its goal is to standardize health care information so that all claims data can be submitted in an electronic transaction to any payee. This activity was mandated by the 1992 Legislature.
- Claims Processing - The bureau processes all claims received by Health Care Financing, ensuring that the claims are properly entered into the MMIS system, and are adjudicated properly. They serve as troubleshooters working with providers in the event there are questions regarding payment or non-payment of claims, and coordinates recoupment processes with other State and Federal agencies.
- Medicaid Management Information System (MMIS) - Bureau staff identifies and approves updates and corrections to the MMIS to ensure the system is properly handling information on services provided by Health Care Financing. The staff also requests additional programming to implement policy changes and new federal/state regulations affecting claims processing. Staff are responsible for maintenance, upgrades, and data input of the MMIS subsystems, i.e. provider file, reference file, and security file.
- Special Projects - The bureau manages special projects under contract with Community and Family Health Services (Pre-natal program) and the Division of Family Services (Custody Medical Care Program). It also manages the Buy-Out program that ensures compliance with the third party liability requirements of the OBRA '90 legislation.

Funding Detail

Budget History - Health - Health Care Financing - Medical Claims					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	853,453	866,200	1,127,200	1,005,000	1,162,400
General Fund, One-time	0	1,500	0	0	(2,000)
Federal Funds	1,933,453	2,429,530	2,408,100	2,679,200	2,751,000
Dedicated Credits Revenue	25,752	(34)	0	0	0
Transfers	0	(28,285)	0	0	0
Transfers - Within Agency	0	0	24,800	27,000	24,800
Lapsing Balance	0	239,630	0	0	0
Total	$2,812,658	$3,508,541	$3,560,100	$3,711,200	$3,936,200
Categories of Expenditure					
Personal Services	1,754,444	1,966,721	2,119,000	2,355,400	2,491,100
In-State Travel	2,440	3,263	2,100	4,800	2,000
Out of State Travel	0	1,729	6,900	8,000	6,800
Current Expense	945,543	1,264,263	1,161,100	1,141,800	1,165,300
DP Current Expense	110,231	272,565	271,000	199,400	271,000
DP Capital Outlay	0	0	0	1,800	0
Total	$2,812,658	$3,508,541	$3,560,100	$3,711,200	$3,936,200
Other Data					
Budgeted FTE	46.0	49.5	51.0	53.0	53.0

Table 7-8

ELIGIBILITY SERVICES

Function

The Bureau of Eligibility Services is responsible for eligibility policy and operations related to Medicaid eligibility, including nursing home eligibility determinations and out-stationed eligibility workers who are in hospitals and public health clinics. The bureau is also responsible for eligibility determination for the CHIP and Primary Care Network. The bureau coordinates and oversees the eligibility contract with the Department of Workforce Services and also coordinates Medicaid recovery activities with the Office of Recovery Services. Besides administration and office support staff, the bureau has 234 eligibility staff stationed throughout the State, with a total caseload (as of June 2006) of 67,288, including CHIP.

Medicare Part D

The federal government implemented the Medicare Prescription Drug Coverage (Part D) beginning January 2006. This program has had an impact on the Eligibility Office workload, though not as great as originally estimated. No additional staff were added for this anticipated workload increase. Numerous drug prescription plans are available which can be confusing to those qualified for the program. Other program nuances including "donut holes" which leave an individual uncovered for assistance between $2,500 and $3,600 of annual prescription drug costs further complicate the scenarios and could increase the time necessary to verify an individual's eligibility.

Medicaid Interim Committee

The 2006 Legislature established a Medicaid Interim Committee during the 2006 Interim period. One of the items they are considering is the consolidation of the Medicaid eligibility systems in the Departments of Health and Workforce Services. This is being studied by the Legislative Fiscal Analyst Office, the Governor's Office of Planning and Budget and representatives from the Departments. The eligibility system is being restructured with the implementation of eRep, a rules based management information system that will do eligibility for a variety of programs.

The following table shows the caseload that each eligibility worker handles during the course of a year.

Eligibility Services - Historical Caseloads and FTE

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Medicaid Caseload	40,467	40,504	43,100	45,966	43,346	45,926
CHIP Caseload	11,071	10,217	10,818	14,115	14,213	13,332
PCN				5,000	5,000	5,000
Total Caseload	51,538	50,721	53,918	65,081	62,559	64,258
Medicaid FTE	156.50	152.00	155.50	154.00	151.25	155.50
CHIP/Supervisory FTE	57.00	50.00	50.00	50.00	53.00	53.00
Total FTE	213.50	202.00	205.50	204.00	204.25	208.50
Medicaid Caseload per FTE	**259**	**266**	**277**	**298**	**287**	**295**

Table 7-9

Funding Detail

Budget History - Health - Health Care Financing - Eligibility Services

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	3,828,064	5,337,500	5,510,100	5,000,000	4,776,900
General Fund, One-time	0	482,700	0	0	(24,700)
Federal Funds	7,348,325	8,088,751	8,479,800	9,236,700	10,521,300
Dedicated Credits Revenue	3,880,674	1,339,265	1,410,200	1,279,000	1,420,200
Transfers	0	1,794,331	0	0	0
Transfers - Medicaid	0	0	396,100	33,300	396,100
Transfers - Other Agencies	0	0	1,565,000	692,500	1,565,000
Transfers - Within Agency	0	0	22,400	2,005,300	15,600
Beginning Nonlapsing	0	0	247,300	0	0
Closing Nonlapsing	0	(247,275)	(247,300)	0	0
Lapsing Balance	0	(749,928)	0	0	0
Total	$15,057,063	$16,045,344	$17,383,600	$18,246,800	$18,670,400
Categories of Expenditure					
Personal Services	12,961,831	13,589,084	14,686,100	15,774,300	15,945,800
In-State Travel	31,131	31,205	34,600	38,800	34,600
Out of State Travel	254	1,303	2,700	7,900	2,800
Current Expense	1,472,121	1,390,344	1,544,900	1,585,800	1,565,600
DP Current Expense	165,323	498,800	323,100	249,200	329,400
DP Capital Outlay	0	0	792,200	10,000	0
Other Charges/Pass Thru	426,403	534,608	0	580,800	792,200
Total	$15,057,063	$16,045,344	$17,383,600	$18,246,800	$18,670,400
Other Data					
Budgeted FTE	265.5	256.5	264.3	276.5	276.5
Vehicles	13	13	12	12	13

Table 7-10

COVERAGE AND REIMBURSEMENT

Function

The Bureau of Coverage and Reimbursement Policy has the following seven basic functions:

- Research, analyze, formulate, and make recommendations for policy modifications and to develop new policy;
- Analyze all pending and current federal and state legislation dealing with health care;
- Formulate and process all State Plan changes and all rule-makings dealing with the Medicaid program;
- Manage Utilization Review through medical professional evaluation of requests for medically necessary services that vary from policy, or which need additional professional review;
- Evaluate Medicaid expenditures through post payment review to ensure that payments were in compliance with Medicaid policy, and to identify possible situations of fraud or abuse;
- Determine appropriate reimbursement rates and methodology reflecting state and federal mandates and budget allocations.

Accountability

The Coverage and Responsibility Division within Health Care Financing reported goals to:

- Implement key provisions of the Deficit Reduction Act (DRA) of 2005; and
- Implement the Payment Error Rte Measurement (PERM) program.

The Department reported that the above goals have output measures associated with their implementation. The most important output measures are the implementations of applicable provisions of the DRA and to meet the requirements of PERM. No actual quantitative data was supplied by the department for this measure.

Funding Detail

Budget History - Health - Health Care Financing - Coverage and Reimbursement					
	2003	2004	2005	2006	2007
Sources of Finance	**Actual**	**Actual**	**Actual**	**Actual**	**Appropriated**
General Fund	755,484	704,100	910,000	1,171,700	1,008,500
General Fund, One-time	0	2,500	0	0	(3,300)
Federal Funds	1,870,842	1,868,085	2,141,100	2,336,500	2,621,400
Dedicated Credits Revenue	18	0	0	0	0
Transfers	413,462	358,901	0	0	0
Transfers - Within Agency	0	0	421,700	443,600	421,700
Lapsing Balance	0	96,518	0	0	0
Total	$3,039,806	$3,030,104	$3,472,800	$3,951,800	$4,048,300
Categories of Expenditure					
Personal Services	2,073,022	1,995,631	2,406,100	2,727,000	2,947,500
In-State Travel	1,971	2,509	1,300	5,100	1,200
Out of State Travel	1,748	9,077	8,600	5,300	8,500
Current Expense	951,887	972,098	1,020,900	1,176,200	1,054,200
DP Current Expense	11,178	50,789	35,900	37,100	36,900
DP Capital Outlay	0	0	0	1,100	0
Total	$3,039,806	$3,030,104	$3,472,800	$3,951,800	$4,048,300
Other Data					
Budgeted FTE	28.5	25.5	30.0	33.5	33.5

Table 7-11

CONTRACTS

Function

Agencies both within and outside of the Department of Health contract with this program, by sending some of their General Fund appropriations to the Division of Health Care Financing, which then uses those funds to draw down the matching federal Medicaid funds, then forwards all of the funds back to the original agencies. This helps those agencies leverage their state funds by the Federal match. Contracts are for non-medical services performed for the Division by the Departments of Human Services and Workforce Services, such as recovery services, training, and administration. When eligibility for Medicaid services involves more services than just medical (e.g. food stamps), then eligibility is determined by employees of the Department of Workforce Services.

In addition, this program deals with medical and dental consultants and CPA audits and reviews, which serve the Medicaid program.

Funding Detail

Budget History - Health - Health Care Financing - Contracts					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	12,510	277,900	352,100	400,000	474,200
Federal Funds	18,464,672	13,000,111	14,814,400	17,919,000	15,322,000
Dedicated Credits Revenue	5,858,285	0	563,300	1,213,700	563,300
Transfers	10,811,928	11,500,532	0	0	0
Transfers - Other Agencies	0	0	6,721,200	6,888,200	6,706,600
Transfers - Within Agency	0	0	6,045,100	7,731,600	6,023,400
Lapsing Balance	0	(237,334)	0	0	0
Total	$35,147,395	$24,541,209	$28,496,100	$34,152,500	$29,089,500
Categories of Expenditure					
Personal Services	19,519	0	0	0	0
Current Expense	2,410,439	2,023,182	2,164,700	2,546,000	2,251,200
Other Charges/Pass Thru	32,717,437	22,518,027	26,331,400	31,606,500	26,838,300
Total	$35,147,395	$24,541,209	$28,496,100	$34,152,500	$29,089,500

Table 7-12

CHAPTER 8 MEDICAL ASSISTANCE

Function

Medical Assistance is a joint federal/state entitlement service that provides health care to selected low-income populations. The program is commonly referred to as Medicaid.

There are three programs within the Medicaid line item, which include the Medicaid Base Program, Title XIX Funding for the Department of Human Services, and DOH Health Clinics.

The Medicaid Base Program is the program most commonly identified with Medical Assistance. It provides a number of health services to specific eligible populations. While Federal law and regulations currently mandate some specific services within the program, the State has some flexibility and has been granted waivers that allow some latitude in program implementation, as well as to offer some optional services. The FY 06 estimated base program makes up over 88 percent of all Medical Assistance expenditures. This program also includes the Primary Care Network (PCN). Also included in the Medical Assistance is the new Utah Premium Partnership Program (UPP). This was implemented as a result of HB 276 (2006 GS) Covered at Work Premium Subsidy Program.

Title XIX Funding for the Department of Human Services consists of programs and services provided by the Department of Human Services to individuals who are qualified to receive Medicaid services. The State's share of the funding is from the General Fund appropriated to the Department of Human Services, which is transferred to the Medicaid program to be matched with Federal Funds.

The Utah Medical Assistance Program (UMAP) was the State program designed to provide a very limited number of services to a population that previously did not qualify for any other medical assistance programs. With the PCN now in place, this funding is now incorporated in the Medicaid Base program. However, there are still some costs for specialty physician services which are paid for entirely with State dollars and fees. These are included in the DOH Medical/Dental Clinics.

Statutory Authority

The Medical Assistance Program is governed by several chapters of the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-18 establishes the Medical Assistance Program, commonly referred to as Medicaid and its administrative arm, the Division of Health Care Financing.
- UCA 26-19 authorizes the department to recover Medicaid benefits paid by the division from third parties, including estates and trusts.
- UCA 26-20 prohibits false Medicaid claims and establishes the Medicaid Fraud Unit.
- UCA 26-35a creates the Nursing Care Facilities Account and levies an assessment on the owners of nursing care facilities to generate seed

money which draws down additional federal funds for the operation of those facilities.

Accountability

The Medical Assistance Program has outlined key performance measures detailed in the following figures. The first four figures detail the trends in Managed Care organizations. The results are reported by the Department. Note - In most cases, the targets are below the actual observed. The assessment evaluates Adult programs in odd years and Children programs in even years.

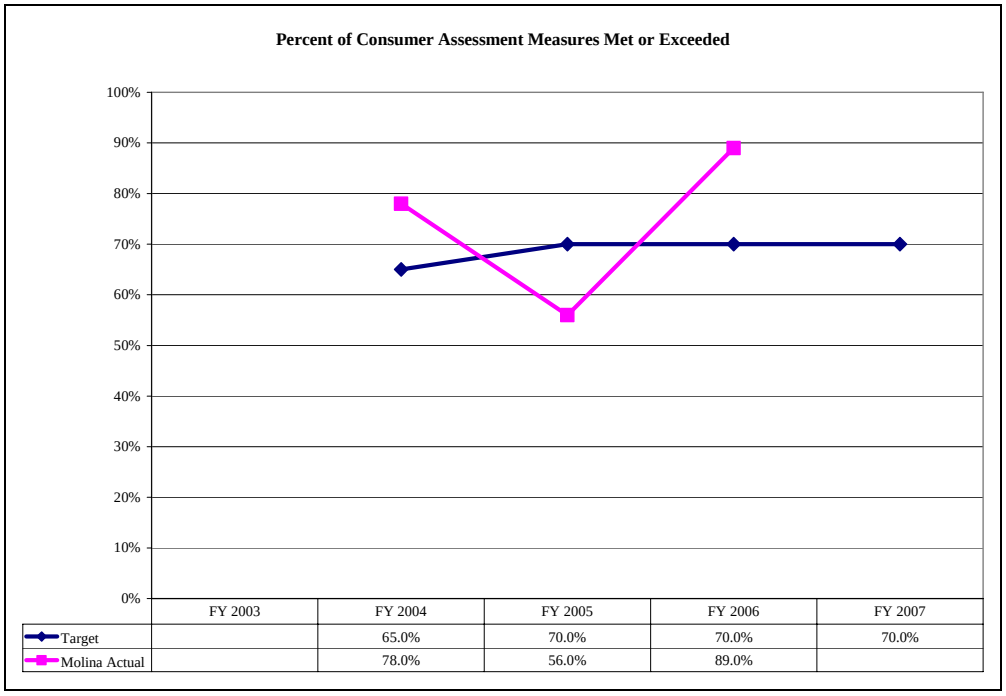


Figure 8-1

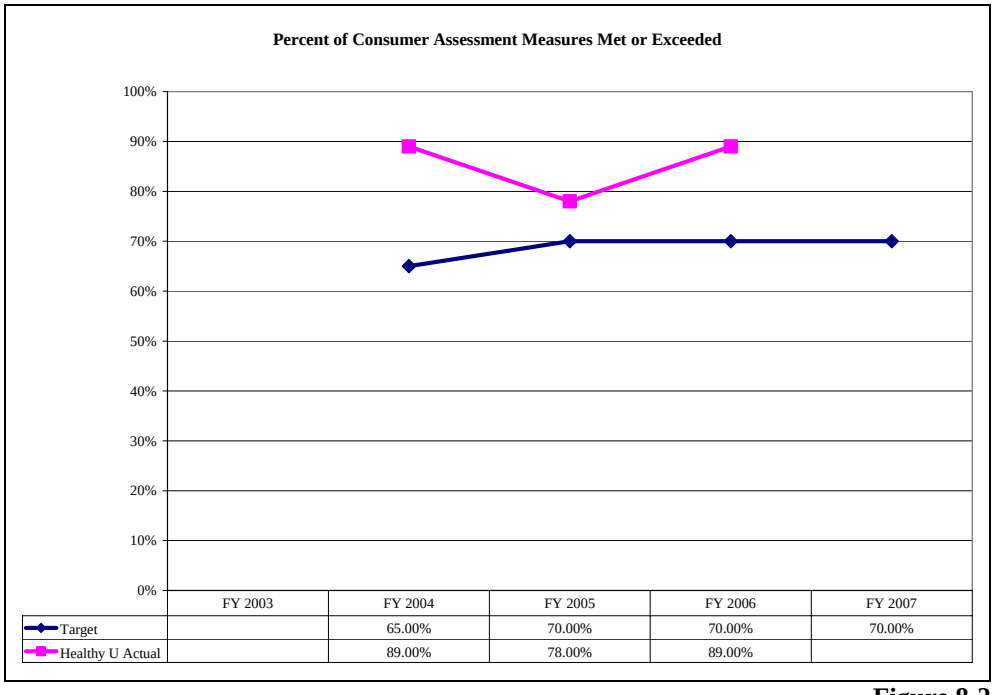


Figure 8-2

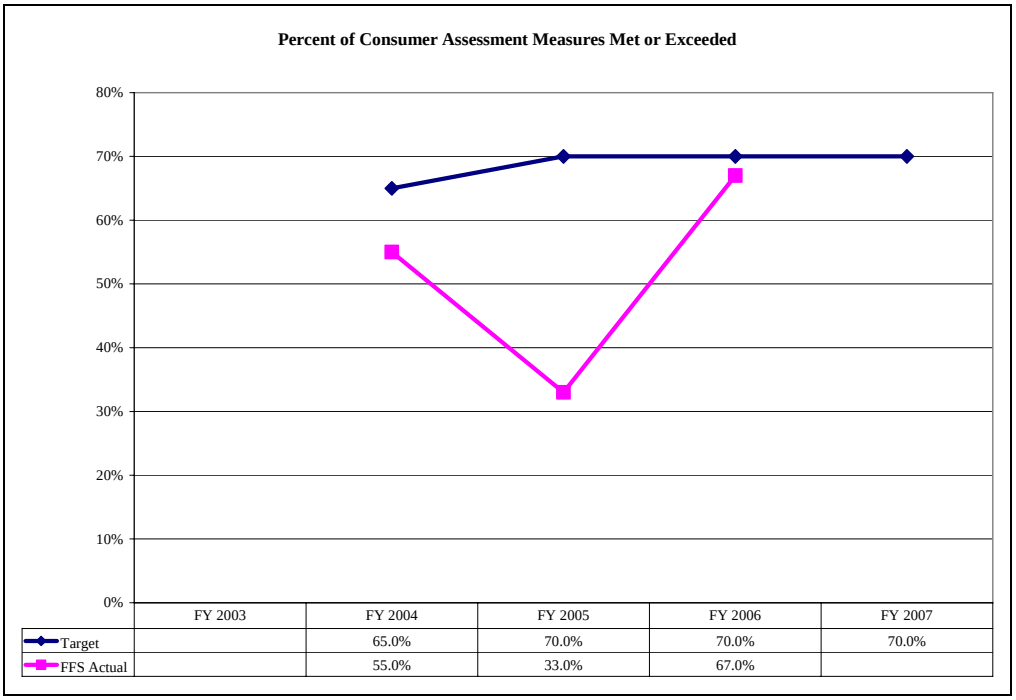


Figure 8-3

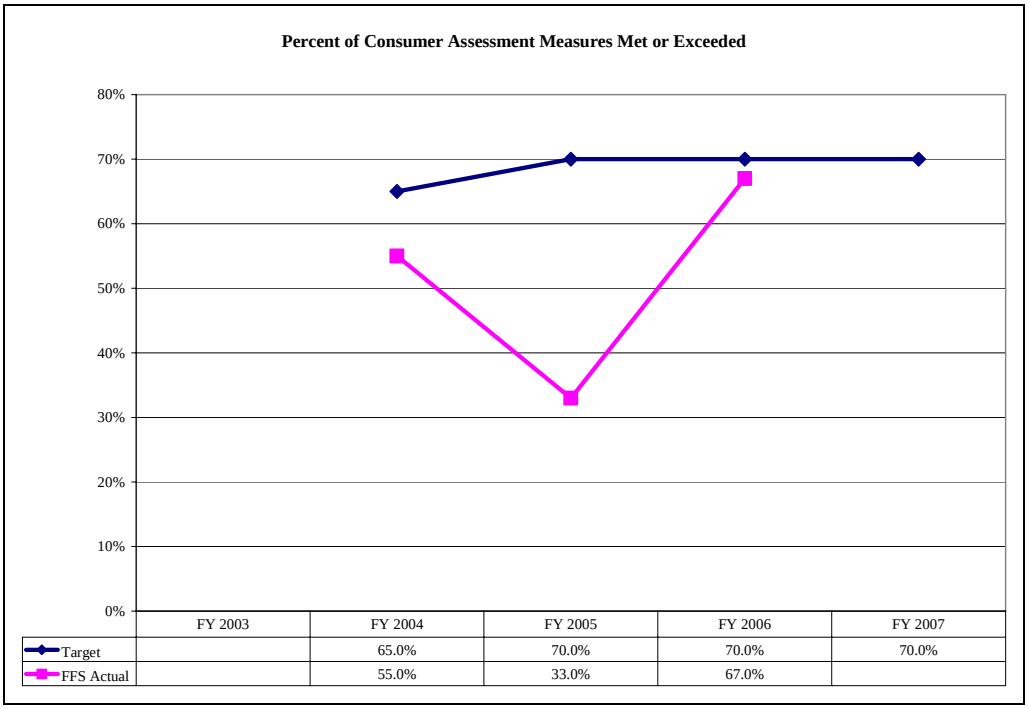


Figure 8-4

Note - The groups identified and assessed are Molina, Select Health (Intermountain Healthcare), Healthy U, and Fee-For-Services (FFS).

Funding Detail

This division's primary source of revenue is federal funds due to the matching monies available for the cost of services within the Medicaid program. Other significant funding sources include the state General Fund, dedicated credits, transfers, and one restricted fund.

Budget History - Health - Medical Assistance

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	199,583,500	229,967,400	252,966,000	282,776,500	297,922,700
General Fund, One-time	0	(37,347,300)	0	18,582,100	19,596,400
Federal Funds	765,098,122	915,450,204	964,057,200	1,027,531,200	1,062,353,800
Dedicated Credits Revenue	50,904,918	68,921,848	82,441,600	72,430,700	89,897,000
GFR - Medicaid Restricted	1,573,000	0	0	0	0
GFR - Nursing Care Facilities Account	0	5,347,300	9,800,000	10,107,500	11,254,300
Transfers	49,853,238	52,348,346	0	0	0
Transfers - Human Services	40,219,454	40,155,281	85,993,300	109,499,300	61,612,200
Transfers - Other Agencies	0	0	380,300	536,500	42,068,300
Transfers - Within Agency	0	0	2,649,500	2,441,100	2,500,200
Beginning Nonlapsing	(1,366,509)	476,404	620,900	620,900	620,900
Closing Nonlapsing	(476,404)	(620,901)	(620,900)	(5,079,900)	(620,900)
Lapsing Balance	(5,226,655)	(270,088)	(1,080,700)	(1,355,100)	0
Total	$1,100,162,664	$1,274,428,494	$1,397,207,200	$1,518,090,800	$1,587,204,900
Programs					
Medicaid Base Program	923,387,419	1,095,156,768	1,208,595,000	1,341,000,600	1,377,123,700
Title XIX for Human Services	172,348,339	175,139,165	184,383,300	172,783,100	205,341,700
DOH Health Clinics	4,426,906	4,132,561	4,228,900	4,307,100	4,739,500
Total	$1,100,162,664	$1,274,428,494	$1,397,207,200	$1,518,090,800	$1,587,204,900
Categories of Expenditure					
Personal Services	2,986,022	3,463,246	3,659,300	3,869,800	4,069,500
In-State Travel	40,259	32,753	21,400	34,800	21,300
Out of State Travel	2,464	1,099	5,100	2,700	5,100
Current Expense	716,668	713,448	1,017,100	11,477,200	1,036,100
DP Current Expense	15,393	41,980	23,800	18,200	24,300
DP Capital Outlay	0	49,050	0	2,300	0
Other Charges/Pass Thru	1,096,401,858	1,270,126,918	1,392,480,500	1,502,685,800	1,582,048,600
Total	$1,100,162,664	$1,274,428,494	$1,397,207,200	$1,518,090,800	$1,587,204,900
Other Data					
Budgeted FTE	60.3	62.0	64.8	65.0	65.0

Table 8-1

Special Funding

As shown in Table 8-2, a portion of the funding for this division comes from the Nursing Care Facilities Account, as detailed in the following table. Though the balance in this account is zero, the annual revenue is usually over $10 million.

Restricted Funds Summary - Health Care Financing

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
Nursing Care Facilities Account	26-35a-106	Collections from an assessment imposed on nursing facilities determined by the total number of patient days of care to non-Medicare patients.	Funds appropriated may only be used to increase the rates paid to facilities providing care to Medicaid recipients and up to 3 percent for administrative costs.	$0

Table 8-2

MEDICAID BASE PROGRAM

Function

Medical Assistance is a joint federal/state entitlement service consisting of three programs that provide health care to selected low-income populations: (1) a health insurance program for low-income parents (mostly mothers) and children (in Utah, about 28 percent of all births are covered by Medicaid); (2) a long-term care program for the elderly (nearly 70 percent of all nursing home residents are Medicaid beneficiaries); and (3) a funding source for services to people with disabilities (Medicaid pays for approximately one-third of the nation's bill for this population). Nationwide, Medicaid covers over 53 million people, or about 18 percent of all Americans and nearly half of those living in poverty.

Overall, Medicaid is an "optional" program, one that a state can elect to offer. However, if a state offers the program, it must abide by strict federal regulations. It also becomes an entitlement program for qualified individuals; that is, anyone who meets specific eligibility criteria is "entitled" to Medicaid services. The federal government establishes and monitors certain requirements concerning funding, and establishes standards for quality and scope of medical services. Requirements include services that must be provided and specific populations that must be served. States may expand their program to cover additional “optional” services and/or “optional” populations. In addition, states have some flexibility in determining certain aspects of their own programs in the areas of eligibility, reimbursement rates, benefits, and service delivery.

There are currently 53 services included in the Medicaid Program. Of these, inpatient hospital, outpatient hospital, intermediate care facilities for the mentally retarded, long-term care, physician, dental, pharmacy, and health maintenance organizations make up approximately 66 percent of program expenditures. The line dividing mandatory and optional services is occasionally blurred by the fact that some optional services are mandatory for

specific populations or in specific settings. A brief description of each service is found in Appendix 3.

Mandatory services in the Medicaid Program are those that the federal government requires to be offered if a state has a Medicaid program. These include: inpatient and outpatient hospital, physician, skilled and intermediate care nursing facilities, medical transportation, home health, nurse midwife, pregnancy-related services, lab and radiology, kidney dialysis, Early Periodic Screening Diagnosis and Treatment, and community and rural health centers. The State is also required to pay Medicare premiums and co-insurance deductibles for aged, blind, and disabled persons with incomes up to 100 percent of the poverty level.

The Early Periodic Screening Diagnosis and Treatment Program is a mandatory program which requires the State to screen all Medicaid children at scheduled intervals. The mandate includes providing all medically necessary services that can be covered under the program, such as organ transplants or any other service needed, regardless of cost.

Optional Services require approval from the federal Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration or HCFA). These services are eligible for the state's FMAP matching funds. These include pharmacy, dental, medical supplies, ambulatory surgery, chiropractic, podiatry, physical therapy, vision care, substance abuse treatment, speech and hearing services. The only optional long-term care service is Intermediate Care Facilities for the Mentally Retarded. As noted above, some of these services may be mandatory for certain populations or in certain settings. It should also be noted that while the service, as a whole may be optional, once the state elects to offer that service, it must make it available to all qualified eligibles.

Eligibility for many of the new Medicaid Programs, which Congress has added in recent years, is based on a person's income relative to the federal poverty level. The following table shows the annual federal poverty levels for 2005 by family size. The table also shows 133 percent of poverty because coverage for pregnant women is mandatory for persons with incomes up to 133 percent of poverty. Currently the State has the option of raising eligibility for programs for pregnant women and children to 185 percent of poverty.

2006 FEDERAL POVERTY LEVELS			
Family Size	100%	133%	185%
1	$817	$1,087	$1,511
2	$1,100	$1,463	$2,035
3	$1,384	$1,841	$2,560
4	$1,667	$2,217	$3,084
5	$1,950	$2,594	$3,608
6	$2,234	$2,971	$4,133
7	$2,517	$3,348	$4,656
8	$2,800	$3,724	$5,180
9	$3,084	$4,102	$5,705
10	$3,367	$4,478	$6,229

Table 8-3

The State has designated five major population groupings that may receive health care from the Medicaid program. These include: (1) the elderly who receive federal SSI and persons in nursing facilities (grouped together as Aged); (2) Blind and/or Disabled individuals; (3) Children who receive Temporary Assistance for Needy Families (TANF) benefits, or are in the Foster Care program; (4) TANF Adults, with dependent children; and (5) Pregnant women. Each of these groups is discussed in more detail later in this section.

Much of the effort in the Medicaid program over the past several years was toward moving eligible individuals who live in the populated Wasatch Front counties from the traditional "fee-for-service" providers to managed care, or health maintenance organizations (HMOs). The purpose behind this effort was to provide more cost-effective health care. This was the case early in the movement toward HMOs. However, in recent years the savings gap has shrunk. The Legislature did approve an eight percent increase, but both of those providers later notified the State that they would be terminating their HMO Medicaid services. This prompted the move to non-risk contracts for Medicaid HMO's.

The distribution of FY 2006 Medicaid fee for service eligible individuals, recipients, and expenditures for each group are shown in the chart on the following page.

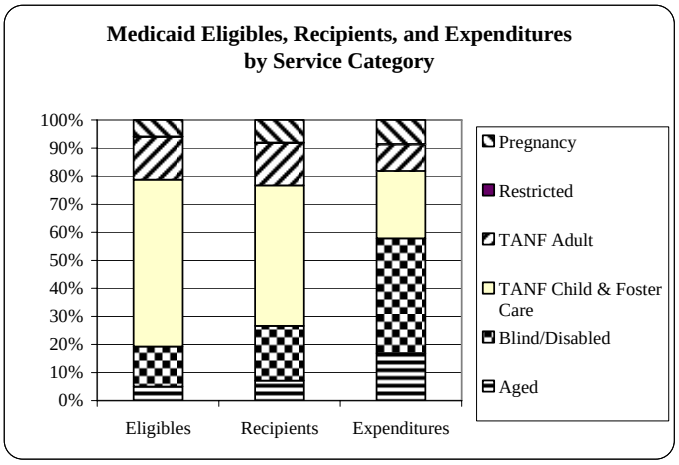


Figure 8-5

FY 2006 Medicaid Funding

The 2005 Legislature increased funding for FY 2006 for the Medical Assistance budget with supplemental appropriations to cover increases due to general utilization and caseload growth (including implementation of Medicare Part D) as well as general inflationary factors for pharmacy and some other "mandatory" groups. The Legislature had not fully funded the enrollment growth and recommended that if enrollment met projections that the Department should submit a supplemental funding request. One-time General Fund of $14,513,000 was added to this budget and will be matched with approximately $33.9 million federal funds. Adult dental and vision services were originally funded with one-time funding in FY 2006. This was not renewed for FY 2007, though donations were accepted by the department to continue the programs.

FY 2007 Medicaid Funding

The State portion of the Medicaid budget was increased for FY 2007 to address caseload growth, utilization and mandatory inflation factors. An increase was also made to provide additional revenue to address the caseload increase due to implementation of Medicare Part D. An increase of $25,352,700 General Fund was made to address these factors. This does not include an increase of $8,601,400 General Fund for the Federal Medical Assistance Percentage (FMAP) rate change. The $25 million will be matched with approximately $60 million of federal funds.

Kaiser Report on States' Efforts to Control Medicaid Costs

The Kaiser Commission on Medicaid and the Uninsured, surveyed Medicaid officials in all 50 states. The following are excerpts from that report to demonstrate that Utah is not alone in its struggle to handle the Medicaid budget in extremely difficult economic times.[1]

Medicaid was the driving force of the increase for the Department of Health, as the balance of the Department also experienced budget reductions. Across the country, states are facing similar situations with their Medicaid budgets exerting tremendous pressures on their budgets. This is attributable to increased enrollment due to post-welfare reform, eligibility expansions, and economic conditions. By the program's design, Medicaid costs can be

[1] "States Budgets Under Stress: How are States Planning to Reduce the Growth in Medicaid Costs?" The Kaiser Commission on Medicaid and the Uninsured, July 30, 2002

expected to increase when the economy weakens and causes more people to enroll in the program. Because Medicaid is means-tested, more people qualify for Medicaid when incomes fall. This is generally at the same time as when state tax revenues fall. These factors create an inevitable tension for the state: the need for the program is frequently the greatest when the sources of state funds to devote to the program are the lowest. The survey identified 49 states that had plans to reduce Medicaid funding growth. Most states are using increased controls on pharmacy sots and payments to providers. States are also increasing cost-sharing, eliminating optional benefits, and reducing eligibility. These changes include:

Increasing controls on prescription drugs, including seeking larger discounts and rebates on purchases, increasing usage of prior authorization, preferred drug lists, generic drugs, and limiting the number of prescriptions filled in a given month. *Utah has implemented requiring generic drugs, reviewing the prescriptions for individuals having more than seven scripts per month, and briefly authorized the return of unused prescription drugs in nursing facilities.* Note: nine states require generic drugs and six limit the number of monthly prescriptions.

Cutting or freezing provider payments to doctors, hospitals, nursing facilities, and managed care providers. *Utah had not reduced reimbursement rates, but began reducing pharmacy product costs by paying average wholesale price (AWP) minus 15 percent instead of 12 percent (January 1, 2003) and reducing hospital payments (January 3, 2003).* Note: There are 37 states that are either cutting or freezing hospital or other provider payments or are increasing their AWP discount, or other provider payments.

Eliminating benefits for Medicaid beneficiaries in 25 states, including dental benefits for adults, home health, podiatry, chiropractic services, eyeglasses, psychological counseling, and translator services.

Initiating or increasing cost-sharing for Medicaid beneficiaries in 15 states. *Utah has increased co-payments for hospital services, physician services, and prescriptions.*

Reducing the number of eligibles through lowering income thresholds, reducing transitional coverage, and changing the period of allowable medical expenses for the medically needy. *Utah has not resorted to this measure.* 27 states have reported that they will reduce or restrict Medicaid eligibility.

The following information details the categorical eligibility groups in the Medicaid program:

Aged

Individuals aged 65 and over qualify for Medicaid if they qualify for the Federal Supplemental Security Income Program, which provides an income of approximately 77.6 percent of poverty. They also qualify for food stamps. During FY 2004, an average of 11,271 people received services under the aged category of eligibility. Many of the elderly also qualify for Medicare coverage. The Medicaid Program pays for the premiums and deductibles for those eligible under both programs. Medicare pays the actual medical cost for

most of these people. The largest expenditure for the elderly, outside of nursing facility services, has for pharmacy items, which have not been covered under Medicare. With Medicare soon to pay for prescription drugs, this expenditure is expected to decrease. However, it will not be a windfall for the State, as the federal government will be recovering the funding from the Medicaid program. Medicaid is also required to pay Medicare premiums, co-insurance, and deductibles for anyone qualifying for Medicare who has income up to 100 percent of poverty, but Medicare premiums only for those between 100 and 135 percent of poverty.

Medicaid also covers non-SSI aged people whose income does not exceed 100 percent of poverty. Aged people with income over 100 percent of poverty can spend down to the Medically Needy Income Limit to receive Medicaid.

In July 1986, there were 5,794 nursing facility beds in the State. The census was 5,034 for an occupancy rate of 87 percent. Medicaid paid for 71 percent of all occupants. As of September 30, 2004, there were 7,025 nursing facility beds which were certified, with a census of 5,097 as shown in the following table.

Nursing Facility Beds
FY 2006

Private Pay	1,384	21.72%
VA Contract	36	0.56%
Part VA Contract	1	0.02%
Medicaid	3,981	62.48%
Medicare	970	15.22%
Total	**6,372**	
Total Certified Beds	7,811	
Percent Occupancy	81.58%	

Table 8-4

A Medicaid waiver has been obtained by the Division of Aging which will allow Medicaid to pay for some services in home and community-based settings. This is diverting some elderly people from nursing facility care.

Blind and Disabled

Persons receiving assistance due to blindness have always been part of the Medicaid Program.

Persons with disabilities are also eligible for services under the Medicaid Program. The monthly average number of blind and/or disabled individuals receiving Medicaid services during FY 2005 was over 30,000. The criteria for disability require that a person be unable to participate in gainful activity for at least a year, or have a medical condition that will result in death. Among the disabilities covered are mental retardation, mental health, spinal injury, and AIDS. Income is limited to 100 percent of the federal poverty level for

blind and disabled individuals. An asset test similar to that for AFDC is required. Eligible individuals also qualify for food stamps.

The Blind and Disabled make up approximately 11 percent of the Medicaid eligible population, while accounting for approximately 12 percent of recipients. In FY 2005, this group accounted for nearly 41 percent of total Medicaid expenditures. Institutional care for disabled individuals is included in this category.

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

A special group of nursing facilities is Intermediate Care Facilities for people with Mental Retardation (ICF/MR). These facilities specialize in the care of people with disabilities. The individuals served by ICFs/MR are in need of more continuous supervision and structure, but are not significantly different from those served in other systems serving people with disabilities. ICFs/MR are long-term care programs certified to receive Medicaid reimbursement for habilitative and rehabilitative services and must provide for the active treatment needs. Nursing services are available for those requiring nursing and medical services.

There are specific federal regulations requiring active treatment programs and other treatment options. Current state law limits the size of new ICF/MR facilities to 16 beds or less. There are currently 14 privately-owned facilities with populations ranging from 12 to 82 and one State ICF/MR facility (the Utah State Developmental Center (USDC)) licensed for 260. Only four of the facilities meet the 16-or-fewer bed standard. ICFs/MR are an optional service in the Medicaid Program, but are part of the basis allowing the Home and Community Based waiver. Occupancy in the private ICFs/MR is near 100 percent and near 88 percent at the USDC. The average cost per client in an ICF/MR for FY 2005 was approximately $50,000 which is a full-service program (including residential, day program, transportation, recreation, and medical services).

Temporary Assistance to Needy Families (TANF) and Foster Care

Aid to Families with Dependent Children (AFDC) was a joint federal-state program which provided financial assistance to families with children deprived of the support of at least one parent. On August 22, 1996, President Clinton signed the welfare reform bill, which ended the Aid to Families with Dependent Children (AFDC) entitlement program and replaced it with block grants to the states and the Temporary Assistance to Needy Families (TANF) program. In general, however, people who meet AFDC eligibility criteria that were in effect on July 16, 1996 will be eligible for Medicaid. Also, those people who qualify for a TANF grant are eligible for Medicaid.

There are two groups of people who qualify for Medicaid under the TANF program. These include: (1) those in the basic program where a child is deprived of the support of one parent, and (2) those in two-parent families that qualify under the unemployed parent program. The TANF-related programs account for approximately 60 percent of all eligible persons in Medicaid, 56 percent of Medicaid recipients, and less than 25 percent of total expenditures.

Over 90 percent of eligible families are deprived because of divorce, desertion, or unwed mothers. TANF families may also qualify for food

stamps. Depending on family size, the AFDC grant and food stamps provide between 62 and 74 percent of the federal poverty level. There is an asset limit of $2,000 for families in the TANF program. The asset limit does not include a residence or a car with an equity value of less than $8,000. The average monthly number of TANF recipients during FY 2005 was over 130,000. This is the category that has shown the most significant growth over the past couple of years.

Family Employment Program (FEP)

In addition to the basic Family Employment Program (FEP), there is also a program for unemployed two-parent families. This program provides cash assistance for seven months in any 13-month period. One parent in families in this program is required to work 32 hours a week (in an emergency work program) and spend at least 8 hours a week seeking regular employment. With the exception of the time limitation and work requirement, the criteria and benefits for the Family Employment Program - Two Parent (FEP-TP) are the same as those for the regular FEP. Federal law requires that the family be eligible for Medicaid for the full 12 months of the year. Besides those eligible through FEP cash assistance, there are several programs which provide transitional Medicaid coverage for periods of 4 months (for child support-related eligibles) or 24 months (for people who no longer receive cash assistance due to child support payments or earnings). Approximately 31 percent of the people who spend down to qualify for Medicaid come under the FEP category of eligibility. This portion of the FEP continues to grow. This likely is the result of self-sufficiency efforts in the FEP which have increased the number of people receiving transitional benefits.

Children in Foster Care are eligible for Medicaid coverage if they meet Medicaid program requirements. The State is responsible for their medical care. Most children placed in foster care have histories of abuse or neglect. This often means there are unresolved medical and mental health problems that must be dealt with.

In addition to the previously mentioned TANF children, there are four groups of children covered under the Medicaid Program. These are (1) medically needy children, (2) children under age 6 with family income up to 133 percent of poverty, (3) children and youth between age 6 and 18 with income up to 100 percent of poverty, (4) children in subsidized adoptions.

The Medically Needy Children program is for children who do not qualify for assistance under normal Family Medicaid because they are not deprived of the support of a parent. The asset test is the same as for TANF; the family is allowed to spend down to become eligible. This is an optional group, meaning it is not required by the federal government, and so coverage could be terminated. Many children who have been eligible for this group in the past have become eligible in the mandatory programs for children.

The program for children under age six with family income up to 133 percent of poverty is a mandatory program. The program for children born after September 30, 1983 with family income up to 100 percent of the poverty level is designed to provide coverage for children in poverty. There is an asset test

required for children in this category of $3,000 for a family of two; one home is exempted, and a car with an equity value of $1,500 is allowed.

Each year, a number of children come into the custody of the State and are placed for adoption. Some of these children have serious medical problems which makes them hard to place. In some of these cases, the State subsidizes the adoption. Some families receive a small stipend to assist in the cost of care for these children, and the State covers the child's medical care under Medicaid until the child is 18 years old.

TANF Adults

The group referred to as TANF Adults includes those adults with dependent children who are either categorically or medically needy and meet the basic program requirements. Some of the individuals may be required to "spend down" to obtain their Medicaid card, which means that they must reduce their disposable income with payments to Medicaid or with medical bills which they have incurred. Some of the waivers expired at the end of 2000, others have continued.

Pregnancy

The prenatal/pregnancy program helps pregnant women receive prenatal care. The program covers the mother from the time of application to 60 days after the birth. A woman only needs to meet the eligibility requirements in any one month to be eligible for the balance of the pregnancy. Children born to women on this program can be covered on Medicaid (after the first 60 days) for the rest of the first year under the postnatal program.

Approximately one-third of all babies born in the state are paid for by Medicaid. This has been the case for the past several years.

Of the mothers in the program, approximately 23 percent are eligible under the FEP program, and 72 percent were eligible through the Pregnancy Program. Other mothers are eligible through other programs such as emergency medical care, blind or disabled, medically needy children, and foster children.

During FY 2005, the number of pregnant women who were eligible for Medicaid was 28,373. These individuals represented 8.83 percent of the Medicaid population and 8.97 percent of those Medicaid recipients receiving Medicaid services. The expenditures represented 5.94 percent of the total Medicaid fee-for-service expenditures.

Funding Detail

Funding for the Medicaid Base Program is approximately 3 federal dollars for every one state dollar. The appropriated budget for FY 2007 includes $19,599,200, of which $19,149,600 resulted from a transfer of ongoing State funds to the Department of Human Services to offset federal fund reductions.

Budget History - Health - Medical Assistance - Medicaid Base Program					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	198,954,125	229,967,400	252,008,700	282,064,800	296,813,200
General Fund, One-time	0	(37,347,300)	0	18,582,100	19,599,200
Federal Funds	641,836,497	789,947,472	833,328,500	904,993,800	918,623,300
Dedicated Credits Revenue	47,873,911	67,742,682	81,304,200	71,346,900	88,506,200
GFR - Medicaid Restricted	1,573,000	0	0	0	0
GFR - Nursing Care Facilities Account	0	5,347,300	9,800,000	10,107,500	11,254,300
Transfers - Human Services	40,219,454	40,155,281	32,614,700	59,253,600	1,000
Transfers - Other Agencies	0	0	320,200	466,000	42,027,100
Transfers - Within Agency	0	0	299,400	0	299,400
Beginning Nonlapsing	(1,366,509)	476,404	620,900	620,900	620,900
Closing Nonlapsing	(476,404)	(620,901)	(620,900)	(5,079,900)	(620,900)
Lapsing Balance	(5,226,655)	(511,570)	(1,080,700)	(1,355,100)	0
Total	$923,387,419	$1,095,156,768	$1,208,595,000	$1,341,000,600	$1,377,123,700
Categories of Expenditure					
Personal Services	169,619	379,968	435,800	454,700	409,300
In-State Travel	0	10	1,400	0	1,400
Current Expense	182,386	157,821	492,800	10,858,900	512,100
DP Current Expense	7,117	7,348	700	3,400	1,000
DP Capital Outlay	0	0	0	300	0
Other Charges/Pass Thru	923,028,297	1,094,611,621	1,207,664,300	1,329,683,300	1,376,199,900
Total	$923,387,419	$1,095,156,768	$1,208,595,000	$1,341,000,600	$1,377,123,700
Other Data					
Budgeted FTE	4.0	0.0	6.0	6.0	5.8

Table 8-5

TITLE XIX FUNDING FOR HUMAN SERVICES

Function

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

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

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

Funding Detail

The funding here is federal funds which are obtained using matching funds provided by the Department of Human Services. These funds are used for DHS programs.

Budget History - Health - Medical Assistance - Title XIX for Human Services					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
Federal Funds	122,513,951	125,502,732	130,728,700	122,537,400	143,730,500
Transfers	49,834,388	49,636,433	0	0	0
Transfers - Human Services	0	0	53,378,600	50,245,700	61,611,200
Transfers - Within Agency	0	0	276,000	0	0
Total	$172,348,339	$175,139,165	$184,383,300	$172,783,100	$205,341,700
Categories of Expenditure					
Other Charges/Pass Thru	172,348,339	175,139,165	184,383,300	172,783,100	205,341,700
Total	$172,348,339	$175,139,165	$184,383,300	$172,783,100	$205,341,700

Table 8-6

MEDICAL/DENTAL CLINICS

Function

The Clinics are designed to provide access to medical and dental services to Medicaid, Primary Care Network (PCN), and Children's Health Insurance Program (CHIP) clients. There are three medical clinics supported by the Department of Health. They are located in Provo, Salt Lake City and Ogden. The six dental clinics supported by this program are located in Provo, Salt Lake City, Ogden, Kearns, Layton, and St. George.

Funding Detail

Budget History - Health - Medical Assistance - DOH Health Clinics					
Sources of Finance	**2003 Actual**	**2004 Actual**	**2005 Actual**	**2006 Actual**	**2007 Appropriated**
General Fund	629,375	0	957,300	711,700	1,109,500
General Fund, One-time	0	0	0	0	(2,800)
Federal Funds	747,674	0	0	0	0
Dedicated Credits Revenue	3,031,007	1,179,166	1,137,400	1,083,800	1,390,800
Transfers	18,850	2,711,913	0	0	0
Transfers - Other Agencies	0	0	60,100	70,500	41,200
Transfers - Within Agency	0	0	2,074,100	2,441,100	2,200,800
Lapsing Balance	0	241,482	0	0	0
Total	$4,426,906	$4,132,561	$4,228,900	$4,307,100	$4,739,500
Categories of Expenditure					
Personal Services	2,816,403	3,083,278	3,223,500	3,415,100	3,660,200
In-State Travel	40,259	32,743	20,000	34,800	19,900
Out of State Travel	2,464	1,099	5,100	2,700	5,100
Current Expense	534,282	555,627	524,300	618,300	524,000
DP Current Expense	8,276	34,632	23,100	14,800	23,300
DP Capital Outlay	0	49,050	0	2,000	0
Other Charges/Pass Thru	1,025,222	376,132	432,900	219,400	507,000
Total	$4,426,906	$4,132,561	$4,228,900	$4,307,100	$4,739,500
Other Data					
Budgeted FTE	56.3	62.0	58.8	59.0	59.3

Table 8-7

CHAPTER 9 CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Function

The 1998 Legislature passed House Bill 137, which established the Children's Health Insurance Program (CHIP) for the state. This program provides health insurance coverage to uninsured children up to age 19 living in families whose income is less than 200 percent of the Federal Poverty Levels. The program receives approximately 80 percent of its funding from Federal Funds, but requires a state match, which, beginning in FY 2001, comes from proceeds from the Master Settlement Agreement between the State and tobacco companies. The 2003 Legislature increased the funding from the Tobacco Settlement Account from $5.5 million to $7 million to allow for the expansion of the program to cover more children and to restore dental services. The appropriations for FY 2006 were increased again to $10.3 million.

In November 2006, Utah's Premium Partnership for Health Insurance (UPP) was created to enable families to take CHIP funds as a voucher to purchase their employer's health care coverage.

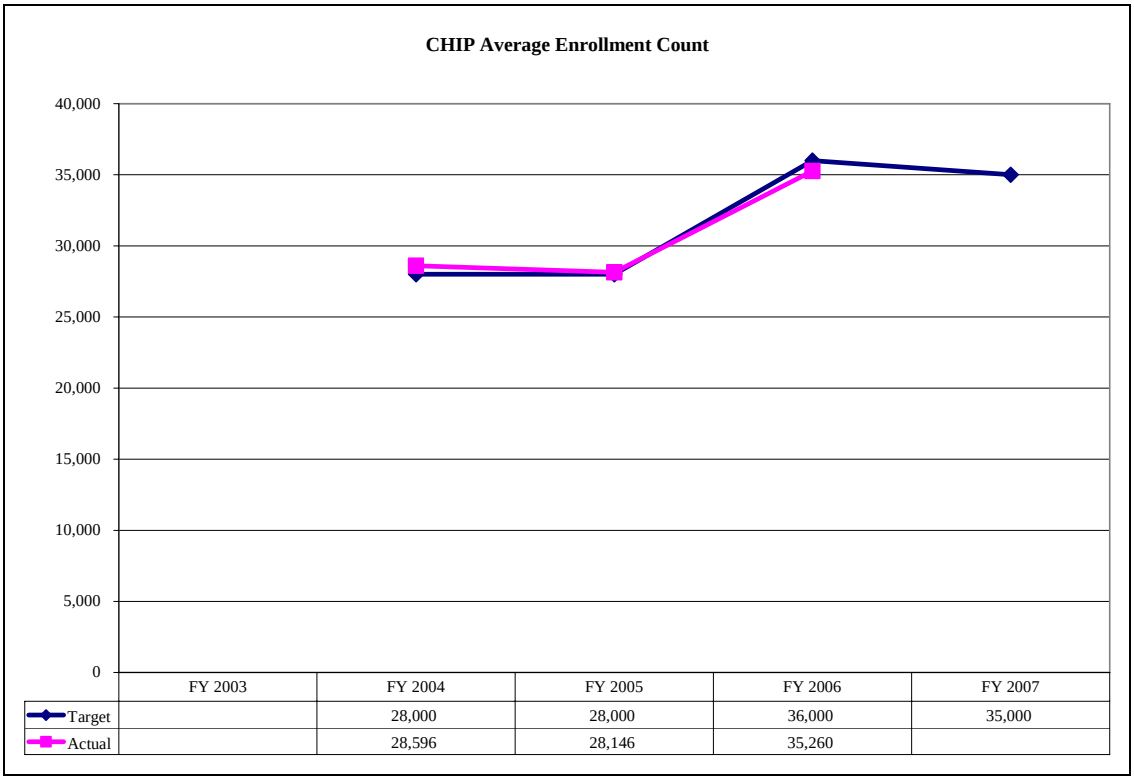
Statutory Authority

The Children's Health Insurance Program is governed by the Utah Health Code, Title 26 of the Utah Code.

- UCA 26-40 details the eligibility qualifications, minimum program benefits, and the funding mechanism for the program.

Accountability

The CHIP has reported the following performance measure regarding average enrollment. Enrollment for CHIP is limited by funding.



	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Target		28,000	28,000	36,000	35,000
Actual		28,596	28,146	35,260	

Figure 9-1

Funding Detail

The Department utilizes funding from the Tobacco Settlement account to match with federal funds. In addition, premiums are collected from some recipients, which are listed as dedicated credits.

Budget History - Health - Children's Health Ins Prog

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
Federal Funds	21,936,718	26,044,062	28,312,800	40,698,600	40,034,900
Dedicated Credits Revenue	451,970	629,690	664,000	790,100	929,700
GFR - Tobacco Settlement	5,496,800	7,003,200	7,006,200	10,312,200	10,321,100
Transfers	1,663,348	575,361	0	0	0
Transfers - Other Agencies	0	0	56,200	61,700	56,200
Transfers - Within Agency	0	0	14,900	24,700	0
Lapsing Balance	0	(578,294)	(187,400)	(39,800)	0
Total	$29,548,836	$33,674,019	$35,866,700	$51,847,500	$51,341,900
Programs					
Children's Health Insurance Program	29,548,836	33,674,019	35,866,700	51,847,500	51,341,900
Total	$29,548,836	$33,674,019	$35,866,700	$51,847,500	$51,341,900
Categories of Expenditure					
Personal Services	538,317	406,658	430,200	519,100	626,700
In-State Travel	5,560	907	1,000	1,000	900
Out of State Travel	8,963	179	0	1,600	2,000
Current Expense	750,325	341,692	396,800	276,100	407,200
DP Current Expense	9,875	40,414	17,300	48,900	21,500
DP Capital Outlay	0	0	0	300	0
Other Charges/Pass Thru	28,235,796	32,884,169	35,021,400	51,000,500	50,283,600
Total	$29,548,836	$33,674,019	$35,866,700	$51,847,500	$51,341,900
Other Data					
Budgeted FTE	12.3	8.8	8.8	9.0	9.0

Table 9-1

Special Funding

As shown in Table 9-2, the state portion the funding for CHIP comes from the Tobacco Settlement Restricted Account, as detailed in the following table.

Restricted Funds Summary - Children's Health Insurance Program

Fund/Account Name	Statutory Authority	Revenue Source	Prescribed Uses	FY 2006 Balance
Tobacco Settlement Restricted Account	63-97-201	75% of all funds received by the state relative to the settlement agreement with the tobacco manufacturers. (The allocation drops to 60% on July 1, 2007 - see UCA 63-97-201(e))	Alcohol, tobacco, and other drug prevention, reduction, cessation, and control programs . . . with a preference in funding given to tobacco-related programs.	$3,190,296 (balance listed is total amount in account for all designated purposes)

Table 9-2

The Federal government created the State Children's Health Insurance Initiative (Title XXI) as a part of the Balanced Budget Act of 1997. The purpose of this act is to provide health insurance to children who (1) are age 18 or under, (2) live in families with incomes below 200 percent of the

Federal Poverty Level, (3) are not eligible for Medicaid, and (4) are uninsured.

During the 1998 Legislative session, the Legislature passed House Bill 137 which established the Children's Health Insurance Program for Utah.

The major portion of the funding for CHIP comes from Federal Funds. The authorized level of Federal Funds is tied to the State's Medicaid rate, but at an enriched level. Because the State of Utah has a relatively high Medicaid rate, the CHIP services match rate is also fairly high (approximately 80 percent), with the State putting up the balance of 20 percent. An assessment levied on hospitals in the State was established during the 1998 Legislature to provide the necessary revenue stream for the State's match requirement. This revenue source helped to fund the CHIP in FY 1999. Beginning in FY 2000, the revenue source was switched to the Tobacco Settlement Restricted Account and capped at $5.5 million. For Fiscal Year 2006, the Legislature authorized the State funding level to be increased to $10.3 million.

Enrollment in CHIP began the first part of August 1998. Through October 2006, there were 35,706 children enrolled - about 64 percent of whom are in families with incomes below 150 percent of poverty (Plan A), with the other 36 percent from families with incomes between 150 and 200 percent (Plan B). Approximately 36 percent of the enrolled children come from rural areas and 64 percent from urban areas.

Since the inception of CHIP, 110,612 children have been enrolled. The difference between this figure and the current enrollment of 35,706 indicates that a significant number are enrolled only temporarily – until other medical insurance coverage is obtained for the family. Approximately 1/2 of the children leaving CHIP do so after enrolling in an employer-sponsored insurance plan, 18 percent were enrolled in Medicaid, 3 percent moved or could not be located, 16 percent later exceeded income limitations, with the balance leaving for other reasons.

Based on available funding, CHIP holds open enrollment periods. When enough funded slots have become vacant from children leaving CHIP, the program has another open enrollment.

The FY 2006 cost for the program is approximately $117 per member per month for both health and dental coverage. The FY 2007 cost is estimated to be higher at $122.00 per member per month.

CHIP Benefit Package

The benefit package for the CHIP is based on the benefit package for public employees, but emphasizes prevention. Well-child exams and immunizations are covered at 100 percent. In FY 2002, dental services were eliminated, except for preventative dental procedures, due to an increase in enrollment. With the increased funding from the 2003 Legislature, dental services were restored.

Some services require co-payments, which vary, depending on the family's income level.

CHAPTER 10 LOCAL HEALTH DEPARTMENTS

Function

Local Health Departments (LHDs) cover all areas of the state and provide local public health services. The State utilizes the local health departments to administer many of the services required by state law. A significant portion of the funding for the local health departments comes from a General Fund block grant in the amount of $2 million. While this line item is for the General Fund block grant funding only, the Utah Department of Health contracts with the LHDs for other services, totaling another $2.4 million in State funds and $18.4 million in Federal Funds. The funding for these contracts is appropriated to and included in the various line items of the Department.

Statutory Authority

The Local Health Departments are governed by Title 26a, Local Health Authorities, of the Utah Code. In addition, several statutes in the Utah Health Code detail responsibilities and enforcement by local health departments.

- UCA 26a establishes local health departments, local boards of health, powers and duties of the departments, and various authorized funding mechanisms.
- UCA 26-15 outlines the Department's efforts, in conjunction with those of local health departments, in relation to general sanitation, including those dealing with the Indoor Clean Air Act.
- UCA 26-15a outlines the Department's efforts, in conjunction with those of local health departments, in relation to food safety.
- UCA 26-38 is the Utah Indoor Clean Air Act, which restricts smoking in indoor public places, and establishes enforcement authority and penalties for noncompliance.
- UCA 26-42 establishes civil penalties for individuals and/or licensees that sell tobacco products to underage minors.

Funding Detail

The funding associated with this line item is a General Fund block grant.

Budget History - Health - Local Health Departments

Sources of Finance	2003 Actual	2004 Actual	2005 Actual	2006 Actual	2007 Appropriated
General Fund	2,085,700	2,012,600	2,041,200	2,055,700	2,092,200
Total	$2,085,700	$2,012,600	$2,041,200	$2,055,700	$2,092,200
Programs					
Local Health Department Funding	2,085,700	2,012,600	2,041,200	2,055,700	2,092,200
Total	$2,085,700	$2,012,600	$2,041,200	$2,055,700	$2,092,200
Categories of Expenditure					
Other Charges/Pass Thru	2,085,700	2,012,600	2,041,200	2,055,700	2,092,200
Total	$2,085,700	$2,012,600	$2,041,200	$2,055,700	$2,092,200

Table 10-1

A major item of funding is the General Fund block grant for the 12 LHDs. The block grant is distributed to the LHDs according to a formula. The pass-through funding is appropriated to the Department as a separate line item, in order to maintain a clean record of the funding and to distinguish between the Department's administrative budget and the local health departments' state-funded services.

In addition to the General Fund block grant, the Department provides state and federal funds to local health departments for several different categorical programs.

GLOSSARY

APPENDIX 1: BUDGETING TERMS

Finance categories used by the state

General Fund This is one of the state's most important sources of income. The primary revenue source is the sales tax, although there are other taxes and fees which are deposited into this fund. General Funds may be spent at the discretion of the Legislature, as the Constitution allows. Personal income taxes and corporate franchise taxes are not deposited into the General Fund, but into the Uniform School Fund.

School Funds This is another of the state's most important sources of income. Revenues come primarily from personal income taxes and corporate franchise taxes. Funds are constitutionally restricted to public and higher education. In the Capital Facilities subcommittee, these funds are used for debt service and capital improvements (alteration, repair and improvements).

Transportation Funds Transportation funds are derived primarily from the gas tax and are constitutionally restricted to road and highway related issues. In the Capital Facilities subcommittee, these funds are used for debt service on highway bonds, especially for Centennial Highway Fund projects.

Federal Funds Federal agencies often make funds available to the state for programs that are consistent with the needs and goals of the state and its citizens and are not prohibited by law. Generally, federal funds are accompanied by certain requirements. A common requirement is some form of state match in order to receive the federal dollars. The Legislature must review and approve most large federal grants before state agencies may receive and expend them.

Dedicated Credits Dedicated Credits are funds that are paid to an agency for specific services and are dedicated to financing that service. For example, fees collected by an internal service fund agency from another state agency are dedicated credits. By law, these funds must be spent before other appropriated state funds are spent. An agency must estimate the level of its service for the following fiscal year, and thus its level of dedicated credits.

Restricted Funds Restricted funds are statutorily restricted to designated purposes. The restricted funds usually receive money from specific sources, with the understanding that those funds will then be used for related purposes.

Lapsing/Nonlapsing Several other small funds are used by certain agencies. These will be discussed in further detail as the budgets are presented. Lapsing funds, however, should be addressed. Funds lapse, or revert back to the state, if the full appropriation is not spent by the end of the fiscal year. Since it is against the law to spend more than the Legislature has appropriated, all programs will either spend all the money or have some left over. The funds left over lapse to the state, unless specifically exempted. Those exceptions include funds that are setup as nonlapsing in their enabling legislation, or appropriations designated nonlapsing by annual intent language per UCA 63-38-8.1. In these cases, left over funds do not lapse back to the state, but remain with the

agency in a special nonlapsing balance, for use in the next fiscal year. In the budgets, the Beginning Nonlapsing balance is the balance on July 1, while the balance on the next June 30 is termed the Closing Nonlapsing balance. The Closing Nonlapsing balance from one fiscal year becomes the Beginning Nonlapsing balance of the following fiscal year. The reasoning behind nonlapsing funds is that a specific task may take an indeterminate amount of time, or span more than one fiscal year. By allowing departments to keep their unexpended funds, the state not only eliminates the rush to spend money at the end of a fiscal year, but also encourages managers to save money.

Expenditure categories used by the state

Personal Services Includes employee compensation and benefits such as health insurance, retirement, and employer taxes.

Current Expenses Includes general expenses such as utilities, subscriptions, communications, postage, professional and technical services, maintenance, laundry, office supplies, small tools, etc. that cost less than $5,000 or are consumed in less than one year.

Data Processing Current Expense Includes items such as small computer hardware and software, port charges, programming, training, supplies, etc.

Capital Outlays Includes items that cost over $5,000 and have a useful life greater than one year.

Pass Through Includes funds passed on to other non-state entities for use by those entities, such as grants to local governments.

Other budgeting terms and concepts that Legislators may encounter

Performance Measures In recent years, performance based budgeting has received more attention as citizens and decision-makers demand evidence of improved results from the use of tax dollars.

Care must be exercised in crafting performance measures to avoid misdirected results. Moving to performance based budgeting is a long term commitment. The Analyst has drafted some ideas for performance measures in the write-up, however, it is recognized that the measures are a work in progress and that long-term tracking of measures would require a statewide commitment in both the executive and legislative branches.

Intent Language Intent language may be added to an appropriation bill to explain or put conditions on the use of the funds in the line item. Intent language may restrict usage, require reporting, or impose other conditions within the item of appropriation. However, intent language cannot contradict or change statutory language.

Supplemental Appropriation The current legislative session is determining appropriations for the following fiscal year. However, it may be determined that unexpected circumstances have arisen which require additional funding for the current year. The appropriations subcommittee can recommend to the Executive Appropriations

Committee that a supplemental appropriation be made for the current fiscal year.

FTE An abbreviation for Full Time Equivalent, this is a method of standardizing personnel counts. A full time equivalent is equal to one employee working 40 hours per week. Four employees each working ten hours per week would also count as 1 FTE.

Line Item This is a term that applies to an appropriation bill. A line number in the appropriations bill identifies each appropriated sum. Generally, each line item may contain several programs. Once the appropriation becomes law, the money may be moved from program to program within the line item, but cannot be moved to another line item of appropriation.

APPENDIX 2: GLOSSARY OF HEALTH TERMS AND ACRONYMS

Access Often defined as the potential and actual entry of a population into the healthcare system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.

Actual Charge One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge.

Acute Care Medical treatment rendered to individuals whose illnesses or health problems are of short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

Acute Disease A disease which is characterized by a single episode of a relatively short duration from which the patient returns to his normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.

AFDC Aid To Families with Dependent Children. Replaced by federal welfare reform with Temporary Assistance to Needy Families (TANF).

Allowable Costs Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs which are not reasonable expenditures, which are unnecessary, for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure which was disapproved by a heath planning agency.

Alternatives to Long-Term Institutional Care The whole range of health, nutritional, housing, and social services designed to keep persons out of institutions, such as skilled nursing facilities, which Institutional Care provide care on a long-term basis. The goal is to provide the range of services necessary to all to allow the person to continue to function in the home and community environment. Alternatives to long-term care usually focus on the aged, disabled, and retarded, and include: day care centers, foster homes, or homemaker services.

Ambulatory Care All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory setting and outpatient.

Ambulatory Setting A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

Auxiliary Services Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.

Appropriate Health Care Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

Area Health Education Center (AHEC) An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use, and efficiency of health care personnel in specific medically underserved areas. The objectives of an AHEC are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions in scarcity areas.

Capitation A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the Federal Government for each student enrolled.

Carve Out Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

Case Management The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.

Case-Mix A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' difference needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

Catastrophic Health Insurance Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Catchment Area A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.

Centers for Disease Control and Prevention (CDC) The Centers for Disease Control and Prevention, based in Atlanta, Georgia, is the Federal agency charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. CDC is the U.S. Public Health Service agency that led efforts to prevent such diseases as malaria, polio, smallpox, toxic shock syndrome, Legionnaire's disease and, more recently, acquired immunodeficiency syndrome (AIDS) and tuberculosis. CDC's responsibilities as the nation's prevention agency have expanded over the years and will continue to evolve as the agency addresses contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.

CHEC Child Health, Evaluation and Care program (see EPSDT)

ChIP Child Injury Prevention program

CHIP Children's Health Insurance Program

Chronic Care Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

Chronic Disease A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alternation, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

Clawback This is the state dollars that the state would have spent on the dual eligible pharmacy benefit had Part D not been enacted. Every month, beginning January 1, 2005, State Medicaid is required to send this amount (about $1.8 million for Utah) to CMS for their "maintenance-of-effort" for Part D.

Clinic A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.

COB Coordination of Benefits

Coinsurance A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

Community-Based Care The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

Community Health Center (CHC) An ambulatory health care program (defined under section 330 of the Public Health Center Health Service Act) usually serving a catchment area which has scarce or (CHC) nonexistent health services or a population with special health needs; sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Mental Health Center (CMHC) An entity which provides comprehensive mental health services (principally Mental Health ambulatory), primarily to individuals residing or employed in a defined Center (CMHC) catchment area.

Community Rating A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for difference groups or subgroups of subscribers on the basis of their specific claims experience.

Continuing Medical Education (CME) Formal education obtained by a health professional after completing his or her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

Cost Containment A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of health services could be reduced by using a different combination of resources.

Cost-Shifting The situation that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.

Covered Services Health care services covered by an insurance plan.

CTRPN Counseling, Testing, Referral and Partner Notification (HIV/AIDS)

Customary Charge One of the factors that determines a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.

DCP Diabetes Control Program

Developmental Disability (DD) A severe, chronic disability which is attributable to a mental or physical) impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care treatments of services which are of lifelong or extended duration and are individually planned and coordinated.

Diagnosis Related Groups (DRGs) Group of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.

Disability Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

Disease May be defined as failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.

DHCF Division of Health Care Financing (Medical Assistance Administration)

"Donut Hole"	This refers to a break in prescription coverage after a person has reached $2,500 in deductible, copays and insurance payments but has not yet reached $3,600. At the $3,600 level, catastrophic coverage is reached and pays 95 percent of the eligible expenses.
Drug Abuse	Persistent or sporadic drug use inconsistent with or unrelated to acceptable medical or cultural practice. the definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), dependence, or illegal use.
Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)	A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.
ECF	Extended Care Facility
Emergency Medical Services (EMS)	Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.
Employee Retirement Income Security Act (ERISA)	A Federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.
Epidemic	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.
Epidemiology	The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.
ER	Emergency Room
Exclusive Provider Arrangement (EPA)	An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

Experience Rating	A method of adjusting health plan premiums based on the historical Rating utilization data and distinguishing characteristics of a specific subscriber group.
Favorable Selection	A tendency for utilization of health services in a population group to be lower than expected or estimated.
FDA	Food and Drug Administration
Fee for Service	Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. country's physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.
Fee Schedule	An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.
Handicapped	As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.
Health	The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.
Health Care Financing Administration (HCFA)	The Government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.
Health Education	Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.
Health Facilities	Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an

office building which includes a physician's office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.

Health Insurance Financial protection against the medical care costs arising from disease or Insurance accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Maintenance Organization (HMO) An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Manpower Shortage Area (HMSA) An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

Health Personnel Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.

Health Promotion Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

Health Service Area Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.

Health Status The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts

to relate effects of available medical care to variations in health status have proved difficult.

Home Health Care Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care are the following: nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.

Hospice A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

Hospital An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or nonteaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat,), and by type of ownership or control (Federal, State, or local government; for profit and nonprofit). The hospital system is dominated by the short-term, general, and nonprofit community hospital, often called a voluntary hospital.

ICU Intensive Care Unit

ICF/MR Intermediate Care Facility for the Mentally Retarded

Indemnity Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services.

Indigent Care Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

Inpatient A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his or her room and board) for the purpose of receiving diagnostic treatment or other health services.

Institutional Health Services Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on

an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

Intermediate Care Facility (ICF) An institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded or people with related conditions are also included in the definition. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.

Intervention or Intervention Strategy A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.

License/Licensure A permission granted to an individual or organization by a competent authority, usually public, to a engage lawfully in practice, occupation, or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education, or proof of competence.

Long-Term Care A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g. the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

LPN License Practical Nurse

Managed Care Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.

MCAC Medical Care Advisory Committee

MCH Maternal and Child Health

Medical Assistance/Medicaid (Title XIX) A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, State determine the benefits covered, program

	eligibility, rates of payment for providers, and methods of administering the program.
Medicaid Notch	The reduction in real income that occurs which increased earnings removes a person from not only public cash-assistance programs, and from Medicaid.
Medically Indigent	People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.
Medically Underserved Population	A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).
Medicare (Title XVIII)	A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums for beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).
Mental Health	The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and sometimes improperly used as a synonym for mental illness.
Mental Health Services	Comprehensive mental health services, as defined under some State laws and Federal statutes, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.
Mental Illness	All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types and severities.
MMIS	Medicaid Management Information System
Morbidity	The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

Mortality Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

Need In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.

Neighborhood Health Center An ambulatory health care program usually serving a catchment area which has scarce or nonexistence health services or population with special health needs and is often known as a community health center. Neighborhood health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health care and related social services to a defined population.

Nurse An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses.

Nurse Practitioner A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for service reimbursement for their services.

Nursing Facility Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.

OBRA Omnibus Budget Reconciliation Act

Occupancy Rate A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

Occupational Health Services Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S., the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

Open Enrollment A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during specific period each year.

Outpatient A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.

Passive Intervention Health promotion and disease prevention initiatives which do not require the direct involvement of the individual (e.g., fluoridation programs) are termed "passive". Most often these types of initiatives are Government sponsored.

Peer Review Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 Conference Agreement for HR 3734: Public Law 104-193. Federal and welfare reform passed by the United State Congress on July 31, 1996 (U.S. House) and August 1, 1996 (U.S. Senate) and signed into law by Pres. Clinton on August 22, 1996. "Ends welfare as we know it."

Physician Assistant (PA) Also known as a physician extender, a PA is a specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.

Point of Service A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of medical services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or noncontracting providers.

Poverty Area An urban or rural geographic area with a high proportion of low income families. Normally, average income is used to define a poverty area, but other indicators, such as housing conditions, illegitimate birth rates, and incidence

	of juvenile delinquency, are sometimes added to define geographic areas with poverty conditions.
Preferred Provider Arrangement (PPA)	Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.
Preferred Provider Organization (PPO)	Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at (discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.
Prevailing Charge	One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.
Prevalence	The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year.
Preventive Medicine	Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.
Primary Care	Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.
Primary Prevention	The prevention of an illness or disease before any symptoms manifest themselves.
Provider	Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

Public Good A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.

Public Health The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.

QMB Qualified Medicare Beneficiary

Quality of Care Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

Rate A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons.

Rehabilitation The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.

Reimbursement The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Reinsurance The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

Screening	The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.
Secondary Care	Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.
Secondary Prevention	Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful and the goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment, and follow up programs.
Service Period	Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.
Severity of Illness	A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pretreatment risk.
Skilled Nursing Facility (SNF)	A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.
SLAG	State Legalization Impact Assistance Grant
SLIMB	Special Low-Income Medicare Beneficiary
Sole Community Hospital (SCH)	A hospital which (1) is more than 50 miles from any similar hospital, (2) is Hospital (SCH) 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.

Spend Down	The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.
STD	Sexually transmitted diseases
Survey	An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalization of results depends upon the extent to which those surveyed are representative of the entire population.
Symptomatic	Someone who has symptoms of a disease or illness is symptomatic. Someone who has smoked all his/her life and has a heavy cough is said to be symptomatic. A heavy lifelong smoker who has not yet developed symptoms is said to be pre-symptomatic.
Technology Assessment	A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.
Temporary Assistance for Needy Families (TANF)	The federal block grants to states for assistance payments. Replaces the entitlement program known as Aid to Families with Dependent Children (AFDC).
Tertiary Care	Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.
Tertiary Prevention	Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.
Third-Party Payer	Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).
Title XVIII (Medicare)	The title of the Social Security Act which contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid)	The title of the Social Security Act which contains the principal legislative authority for the Medicaid program and therefore a common name for the program.
UMAP	Utah Medical Assistance Program (discontinued)
Uncompensated Care	Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.
Underinsured	People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.
Uninsured	People who lack public or private health insurance.
Usual, Customary and Reasonable (UCR) Fees	The use of fee screens to determine the lowest value of physician and Reasonable reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.
Utilization	Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.
Vital Statistics	Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.
WIC	Women, Infant, and Children supplemental food program
Wellness	A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

APPENDIX 3: DEFINITIONS OF MEDICAID CATEGORIES OF SERVICE

Aging Waiver	The aging waiver allows state Medicaid agencies to cover services not otherwise available under Medicaid to individuals 65 and over, who would be in an institution without these services. This allows these older adults to retain some level of independence and a greater quality of life by enabling them to remain in their own homes.
Ambulatory Surgical	Surgery on an ambulatory basis is provided.
CMS	Centers for Medicare & Medicaid Services, a program within the Federal Department of Health and Human Services. They are the primary manager of the Medicaid and Medicare Programs.
Case Management Fees	Payments made to local health departments for case management services.
Child Health Evaluation and Care (CHEC/EPSDT)	Screening, diagnostic, health care, treatment, and other measures to correct and/or ameliorate any defects and chronic conditions discovered in recipients under age 21. This is Utah's version of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program.
Chiropractic Services	Services which involve manipulation of the spine that a chiropractor is legally authorized to perform under state law.
Clawback	This is the state dollars that the state would have spent on the dual eligible pharmacy benefit had Part D not been enacted. Every month beginning on January 1, 2005, State Medicaid Programs are required to send this amount (about $1.8 million for Utah) to CMS for their "maintenance of effort" for Part D.
Contracted Mental Health Services	Mental health services provided to children in foster care and under the authority of Division of Family Services/Division of Youth Corrections Services (DFS/DYC) are eligible for reimbursement effective 7/1/93. These services must be provided by a provider under contract with DFS/DYC. DFS and DYC will provide the state match for these services.
Dental Services	Diagnostic, preventative, or corrective procedures provided by a dentist in the practice of his/her profession.
Dual Eligibility	When a recipient is enrolled in Medicare and in Medicaid, he is a dual eligible. He has "dual eligibility" because he is eligible in both programs. Creation of Medicaid Part D will increase the number of those dual eligible and, consequently, increase State and Federal expenses.
Early Intervention	Diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers (up to age four) with disabilities. The program is administered by Family Health Services which contracts with providers consisting of multi-disciplinary teams of health care professionals who work with the family to evaluate and coordinate services to ensure that the needs of the child are met.

Group Pre/Postnatal Education	Classroom learning experience for the pregnant woman with the objective of improving knowledge of pregnancy, labor and childbirth, informed self care, and preventing development of conditions which might complicate pregnancy. Infant, feeding, or parenting classes may also be included.
Health Maintenance Organizations (HMOs)	Basic medical and dental covered services provided by health maintenance organizations.
Home and Community-Base Waiver for Developmentally Delayed/Mentally Retarded (DD/MR)	Services provided within the community to a limited number of individuals who meet criteria established for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services. The State may provide waivered services, including residential treatment, day training, respite care, family support, and case management.
Home Health Services/Hospice	A program of intermittent and part-time nursing care provided in the patient's place of residence as an alternative to premature or inappropriate institutionalization.
Inpatient Hospital	A required service that provides medically necessary and appropriate diagnostic and therapeutic services for the care and treatment of injured, disabled, or sick people who must remain in the hospital for more than 24 hours.
Inpatient Hospital Mental-Mental Youth and Aged	Mentally ill, youth and aged clients in an inpatient hospital setting, requiring constant care.
Intermediate Care Facilities	Intermediate care facilities offer care to chronically ill patients.
Intermediate Care Facilities for the Mentally Retarded (ICF/MR)	Intermediate care facilities cater to clients with mental retardation who require less care than an inpatient hospital patient.
ICF/MR Day Treatment	Day treatment is provided to intermediate care and mentally retarded individuals.
Kidney Dialysis	Kidney Dialysis is a program for people who have irreversible and permanent end-stage renal disease and require a regular course of dialysis.
Lab and Radiology	Laboratory and radiological services are provided for the client.
Medicaid Waiver	A program that authorizes that certain federal regulations be by passed and implements a program outside of current regulations. The waivered program must be approved by CMS for the state to be eligible for federal matching funds.

Medical Supplies Medical supplies necessary for treatment are provided to individuals who require them.

Medical Transportation Transportation is provided to and from medical appointments and treatment when needed.

Medicare Part D A new Medicare benefit adding pharmaceutical coverage for those who are covered by Part A or Part B. It is voluntary, one is not required to sign up. There are premiums, annual deductibles and copayments and drugs are supplied through local pharmacies who are providers for Medicare contracted Prescription Drug Program (PDP) providers.

Beginning January 1, 2006, Medicare dual eligibles will not receive a pharmacy benefit through Medicaid, but must (and will be automatically enrolled) enroll in Medicare Part D to receive a drug benefit. They automatically receive a low income subsidy benefit which waves the premiums, deductibles and limits the copay to $1 generic and $3 brand name.

Mental Health Services These include the continuum of mental health services provided by the 11 community mental health centers, including the three prepaid mental health clinics. The county mental health authorities provide the state match for these services.

Nutritional Assessment/ Counseling Service provided by a dietician for pregnant women with complex nutritional, medical, or social risk factors identified in early prenatal visits and referred for intensive nutritional education, counseling, and monitoring for compliance and improvement.

Occupational Therapy Occupational therapy is provided to needy individuals to assist them in returning to the work force.

Optical Supplies Services which include lenses, frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist to the extent permitted under state law.

Outpatient Hospital A required service that provides medically necessary diagnostic and therapeutic services ordered by a physician or other practitioner of the healing arts. These services must be appropriate for the adequate diagnosis and treatment of the patient's illness.

Part D Medicare A new Medicare benefit adding pharmaceutical coverage for those who are covered by Part A or Part B. It is voluntary, one is not required to sign up. There are premiums, annual deductibles and copayments and drugs are supplied through local pharmacies who are providers for Medicare contracted Prescription Drug Program (PDP) providers.

Beginning January 1, 2006, Medicaid dual eligibles will not receive a pharmacy benefit through Medicaid, but must (and will be automatically enrolled) enroll in Medicare Part D to receive a drug benefit. They automatically receive a low income subsidy benefit which waves the premiums, deductibles and limits the copay to $1 generic and $3 brand name.

Pediatric/Family Nurse Practitioner	Registered nurses with specialty training and certification, licensed within the State to provide general and preventive services within a specific specialty as authorized by licensure within the State. See specialized nursing above. (Coverage of these practitioners is mandated.)
PERINATAL CARE COORDINATION	Targeted case management for pregnant women. Services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services. The purpose is to coordinate care and services to meet individual needs and maximize access to necessary medical, social, nutritional, educational, and other services for the pregnant woman throughout pregnancy and up to the end on the month in which the 60 days following pregnancy ends.
Personal Care Services	The personal care services program enables recipients to maintain a maximal functional level in their place of residence through providing minimal assistance with the activities of daily living.
Pharmacy	Drugs prescribed by their respective physicians are provided to individuals which are required for treatment.
Physical Therapy	Services prescribed by a physician and provided by a physical therapist.
Physical Services	"Physician services", whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services furnished by a physician, (1) within the scope of practice of medicine or osteopathy as defined by state law and (2) by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy.
Podiatry Services	Services provided by a podiatrist who is licensed under state law to render medical or remedial care for the foot and associated structures.
Pre/Postnatal Home Visits	Home visits are part of the management plan for a pregnant woman. The visits are for the purpose of assessing the home environment and implications for management of care, to provide emotional support, determine educational needs, provide direct care and encourage regular visits for prenatal care.
Pre/Postnatal Psychosocial Counseling	Evaluation to identify families with high psychological and social risks and follow up to develop a plan of care to provide or coordinate appropriate intervention, counseling, or referral necessary to meet the identified needs of families.
Private Duty Nursing	Nursing service provided in a client's home for up to 24 hours per day as an alternative to prolonged hospitalization or institutionalization of technology dependent individuals. This option, when compared to other alternatives, must provide quality and cost effectiveness over the long term, and requires participation of family members in the care during hours when nurses are not present.
Psychologist Services	Licensed psychologists may provide evaluation and testing to individuals with a diagnosis of delayed development (DD) or mental retardation (MR), early periodic screening diagnosis and treatment (EPSDT)-eligible Medicaid

	recipients and to victims of sexual abuse. They may provide individual, group, and family therapy to those eligibles. The Department of Human Services provides the state match for services provided to the Division of Family Services (DFS) and the Division of Services to People with Disabilities (DSPD) clientele. Psychological evaluation and testing for Medicaid clients who exhibit mental retardation, developmental disabilities or are victims of sexual abuse and are eligible for EPSDT.
Rural Health Services	Health services are provided to individuals who live in rural areas.
Skilled Nursing Facilities	Skilled Nursing Facilities offer skilled nursing care to chronically ill patients.
Skills Development	Medically necessary services to improve and enhance the health and functional abilities of the children ages 2 to 22 and prevent further deterioration. Services include individual or group therapeutic intervention to ameliorate motor impairment, sensory loss, communication deficits, or psycho-social impairments and skills training to the family to enable them to enhance the health and development of the child. Services are identified in the child's I.E.P. and provided by or under the supervision of specified licensed practitioners.
Specialized Nursing Service	The following specific practitioners are covered as Medicaid providers. Services of nurses practicing within a specialty area to the extent of licensure within the state. Four groups currently have provider status: 1. Certified Registered Nurse Anesthetists (CRNA) 2. Certified Registered Nurse Midwives (CNM) 3. Certified Family Nurse Practitioners (CFNP) 4. Certified Pediatric Nurse Practitioners (CPNP)
Specialized Wheel Chairs	Special wheel chairs are provided to needy individuals.
Speech and Hearing	Diagnostic, screening, preventive, or corrective services provided by a speech pathologist or audiologist for which a patient has been referred by a physician.
Substance Abuse	Treatment is given to clients for alcohol and drug abuse and misuse.
Targeted Case Management	Targeted case management services designed to assist an individual in a targeted group to gain access to needed medical, social, educational, and other services. In Utah, there are several targeted groups which assist individuals in the groups in planning, coordinating, and accessing needed services.
Targeted Case Management for AIDS	A set of planning, coordination, and monitoring activities that assist recipients in their target group to access services.

Vision Care Services Diagnostic, screening, preventive, or corrective services provided by a physician skilled in disease of the eye or an optometrist to the extent permitted under state law.

Waiver A program that authorizes that certain federal regulations be by passed and implements a program outside of current regulations. The waivered program must be approved by CMS for the state to be eligible for federal matching funds. Example: The PCN and Non-Traditional Medicaid programs operate under a waiver.

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