STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

Payment rates for the services listed below are effective for services provided on or after the corresponding date:

Service	Attachment	Effective Date
Physician and Anesthesia Services	Attachment 4.19-B, Pages 4 and 5	July 1, 2022
Optometry Services	Attachment 4.19-B, Page 7	July 1, 2022
Eyeglasses Services	Attachment 4.19-B, Page 8	July 1, 2022
Home Health Services	Attachment 4.19-B, Page 10	July 1, 2022
Clinic Services	Attachment 4.19-B, Pages 12b and 34	July 1, 2022
Dental Services and Dentures	Attachment 4.19-B, Page 13	July 1, 2022
Physical Therapy and Occupational Therapy	Attachment 4.19-B, Page 14	July 1, 2022
Speech Pathology Services	Attachment 4.19-B, Page 16	July 1, 2022
Audiology Services	Attachment 4.19-B, Page 17	July 1, 2022
Transportation Services (Special Services)	Attachment 4.19-B, Page 18	July 1, 2022
Transportation Services (Ambulance)	Attachment 4.19-B, Page 18	July 1, 2022
Medication-Assisted Treatment for Opioid Use Disorders	Attachment 4.19-B, Page 36	July 1, 2022
Targeted Case Management for Individuals with Serious Mental Illness	Attachment 4.19-B, Page 22a	July 1, 2022
Rehabilitative Mental Health Services	Attachment 4.19-B, Page 25	July 1, 2022
Chiropractic Services	Attachment 4.19-B, Page 30	July 1, 2022

A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Effective for service end dates on or after September 1, 2011, the payment for outpatient hospital claims will be based on Medicare's Outpatient Prospective Payment System (OPPS) payment methodology. Medicare's Outpatient Code Editor and CMS pricer will be utilized for payment amounts.

   A. OPPS hospitals will be paid per applicable APC, Medicare fee schedule, or reasonable cost method (reasonable cost will be paid using the facility-specific cost-to-charge (CCR) multiplied by the line-item billed charge). A factor, rounded to four (4) decimal places, will then be applied to the rate to offset the annual Medicare inflation changes. The following example is provided for illustrative purposes only:

Year	Inflation	Change (based on $100)	Factor	Adjusted Payment
1	2.6%	$102.60	0.9747	$100.00
2	2.0%	$104.65	0.9555	$100.00

   The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

   B. Services not priced using OPPS or CAH methodology will be based on the established Medicaid fee schedule and the reimbursement policies for those services may be found in Attachment 4.19-B as follows:

   - Section C – Laboratory and Radiology Services
   - Section D – Physicians
   - Section E – Anesthesiologist/Anesthetist
   - Section F – Podiatrists
   - Section G – Optometrists
   - Section H – Eyeglasses
   - Section K – Medical Supplies and Equipment
   - Section M – Dental Services and Dentures
   - Section N – Physical and Occupational Therapy
   - Section O – Prosthetic Devices and Braces
   - Section P – Speech Pathology
   - Section Q – Audiology
   - Section S – Prescribed Drugs

   Typically, these services are not covered by Medicare.

   Except as otherwise noted in the plan, payments for these services based on state-developed fee schedule rates, are the same for both governmental and private providers. All rates are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at http://health.utah.gov/medicaid/.

   C. Vaccines for Children (VFC) services will be paid using the Medicaid VFC rates. Non-VFC services will be paid using Medicare's pricer. The reimbursement policies for those services may be found on Page 9a of Section 1.5.

   D. Revenue code 72[0-9], if not accompanied with procedure code detail, will be paid using the reasonable cost methodology.

   E. Transitional Outpatient Payments (TOPs) will be calculated according to Medicare principles and paid on a semi-annual basis to in-state providers only.

   F. Dialysis services are paid at the OPPS rate for the first encounter per member per hospital. Subsequent outpatient hospital visits for end-stage renal disease requiring dialysis treatment will reimburse, for all billed services (e.g., labs, evaluation and management, IV fluids, EKG), at the Medicare ESRD PPS Base Rate as stated in Attachment 4.19-B, Page 12a.

2. Critical Access Hospitals (CAH) will be paid 101% of costs using the facility-specific CCR.

   The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

3. Out-of-state hospitals will be paid by hospital type (OPPS or CAH) like in-state hospitals, but will not receive any specialty payments (e.g., TOPs).

4. Billed charges shall not exceed the usual and customary charge to private pay patients.

OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

a. FQHCs located in Utah that serve Utah Medicaid clients

FQHCs may be paid under one of two payment methods – the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). To be paid under an APM, each FQHC must elect the payment methodology and give notice to the Medicaid agency. If an FQHC elects to change their APM election, it must be made no later than thirty (30) calendar days prior to the beginning of the FQHC's fiscal year by written notice to the Department.

FQHCs are reimbursed for one encounter per day per patient. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day constitute a single encounter.

i. Prospective Payment System

Payment under PPS methodology conforms to the Federal methodology as contained in section 702 of the Benefits Improvement and Protection Act of 2001. PPS is the only approved methodology for the time period January 1, 2001, through February 2, 2004, under the State Plan in effect for that time period.

PPS rates for each FQHC are determined on the basis of their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of services. The average of the two-year costs are divided by the average number of visits (physician services as defined by the State Plan, Attachment 3.1-A, Attachment #5) for the same two-year period. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services. Effective calendar year 2022, the annual increase will occur each April 1 rather than January 1. The updated rates are effective for services on or after that date (April 1 of the applicable year). Payment will be based on the established PPS rates. Supplemental payments may be paid to ensure the PPS rate is received if, due to claims system limitations, the State isn't able to pay the PPS rate.

1. PPS Rate Establishment for new FQHCs

New FQHCs established after fiscal year 2000 will have their PPS rate established for their first year using 100 percent of the reasonable costs used in calculating the rates of like or similar FQHCs in the same or adjacent areas with similar caseload.

If there are no FQHCs in the same or adjacent area with a similar caseload, their PPS rate will be calculated from a cost report, based on projected costs, after applying a test of reasonableness. For year two, the year one PPS rate is inflated by the MEI. For year three, once the first full fiscal year's actual costs are established, the baseline PPS is re-calculated by dividing the total actual FQHC costs by the number of FQHC visits. The result is then inflated by the MEI for two periods to properly trend the PPS to the year three period.

The resulting PPS rate is annually trended by the MEI and adjusted for any subsequent change in scope of services. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services. Effective calendar year 2022, the annual increase will occur each April 1 rather than January 1. The updated rates are effective for services on or after that date (April 1 of the applicable year). Payment will be based on the established PPS rates.

OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

2. Scope of Service Changes

A change in the 'scope of services' is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services. Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive consideration for an adjustment to the FQHC's PPS rate. Once approved, the modified PPS rate will be effective for the prospective fiscal period. Approximately two years after as PPS rate change for scope of service changes, cost reports will be reviewed to verify the PPS rate update. If the scope of service change costs were over or under-estimated, a prospective, not retro-active, correction will be made to the PPS rate. There will be no retroactive correction made.

3. Mental Health Services

Mental Health Services provided by an FQHC are in-scope services reimbursed at the PPS rate which can only be billed under fee for service and not under managed care. Therefore, FQHC mental health service claims will not be included in the state wrap settlements for managed care payments up to PPS.

4. State wrap for managed care payments

For FQHCs which contract with Managed Care Entities (MCEs):

a. Supplemental payment amounts will be estimated and paid quarterly to the FQHCs based on the difference between amounts paid by the MCEs and amounts the FQHCs are entitled to under the PPS.
    i. Quarterly interim payments will be made approximately thirty (30) days after the end of the quarter.
    ii. The quarterly amount may be less than the calculated amount if requested by the FQHC.
b. Annual reconciliations to ensure FQHCs are paid at least up to the PPS rate will be made and settled. If the State Medicaid Agency over-paid, pay-back to the State of the settlement amount is required from the FQHC. If Medicaid under-paid, a payment for the settlement amount will be made to the FQHC.
c. The PPS cost settlement using MCE patient claim records:
    i. Summary Cost Settlement Payment Report – This report presents the total amount due to or from the FQHC. There are two parts to this calculation. First, a calculation of the difference between the total amount that would have been paid under PPS principles and the total actual payment amount. Second, the sum of the quarterly interim payments made to the provider is then subtracted from the amount from step one. The difference is the settlement amount. If the settlement amount is negative, the provider is only required to pay back the portion of the settlement related to the interim payments (any payments by the MCE in excess of the PPS is not required to be paid back).
    ii. Claim Detail Cost Settlement Report – This report contains medical and dental managed care claim detail and is the source for the summary report described in section (a) above.

OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

ii. Alternative Payment Method (APM) - Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost (RCCAC).

The Alternative Payment Methodology Cost Settlement (APM) – The APM is available effective January 1, 2022, for providers that elect to receive the APM methodology. FQHCs must agree to receive the APM and the total amount paid under the APM must be at least what would be paid under the PPS methodology. The APM pays 100% of billed charges as an interim rate for FQHC services on a per claim basis as well as a one-time annual settlement amount that is the greater of the settlement amounts calculated under either the cost based methodology (a) or what would have been paid under PPS (b).

a. **Cost basis methodology**
FQHCs electing to receive the APM shall provide the Department with annual cost reports and audited financial statements required by the Department within twelve months of the close of their fiscal year period. The Department will conduct a review of submitted cost reports and calculate a cost settlement amount as follows:

All of the provider's annual billed Medicaid charges for FQHC services are divided by all of the provider's annual billed charges for FQHC services to calculate a Medicaid charge percentage. The Medicaid charge percentage is then multiplied by the provider's total annual allowable costs for FQHC services to calculate the provider's Medicaid allowable costs for FQHC services. The difference between the provider's Medicaid allowable cost for FQHC services and the total Medicaid payments made for FQHC services, including all quarterly interim payments, is the APM cost settlement amount.

The amounts billed for services cannot exceed the usual and customary charge to private pay patients.

b. **Prospective Payment System (PPS) Equivalent methodology**
The PPS payment equivalent is calculated in two parts. For FQHC services performed outside a hospital setting, that PPS equivalent is calculated by multiplying the provider's established PPS rate by the number of FQHC encounters that qualify for the PPS rate. For FQHC services performed in a hospital setting (e.g., deliveries), the amounts calculated for the PPS equivalent is the greater of PPS or the group practice fee-for-service amount for each procedure code (https://health.utah.gov/stplan/lookup/CoverageLookup.php).

Total Medicaid payments for FQHC services are subtracted from the sum of the total PPS payment equivalent (PPS payment equivalent for FQHC services provided inside a hospital + PPS payment equivalent for FQHC services provided outside of a hospital setting) to arrive at the settlement amount under the PPS payment methodology.

OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

c. The settlement amount calculated under the cost basis methodology is compared to the settlement amount calculated under the PPS equivalent methodology. The most advantageous settlement amount for the provider is the settlement amount that will be paid under this APM. If Medicaid over-paid, pay-back to the State of the settlement amount is required from the FQHC. If under-paid, a payment for the settlement amount will be made to the FQHC.

d. FQHCs electing the APM method may receive supplemental payment amounts which are estimated annually and paid quarterly to the FQHCs based on the difference between amounts paid by the MCEs and amounts the FQHCs are entitled to under the PPS.
   i. Quarterly interim payments will be made approximately thirty (30) days after the end of the quarter.
   ii. The quarterly amount may be less than the calculated amount if requested by the FQHC.

b. FQHCs located outside of Utah that serve Utah Medicaid clients

i. FQHCs located out-of-state that serve Utah Medicaid clients will be paid the PPS reimbursement rate applicable to the state in which services are provided.

ii. These FQHCs shall annually provide the PPS rate applicable to the FQHC to the Utah Medicaid agency's FQHC lead.

10. RURAL HEALTH CLINICS (RHCs)

a. RHCs are subject to the same provisions (Section 9 above) as FQHCs except for the Alternative Payment Methodology section which is not applicable to RHCs.

13. **PRIVATE HOSPITALS SUPPLEMENTAL PAYMENTS**

Privately-owned in-state hospitals shall be eligible to receive a supplemental payment for outpatient hospital services based on a reasonable cost methodology. Reasonable cost is determined using Medicare principles by applying a cost-to-charge ratio derived from the latest filed Medicare cost report to Medicaid claims data as described in #14 below. The UPL room equals the difference between reasonable costs adjusted for inflation and utilization trends and claims payments made pursuant to otherwise applicable methodologies as described on Page 1 of this Attachment. The supplemental payment pool each year shall be the lesser of the total UPL room for this class or the calculated total funds amount using a non-federal share amount equal to $3,777,777.78. The non-federal share amount will be used to generate additional matching Federal Funds. The total funds will be determined for each State Fiscal Year (SFY) by using a blended SFY FMAP rate for the SFY. The following example is for illustrative purposes only:

FFY	FMAP	Quarters	Extended
2018	0.7026	1	0.7026
2019	0.6971	3	2.0913
		Total	2.7939
		Quarters	4
		Blended FMAP (rounded)	0.6985
		Blended State Match Rate (BSMR) for SFY 2019	0.3015
		Non-federal share (NFS) amount	$3,777,777.78
		Total Funds (NFS/BSMR)	$12,529,942.89

Quarterly interim lump sum payments will be made that will each be equal to one-fourth of the total projected supplemental payment pool. Before making the first interim supplemental payment in a state fiscal year, the total projected supplemental payment will be calculated. Using data from the federal HCRIS database, the calculation uses recently filed and available cost reports with provider fiscal year end before the beginning of the state fiscal year for which the calculation is made and as available at the time the calculation is made.

The payments will be allocated to each hospital based on the proportion of the hospital's UPL room that is greater than zero with an increased proportion being given to rural hospitals. The annual payment allocation is divided into two sub-allocations. One allocation is only for rural hospitals and the other is for all hospitals. The allocations are calculated as follows:

Hospital's Annual Payment Allocation = Hospital's Base Allocation + Hospital's Rural Enhancement Allocation

Total Rural Enhancement Allocation = Supplemental Payment Pool x Historical Rural Enhancement Percent (579/544-1)

Total Base Allocation = Supplemental Payment Pool - Total Rural Enhancement Allocation

Hospital's Base Allocation Percent = (Hospital's UPL room that is greater than zero) / (Sum of all hospitals' UPL room that is greater than zero)

Hospital's Base Allocation = Total Base Allocation x Hospital's Base Allocation Percent

Only Rural Hospital's with UPL room greater than zero are included in the Rural Enhancement Allocation below:

Hospital's Rural Enhancement Allocation Percent = (Rural Hospital's Annualized Medicaid Payments) / (Sum of Annualized Medicaid Payments to All Rural Hospitals)
Hospital's Rural Enhancement Allocation = Total Rural Enhancement Allocation x Hospital's Rural Enhancement Allocation Percent

14. **UPL Calculation Overview**

For purposes of calculating the Medicaid outpatient hospital upper payment limits for hospitals, the state shall utilize hospital specific Medicare outpatient cost to charge ratios applied to Medicaid charges. The Medicaid upper payment limit for state hospitals and non-state government owned hospitals are independently calculated. Each Medicaid upper payment limit shall be offset by hospital Medicaid and other third party outpatient payments to determine the available spending room (i.e., the gap) applicable to each Medicaid upper payment limit. The base year utilized to determine each Medicaid upper payment limit shall be trended to the applicable spending year as follows:

- Inflation trend shall be an annual average calculated using the consumer price index available the December prior to the start of each state fiscal year for "Outpatient Hospital Services" as published by the U.S. Department of Labor, U.S. Bureau of Labor Statistics as compared to the previous December.

- Utilization trend shall be calculated using historical Utah Medicaid outpatient hospital services data. The utilization trend for State Fiscal Year 2023 shall be 7 percent.

Following is the data used to calculate the UPL for each state fiscal year:

Medicare Cost to Charge ratio:
- 2552-96: Costs are from Worksheet D, Part V, Columns 9, 9.01, 9.02, 9.03 line 104
- 2552-10: Costs are from Worksheet D, Part V, Columns 5, 6, and 7 line 202
- 2552-96: Charges are from Worksheet D, Part V, Columns 5, 5.01, 5.02, 5.03 line 104
- 2552-10: Charges are from Worksheet D, Part V, Columns 2, 3, 4 line 202

Note: As Medicare may amend the cost report structure from that noted above, corresponding Medicare Cost Report data will be used in place of the elements noted above.

The hospitals in the analysis have fiscal year ends during the state fiscal year

Medicaid Charges and payments - Paid hospital outpatient claims from services in a recent period and as available at the time the calculation is made.

Costs for critical access hospitals shall be calculated at 101 percent of cost with any appropriate inflation and utilization added as noted above.

C. LABORATORY AND RADIOLOGY SERVICES

Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed the usual and customary charge to private pay patients. Payment will not exceed the Medicare fee schedule as required by Section 2303 of P. L. 98-369.

D. PHYSICIANS (Except Anesthesiologists)

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

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D. PHYSICIANS (Except Anesthesiologists)(Continued)

7. ENHANCED PAYMENT RATES

Rural Areas
Physicians, including persons providing services under the direct supervision of a physician as allowed by state law, providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

University of Utah Medical Group
Physicians, including persons providing services under the direct supervision of a physician as allowed by state law, and practitioners (e.g., podiatrist, optometrist, dentist, covered independent nurse practitioners, physician assistants) employed by or associated with University of Utah Medical Group (UUMG) will be paid at a rate commensurate with the average commercial insurance professional rate (ACR) for services. Data used to calculate the ACR will be provided by UUMG based on paid commercial insurance claims for service dates in the previous calendar year.

ACR = (Reimbursement + Third Party Liability + Copayments) / (Total Charges)

The average Medicaid rate (AMR) is also calculated annually based on paid Medicaid claims for service dates in the previous calendar year.

AMR = (Reimbursement + Third Party Liability + Copayments) / (Total Charges)

In order to determine the total payment to UUMG, a rate differential is calculated prior to making any payments for the period. The rate differential will be effective for payments made between September 1st of that year and August 31st of the following year.

Rate Differential = ACR / AMR

Payment = (Rate Differential -1) x Medicaid Allowed Amount

(The *Medicaid Allowed Amount* is the Reimbursement Amount + Third Party Liability + Copayments, during the period under review for payment.)

Anesthesiologists employed by the University of Utah Medical Group will be considered part of this enhanced payment program, regardless of the anesthesiologist exception noted in this section [Section D, Physicians (Except Anesthesiologists)].

The rate differential payment made to the UUMG will be made as a separate annual, semi-annual, quarterly, monthly or any combination thereof payment to the UUMG on behalf of the physicians and practitioners employed based on the paid claims during the period under review for payment. If new or corrected information is identified that would modify the amount of a previous payment the department may make a retroactive adjustment payment in addition to previously paid amounts.

D. PHYSICIANS (Except Anesthesiologists)(Continued)

9. PAIN MANAGEMENT

Physicians may bill for consultations using the appropriate evaluation and management codes. Physicians and other primary care providers may provide chronic pain management services using the appropriate evaluation and management codes. Payment for services does not include facility fees.

A psychiatrist or licensed clinical psychologist may provide the comprehensive psychiatric or psychological evaluation using the appropriate service codes. Effective October 1, 2009, physician consultations and ongoing chronic pain management services are no longer reimbursed an enhanced rate. The agency's fee schedule rate for medical services was set as of May 25, 2009, and is effective for services on or after that date.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.

All rates are published at http://health.utah.gov/medicaid/.

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Notes: The Medicare rates used will only be updated for each January 1 to reflect the then current Medicare rates. The state uses the Deloitte Medicare fee schedule. Additionally, Utah has only one Medicare GPCI.

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19-B, Section D Physician Services, of the State Plan and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

The supplemental calculation is made as follows for each qualifying provider after the end of each quarter and excludes the University of Utah Medical Group providers that are paid at the Average Commercial Rate:

1. By servicing provider, by claim line for qualifying billing codes, identify allowed units and allowed amounts through the claim system for qualifying E&M billing codes paid during the quarter.
2. By servicing provider, by claim line for qualifying billing codes, calculate the sum of the payments that would have been paid for the qualifying codes and the Medicare rate effective as of January 1 of the calendar year in which the service was incurred (Total Allowed Units x Medicare Rate).
3. By servicing provider, by claim line for qualifying billing codes, calculate the difference between step 2 and step 1 (step 2 result less step 1 result).
4. By billing provider, the sum difference calculated in step 3 will be paid after the end of each quarter.

The calculation for the 100 percent federal match will be based on the difference between the Medicare rate effective as of January 1 of the calendar year in which the service was incurred and the Medicaid rates in effect on July 1, 2009. This calculation will exclude any FFP already claimed when the base payments were made to the provider; to the extent those base payments were greater than the July 1, 2009 rate. The 2009 base rate for codes not covered in 2009 but subsequently added will be $0.
In addition to the quarterly payments, if an audit or review reveals an overpayment or underpayment, then recoveries or additional payments will also occur.

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
☒ This payment applies to all covered Evaluation and Management (E&M) billing codes 99201 through 99499 except the following codes for which the State did not make payment as of July 1, 2009 and will not make enhanced payments under this SPA (with the exception of coverage of Medicare Crossover claims):

99224 (1/1/11)	99340	99380	99408	99450
99225 (1/1/11)	99360	99386	99409	99455
99226 (1/1/11)	99363	99397	99412	99456
99239	99364	99401	99420	99485 (1/1/13)
99288	99374	99402	99429	99486 (1/1/13)
99315	99375	99403	99441	99487 (1/1/13)
99316	99377	99404	99442	99495 (1/1/13)
99318	99378	99406	99443	99496 (1/1/13)
99339	99379	99407	99444	

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009:

90460 (1/1/11)	99359 (9/1/11)	99368 (9/1/11)	99466 (9/1/11)	99489 (1/1/13)
90461 (1/1/11)	99366 (9/1/11)	99387 (1/1/14)	99467 (9/1/11)	
99358 (9/1/11)	99367 (9/1/11)	99396 (1/1/14)	99488 (1/1/13)	

Physician Services – Vaccine Administration Related to VFC

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

Method of Payment

The supplemental calculation is made as follows for each qualifying provider after the end of each quarter and excludes the University of Utah Medical Group providers that are paid at the Average Commercial Rate:

1. By servicing provider, by claim line for qualifying VFC billing codes, identify allowed units and allowed amounts through the claim system for qualifying VFC billing codes paid during the quarter.
2. By servicing provider, by claim line for qualifying VFC billing codes, calculate the sum of the payments that would have been paid for the qualifying codes during the covered quarter at the state regional maximum administration fee set by the VFC program ($20.72 from the table in the final rule) (Total Allowed Units x Current Medicare Rate).
3. By servicing provider, by claim line for qualifying VFC billing codes, calculate the difference between step 2 and step 1 (step 2 result less step 1 result).
4. By billing provider, the sum difference calculated in step 3 will be paid to providers after the end of each quarter.

The calculation for the 100 percent federal match will be based on the difference between the state regional maximum administrative fee, as noted above, effective for the service date and $8.37 which is the imputed rate for code 90460. This calculation will exclude any FFP already claimed when the base payments were made to the provider; to the extent those base payments were greater than the July 1, 2009 rate. The 2009 base rate for codes not covered in 2009 but subsequently added will be $0.

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $8.37.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014. Payments will continue while timely filing applies for all services rendered during the time period noted above.
All rates are published at:

http://health.utah.gov/medicaid/stplan/physician.htm.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. Payments will continue while timely filing applies for all services rendered during the time period noted above.
All rates are published at:

http://health.utah.gov/medicaid/stplan/physician.htm.

E. ANESTHESIOLOGIST/ANESTHETIST

1. INTRODUCTION

Payment is based on the lower of billed usual and customary charges or a calculated fee.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

2. CALCULATED FEE

Payment = (Basic Value + Time Values + Modifying Factors) x Conversion Factor.

Time Values are added to the basic value at the rate of one unit for each twelve minutes or fraction thereof.

Rural Areas: Anesthesiologists/Anesthetists providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

*Physical status modifiers and similar to account for various levels of complexity.
**The conversion factor is published at:
http://health.utah.gov/medicaid/stplan/physician.htm

E. ANESTHESIOLOGIST/ANESTHETIST (Continued)

2. CALCULATED FEE (Continued)

Obstetrical Anesthesia

Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there will be a reduction in the unit value after the first hour of anesthesia time. During the second hour of anesthesia, the unit value will be reduced by 50%. During the third and each succeeding hour of anesthesia, the unit value will be reduced by 75%.

Modifying Units

Modifying units may be added to the basic value where increased risk and special technical skills are involved or necessary for extremes of age (under one year or over 70 years), two modifying units may be added.

a. When anesthesia is administered under extenuating circumstances away from the operating room suite, two modifying units may be added.

b Utilization of total body hypothermia, five units may be added.

c Utilization of controlled hypotension, five units may be added.

F. PODIATRISTS

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of podiatric services. The amount billed cannot exceed usual and customary charges. The agency's rates were set in accordance with the methodology described in Section D “Physicians,” and are effective for services on or after the date noted in Section D.

Payments for covered podiatric services are based on the established fee schedule unless a lower amount is billed. All rates are published on the agency's website at http://health.utah.gov/medicaid/.

G. OPTOMETRISTS

Optometrists use the physicians fee schedule described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

H. EYEGLASSES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

I. PHYSICIAN ASSISTANT

Approved procedure codes may be directly billed by a licensed physician assistant (PA). Payment for approved services will be made at the lower of the usual and customary charge or the established physician's fee schedule. The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services. The agency's rates were set in accordance with the methodology described in Section D "Physicians", and are effective for services on or after the date specified in Section D. Payments for covered audiology services are based on the established fee schedule unless a lower amount is billed. All rates are published on the agency's website at http://health.utah.gov/medicaid/.

Rate Adjustment for Rural Areas

Physician Assistants providing services in rural areas of the state are paid a rate differential equal to 112 percent of the physician assistant fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake and Utah counties.

Billing Arrangements

When service is provided by a licensed PA employed and working under supervision in a group practice, private office, community health center, or local health department, the supervising provider shall bill for the service according to their usual and customary fee schedule.

When service is provided by a licensed PA working in a private independent practice, the licensed PA shall bill according to their usual and customary fee schedule.

J. HOME HEALTH SERVICES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

RURAL AREA EXCEPTIONS

Where travel distances to provide service are extensive, enhancements in the home health reimbursement rates are provided. These enhancements are available only in rural counties where one way travel distances from the provider's base of operations are in excess of 25 miles. Rural counties are defined as counties other than Weber, Davis, Salt Lake, and Utah counties. In instances of travel of 50 miles or more, the Home Health fee schedule is multiplied by 1.75 to calculate the payment rate for applicable service codes.

SAN JUAN and GRAND COUNTIES EXCEPTION

To assure continued access to home health services for residents of San Juan County and Grand County, enhancements in home health reimbursement rates are provided. Effective July 1, 2007, for services provided in San Juan County and Grand County, the home health fee schedule is multiplied by 4.08 and 2.95, respectively, to calculate the payment rate for applicable service codes. These enhancement factors are applied irrespective of the distances traveled to provide these services and are in lieu of the rural area exceptions provided for other rural counties. Additionally, to compensate providers for delivering home health services in more remote areas, Medicaid payment is based upon a modifier for the two following zones:

Zone 1: For Aneth and Hatch Trading Posts, and Mexican Hat and Montezuma Creek residents or eligibles, Home Health Agency (HHA) services are billed under Modifier "UA" and mean that a factor or multiplier of 7.12 is applied (multiplied) by the existing HHA fee schedule.

Zone 2: For Monument Valley residents or eligibles, HHA services are billed under Modifier "UB" and mean that a factor or multiplier of 15.02 is applied (multiplied) by the existing HHA fee schedule.

K. MEDICAL SUPPLIES AND EQUIPMENT

State-developed fee schedule rates are the same for both governmental and private providers. Payment are based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after July 1, 2022. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

In order to ensure access to care, for certain durable medical equipment (DME), Medicaid pays the rate established by the state agency through a competitive bidding process. Utah meets the certification requirements of Section 1902(a)(23) of the Social Security Act to permit the selection of one or more providers, through a competitive bidding process, to provide oxygen concentrators and apnea monitors on a statewide basis under the authority of Section 1915(a)(1)(B) of the Social Security Act and 42 CFR 431.54(d).

Rates for DME having a Medicare DME rate are set at 82.47% of the lessor of the Medicare rural, non-rural, and competitive bidding area rates.

HCPCS codes related to medical supplies and DME, classified as either miscellaneous or not otherwise specified, are reimbursed the provider's invoice cost plus 20% over invoice cost plus shipping. ((Invoice Cost X 1.2) + Shipping)

K. MEDICAL SUPPLIES AND EQUIPMENT (Continued)

Deleted 10-1-19

L. CLINIC SERVICES

Clinic services are paid differently depending on the type of services rendered. Such payments are limited to the amount paid by Medicare as specified in 42 CFR 447.321. Subject to these limitations, payments are determined as follows:

L. CLINIC SERVICES (Continued)

1. Dialysis Clinics -- Payment for renal dialysis is based on the established fee schedule unless a lower amount is billed. The amount billed shall not exceed usual and customary charges. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

   Effective for services on or after April 1, 2016, the payment for dialysis claims will be Medicare's ESRD PPS Base Rate. All rates are published on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published as follows:

   http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

L. CLINIC SERVICES (Continued)

2. Surgical Centers -- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

MULTIPLE AND BILATERAL PROCEDURES
The primary surgical procedure with the highest payment rate is paid based on 100% of the established Medicaid fee. The second highest payment rate is paid based on 50% of the established fee schedule. Payment for the other lower payment rates is made at 25% of the established fee schedule for multiple and bilateral procedures. When CPT modifiers are used, the rate is adjusted for CPT modifiers before the percentages are applied for multiple units billed for designated procedure codes to pay at 100% of the established Medicaid fee schedule.

L. CLINIC SERVICES (Continued)

3. Alcohol and Drug Clinics

Deleted July 1, 2015

Deleted July 1, 2015

M. DENTAL SERVICES AND DENTURES

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Enhanced Payments

Urban Counties

As an incentive to improve client access to dental services in urban counties (Weber, Davis, Salt Lake, and Utah counties), dental providers (excluding state-funded clinics) willing to sign an agreement to see 100 or more clients during the next year will be reimbursed at the lesser of billed charges or 120 percent of the established fee schedule.

Rural Counties

As an incentive to improve client access to dental services in rural counties (all counties except Weber, Davis, Salt Lake, and Utah), dental providers in these counties including state-funded clinics will be reimbursed at the lesser of billed charges or 120 percent of the established fee schedule.

M. DENTAL SERVICES AND DENTURES (Cont.)

Deleted 7-1-19

N. PHYSICAL THERAPY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

OCCUPATIONAL THERAPY

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

O. PROSTHETIC DEVICES AND BRACES

Payments are based on the established fee schedule unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Fees are established by discounting historical charges, by professional judgment and by discounting published price lists.

P. SPEECH PATHOLOGY

The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

Q. AUDIOLOGY

The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

R. TRANSPORTATION

1. Ambulance – Payment will be made on an established Medicaid fee schedule. The fee schedule will include base rate, mileage rate, oxygen fee and waiting time. The fee schedule will include both ground, air and water transportation.

   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

2. Special Services – These include Para-Transit, Ambucar, Servicar, and other specialized/similar transportation services. Payment will be the lower of the usual and customary charge or the established fee schedule for Medicaid.

   Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

3. Bus Service – Payment will be the rates established by contract between the provider and Medicaid. If there is no contract, payment will be the same as the fares paid by the general public.

4. NEMT Brokerage Contracted services – Payment is based on the contracted capitated rate derived from a competitive bidding process.

S. PRESCRIBED DRUGS

Covered outpatient drugs will be reimbursed based on an established product cost plus a professional dispensing fee. The payment for individual prescriptions shall not exceed the amount billed. The amount billed must be no more than the usual and customary charge (U&C) to the private pay patient. The following methodology is used to establish Medicaid payments:

Effective for claims adjudicated on or after April 1, 2017, except as otherwise stated in this section and in addition to a reasonable professional dispensing fee as applicable, reimbursement for brand and generic covered outpatient drugs will be as follows:

The lesser of the Utah Estimated Acquisition Cost (UEAC), Federal Upper Limit, National Average Drug Acquisition Cost (NADAC), Utah Maximum Allowable Cost (UMAC), or the Ingredient Cost Submitted.

Federal Upper Limit

The federal upper limit is the maximum allowable ingredient cost reimbursement established by the Federal government (e.g., Centers for Medicare and Medicaid Services (CMS) for selected multiple-source drugs. The aggregate cost of product payment for the drugs on the federal upper limit list will not exceed the aggregate established by the Federal government.

Utah MAC

Utah MAC is the Maximum Allowable Cost reimbursement established by the State for selected drugs.

S. PRESCRIBED DRUGS (Continued)

Utah Estimated Acquisition Cost (UEAC)

The Utah EAC is the Wholesale Acquisition Cost (WAC).

Professional Dispensing Fees

The Utah Medicaid professional dispensing fees are as follows:

1. $9.99 for urban pharmacies located in Utah;

2. $10.15 for rural pharmacies located in Utah;

3. $9.99 for pharmacies located in any state other than Utah; and

4. $716.54 for hemophilia clotting factor.

Urban pharmacies are pharmacies physically located in Weber, Davis, Utah and Salt Lake counties.

Drugs Dispensed by IHS/Tribal facilities

Covered outpatient drugs dispensed by an IHS/Tribal facility to an IHS/Tribal member are reimbursed at the encounter rate in accordance with the Utah Medicaid Indian Health Services Provider Manual.

Specialty Drugs and Covered Outpatient Drugs Primarily Dispensed through the Mail

Specialty drugs and covered outpatient drugs primarily dispensed through the mail are reimbursed in the same manner as other covered outpatient drugs in accordance with the reimbursement rules of this section.

S. PRESCRIBED DRUGS (Continued)

Covered Outpatient Drugs Purchased Through the 340B Program

Covered entities that purchase covered outpatient drugs through the 340B program and used the 340B covered outpatient drugs to bill Utah Medicaid are required to submit the 340B acquisition cost on the claim and identify the medications as being purchased through the 340B by using the Submission Clarification Code = '20' or 'UD' modifier.

Payment for covered outpatient drugs purchased through the 340B program will be the lesser of the 340B acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

Payment for covered outpatient drugs not purchased through the 340B program are to be submitted, and reimbursed, in accordance with the reimbursement rules under this section.

340B covered entities may not utilize contract pharmacies to bill Utah Medicaid unless the covered entity, contract pharmacy, and State Medicaid agency have a written agreement in place to prevent duplicate discounts.

Federal Supply Schedule

Providers that purchase covered outpatient drugs through the Federal Supply Schedule (FSS) and use the covered outpatient drugs to bill Utah Medicaid are required to submit the FSS acquisition cost on the claim, unless the reimbursement is made through a bundled charge or all-inclusive encounter rate.

Payment for covered outpatient drugs purchased through the FSS will be the lesser of the FSS acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

Payment for covered outpatient drugs not purchased through the FSS are to be submitted, and reimbursed, in accordance with the reimbursement rules of this section.

Nominal Price

Providers that purchase covered outpatient drugs at Nominal Price and use the covered outpatient drug to bill Utah Medicaid are required to submit the acquisition cost on the claim.

Payment for covered outpatient drugs purchased at Nominal Price will be the lesser of the Nominal Price acquisition cost plus a professional dispensing fee, as applicable, or the billed charges.

S. PRESCRIBED DRUGS (Continued)

Covered Outpatient Drugs not Dispensed by a Retail Community Pharmacy

Covered outpatient drugs not dispensed by a retail community pharmacy are reimbursed in the same manner as other covered outpatient drugs in accordance with the reimbursement rules of this section.

Provider Administered Drugs

Covered provider administered drugs will be reimbursed according to the Average Sale Price (ASP) Drug Pricing File, published quarterly by the Centers for Medicare and Medicaid Services (CMS), for drugs that have an ASP price set by CMS.

Covered provider administered drugs for which CMS does not publish an ASP price will be reimbursed in accordance with the Utah Medicaid fee schedule published on Medicaid's Coverage and Reimbursement Code Look-up Tool.

Investigational Drugs

Investigational drugs are not covered by Utah Medicaid.

LICENSED CERTIFIED REGISTERED NURSE-MIDWIFE SERVICES

Payments are based on the established fee schedule for selected HCPCS codes unless a lower amount is billed. Selected HCPCS codes are established in compliance with HIPAA requirements. The amount billed cannot exceed usual and customary charges to private-pay patients. Payment for registered nurse-midwife services includes the physician's collaboration fee for the co-management of the case.

Rate Adjustment for Rural Areas

Effective October 1, 1991, licensed certified registered nurse-midwives who provide services in rural areas of the State will be paid the lower of usual and customary charges or rate equal to 112% of the established Medicaid fee schedule. Rural areas are defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

NURSE PRACTITIONERS (NP)

Approved procedure codes may be directly billed by a licensed nurse practitioner (NP). Payment for approved services will be made at the lower of the usual and customary charge or the established physician's fee schedule. The fees are established by using the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of these services. The agency's rates were set in accordance with the methodology described in Section D "Physicians", and are effective for services on or after the date specified in Section D. Payments for covered audiology services are based on the established fee schedule unless a lower amount is billed. All rates are published on the agency's website at http://health.utah.gov/medicaid/.

Rate Adjustment for Rural Areas

The 12% rate differential, not to exceed usual and customary charges, will be paid for services rendered in rural Utah. Rural Utah is defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.

Billing Arrangements

When service is provided by a licensed NP employed and working under supervision in a group practice, private office, community health center, or local health department, the supervising provider shall bill for the service according to their usual and customary fee schedule.

When service is provided by a licensed NP working in a private independent practice, the licensed NP shall bill according to their usual and customary fee schedule.

TARGETED CASE MANAGEMENT SERVICES

Targeted Case Management services for pregnant women are paid based on the established fee schedule for one month of service. Payment is limited by the usual and customary charges of the providers.

TARGETED CASE MANAGEMENT – INDIVIDUALS WITH SERIOUS MENTAL ILLNESS

This payment plan covers targeted case management services for individuals with serious mental illness.

Targeted case management services are paid using a uniform fee schedule. Services are defined by HCPCS code and prices using a fixed fee schedule. Payments are made to providers on a fee-for-service basis for defined units of service. The service unit is a 15-minute unit. The state-developed fee schedule rate is the same for both governmental and private providers. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. Fee schedule payments are based on the established fee schedule unless a lower amount is billed. All rates are published at http://health.utah.gov/medicaid/.

Deleted September 1, 2015

Targeted Case Management – Substance Abuse

Payment for targeted case management services to clients with a substance abuse disorder will be made on a fee-for-service basis to qualified providers. Medicaid payments will be the lesser of (1) the billed usual and customary charges to the general public; or (2) the established fee schedule.

TARGETED CASE MANAGEMENT SERVICES FOR MEDICAID HMO ENROLLEES AND POTENTIAL ENROLLEES

Total reimbursement for targeted case management services for HMO enrollees is based on historical cost adjusted annually (effective July 1) based on Legislatively approved cost of living and merit increases.

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PRESUMPTIVE ELIGIBILITY/EXPANDED PRENATAL SERVICES

Payments are based on the established fee schedule for the defined services unless a lower amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. Reimbursement methodology is based on the established fee schedule for the defined services described in other sections of ATTACHMENT 4.19-B.

PERSONAL CARE SERVICES

Medicaid payments for personal care services will be based on a fee schedule unless a lower amount is billed. Fees will be established based on the historical cost adjusted by economic trends and conditions. Providers must bill their usual and customary fees.

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES

This payment plan covers rehabilitative mental health and substance use disorder services (hereinafter referred to as mental health services).

Rehabilitative mental health services are paid using a uniform fee schedule. Services are defined by HCPCS codes and prices using a fixed fee schedule. Payments are made to providers on a fee-for-service basis for defined units of service. The state-developed fee schedule rates are the same for both governmental and non-governmental providers.

The agency's fee schedule rates for mental health services are effective for services provided on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/stplan/lookup/CoverageLookup.php. Fee schedule payments are based on the established fee schedule unless a lower amount is billed.

Bundled Payments

Assertive Community Treatment (ACT)

All rehabilitative mental health services and targeted case management services for individuals with serious mental illness contained in ATTACHMENT 3.1-A and ATTACHMENT 3.1-B are included in the bundled rate. Reimbursement is based on a monthly service unit. At least one service must be provided during the service unit in order to bill the bundled rate.

Mobile Crisis Outreach Team (MCOT)

Rehabilitative mental health services included in the bundled rate are psychiatric diagnostic evaluation, mental health assessment, psychotherapy for crisis, and peer support services. Reimbursement is made on a per diem basis. At least one service must be provided by the team during the service unit to bill the bundled rate.

The billing providers for ACT and MCOT are generally community mental health centers or other entities with ACT or MCOT teams, or the billing provider is the defined team lead.

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

Substance use disorder (SUD) residential treatment programs with 16 or fewer beds

All rehabilitative mental health services and targeted case management services for individuals with serious mental illness contained in ATTACHMENT 3.1-A and ATTACHMENT 3.1-B are included in the bundled rate. Reimbursement is made on a per diem basis. At least one service must be provided during the service unit to bill the bundled rate. The bundled payment rate does not include room and board or other unallowable facility costs.

Receiving Centers

Receiving centers provide services to address mental health and substance use crisis issues. Rehabilitative mental health services included in the bundled rates are psychiatric diagnostic evaluations, mental health assessments, services of licensed mental health therapists (generally the psychotherapy for crisis service), pharmacologic management (evaluation and management services), nurse medication management services, peer support services, therapeutic behavioral services, psychosocial rehabilitative services, and targeted case management services for individuals with serious mental illness. These rehabilitative services and targeted case management services for individuals with serious mental illness are contained in ATTACHMENT 3.1-A and ATTACHMENT 3.1-B. Reimbursement is made on a per diem basis. At least one service must be provided during the service unit to bill the bundled rate. The bundled payment rate does not include room and board or other unallowable facility costs. The billing providers are community mental health centers or other entities with a receiving center.

There will be two bundled rates. The more intensive rate applies to receiving centers that serve as a psychiatric emergency department. These receiving centers have more intensive physician staffing and the capability to provide psychiatric and medical triage and evaluations. A psychiatrist or other physician is onsite at all times, with a psychiatrist available for consultation when not onsite. These facilities also have licensed mental health therapists onsite at all times, and additional psychiatric tech-level staff to ensure safety of clients due to potential for individuals with higher acuity mental health disorders.

The less intensive rate applies to community mental health centers' receiving centers or other receiving centers that do not meet the more intensive criteria. These receiving centers provide less intensive physician coverage. A psychiatrist, or psychiatric nurse practitioner may be used and must be available via telehealth but is not required to be onsite. The licensed mental health therapist is not required to be onsite at all times but may be off-site during graveyard hours, if they can respond on-site within an average response time of 30 minutes.

The receiving centers will keep records necessary to disclose the extent of services furnished and will, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the receiving center for furnishing services under the plan.

MENTAL HEALTH DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

This documentation includes the date of service at the receiving center, recipient name, Medicaid identification number, name of provider entity and name of provider providing the service, units of service and place of service. For each service provided to the recipient while at the receiving center, the provider of service will document the date of service, the name of the service provided, the unit(s) of service, a summary of the service provided, and signature and credentials.

Mental health residential treatment programs with 16 or fewer beds for individuals 21 years of age or older

All rehabilitative mental health services and targeted case management services for individuals with serious mental illness contained in ATTACHMENT 3.1-A and ATTACHMENT 3.1-B are included in the bundled rate. Reimbursement is made on a per diem basis. At least one service must be provided during the service unit to bill the bundled rate. The bundled payment rate does not include room and board or other unallowable facility costs.

Clinically Managed Residential Withdrawal Management (Social Detoxification)

Social detoxification residential programs provide peer and social support services to members with substance use disorders who need help to safely withdraw from substances. These members are medically stable, and therefore do not require inpatient hospital level of treatment for withdrawal management. Rehabilitative mental health services included in the bundled rate are psychosocial rehabilitative services, peer support services, and targeted case management services for individuals with serious mental illness. These rehabilitative services and targeted case management services for individuals with serious mental illness are contained in ATTACHMENT 3.1-A and ATTACHMENT 3.1-B. Reimbursement is made on a per diem basis. At least one service must be provided during the service unit to bill the bundled rate. The bundled payment rate does not include room and board or other unallowable facility costs.

All Bundled Rates

No outpatient drugs defined in Section 1927(k) of the Social Security Act are included in any of the payment bundles.

Providers delivering services through the bundled rates will only be paid through that bundle's payment rate and may not be paid separately for services included in the bundle. Medicaid providers delivering separate services, outside of the bundle, may bill for those separate services in accordance with the State's Medicaid billing procedures.

The agency's fee schedule rates for rehabilitative mental health services are effective for services provided on or after the date listed on the ATTACHMENT 4.19-B Introduction Page. These rates are published at http://health.utah.gov/stplan/lookup/CoverageLookup.php. Fee schedule payments are based on the established fee schedule unless a lower amount is billed. The rates are the same for both governmental and private providers.

OTHER DIAGNOSTIC, PREVENTIVE, SCREENING, AND REHABILITATIVE SERVICES

Poison Control Center

Payment for the State Poison Control Center will be in the amount established by contract between the Division of Family Health Services and the Division of Health Care Financing. This contract will be renegotiated annually based on the estimated percentage of Medicaid eligibles in the population served by the Center.

Diabetes Self-Management Training

Payments for approved Diabetes Self-Management Training are based on the established fee schedule, unless a lower amount is billed.

PAYMENT FOR PRIVATE DUTY NURSING

Payment for private duty nursing provided to ventilator-dependent individuals will be calculated by multiplying the fixed hourly rate for each level of nursing (RN or LPN) by the number of hours authorized by the Medicaid agency. Payments will not exceed the usual and customary charges to private-pay patients.

PAYMENT FOR HOSPICE SERVICES

Medicaid payments for hospice services will be made at one of five predetermined rate categories that coincide with the categories established under Medicaid. The Medicaid hospice rates will be equal to the Medicaid hospice rates published annually by the Centers for Medicare and Medicaid Services (CMS). Additionally, the hospice payments will be adjusted to specify the differences in the hospice wage index as published by CMS. For each day that an individual is under the care of a Medicaid-certified hospice agency, the hospice agency will be paid in accordance with the established Medicaid fee schedule. Payment rates are based on the type and intensity of the services furnished to the individual for a given day according to one of the following levels of care: routine home care, continuous home care, inpatient respite care, or general inpatient care. All of these levels of care are paid on a per diem basis other than continuous home care that is paid on an hourly basis. Routine home care services are divided into two discrete levels of care that include: Routine Home Care, Days 1-60; and Routine Home Care, 61+. Payments are made according to the area in which the service was provided, not according to the billing office location. Payment to the hospice agency may be considered retroactive to allow the hospice eligibility date to coincide with the Medicaid eligibility date, if the hospice service met the prior authorization criteria at the time service was delivered, and if no other provider was reimbursed by Medicaid for care related to the individual's terminal illness. The hospice agency must provide documentation to the Medicaid agency that demonstrates its service met all prior authorization criteria at the time of delivery.

Concurrent Care for Recipients Under 21 Years of Age

Concurrent treatment allowed under the State Plan for a terminal illness and other related conditions is available to recipients who are under 21 years of age and elect to receive Medicaid hospice care. For life-prolonging treatment provided to these recipients, Medicaid shall reimburse the appropriate Medicaid-enrolled medical care providers directly through the usual and customary Medicaid billing procedures.

Agency Services Delivered in Conjunction with Nursing Home Services

For a recipient in a nursing facility, Intermediate Care Facility for Individuals with Intellectual disability (ICF/ID), or freestanding hospice inpatient facility who elects to receive hospice service from a Medicare-certified hospice agency, Medicaid will pay the hospice agency an additional per diem (for routine home care days only) to cover the cost of room and board in the nursing facility. The room and board rate will be 95 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider (facility/provider "specific rate") if the recipient had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95 percent of the statewide average paid by Medicaid for nursing facility services.

For a recipient who is under 21 years of age, the room and board rate will be 100 percent of the amount that Medicaid would have paid to the nursing facility or ICF/ID provider if the recipient had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 100 percent of the statewide average paid by Medicaid for nursing facility services. With the election to receive hospice services, Medicaid payment to the nursing facility discontinues and the hospice agency pays the nursing facility the cost of room and board. In this context, room and board costs are for the performance of personal care services that include daily living assistance, social activities, administration of medication, room maintenance, supervising and assisting in the use of durable medical equipment and prescribed therapies, and other services associated with a nursing home inpatient stay. The hospice provider is responsible for passing the room and board payment through to the nursing facility.

PAYMENT FOR HOSPICE SERVICES (Continued)

Service Intensity Add-On

Effective for dates of service on and after January 1, 2016, Medicaid hospice providers may receive a Service Intensity Add-On payment (SIA) for client's receiving routine home care by the registered nurse and the clinical social worker during the last seven days of the recipient's life. The SIA payment is provided under the following conditions:

1) SIA payment is provided in addition to the routine home care rate.

2) To qualify for SIA payment, the SIA visit must be a minimum of 15 minutes but not more than four hours combined for both nurse and social worker per day.

3) SIA rates will be equal to the rates established by CMS for each geographical area of the state. The SIA payment amount is calculated by multiplying the Continuous Home Care (CHC) rate per 15 minutes by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

Limitation for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning October 1 of each year and ending September 30 (cap period), the aggregate number of inpatient days (both for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied on an agency-wide basis and is not applied to individual patient stay services. At the end of each cap period, the Department calculates a limitation on payment of inpatient care for each hospice, to ensure that Medicaid payment is not made for days of inpatient care (including inpatient respite and general inpatient care) that exceed 20 percent of the total number of days of hospice care furnished to Medicaid recipients. The hospice agency then repays the Medicaid program a "prorated" share of total inpatient payment. This repayment will be computed as follows: [("Excess" Medicaid inpatient days/total paid Medicaid inpatient days) X (payment rate per diem)]. The inpatient care limitation does not apply to individuals with AIDS or to individuals who are under 21 years of age and receiving life-prolonging treatment for a terminal illness.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

Unless otherwise indicated below, payment for EPSDT services is based on the established fee schedule unless a lower amount is billed.

Orthodontic Services

A fixed fee is paid for attaching the approved orthodontic appliance. In addition, a fixed fee is paid every three months for maintenance service. The maximum number of payments for maintenance is eight quarterly payments. Total payments for the appliance and for the maintenance service are limited to usual and customary charges.

Diagnostic, Preventive, Screening, and Rehabilitative Services

Skills Development Services---

A. Reimbursement Methodology for School Based Skills Development Services

School Based services, known as School Based Skills Development Services (SDS) in Utah, are delivered by the school districts, charter schools, and public K-12 educational institutions (hereinafter referred to as "Local Education Authorities" or "LEAs" for A through H of this section), and include the following Medicaid 1905(a) services:

- Nursing Services;
- Personal Care Services;
- Psychology Services;
- Counseling Services;
- Social Work Services;
- Orientation, Mobility, and Vision Services;
- Speech Language Services;
- Audiology Services;
- Occupational Therapy (OT);
- Physical Therapy (PT)

All costs described within this methodology are for Medicaid services provided by qualified personnel or qualified health care professionals who have been approved under Attachments 3.1-A and 3.1-B of the Medicaid State Plan.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

B. Direct Medical Payment Methodology

LEAs will be paid on a cost basis. LEAs will be reimbursed monthly interim rates based on reported annual costs for rendering SDS direct medical services. On an annual basis a LEA specific cost reconciliation and cost settlement for all over and under payments will be processed.

1. Participating SDS LEAs are reimbursed interim payments based on a monthly calculated rate. Interim payments under the SDS Program are calculated prior to the school year beginning and are divided into twelve equal monthly installments, to be paid July 1 through June 30. Interim payments shall be tied to claim submissions by the LEA.
    a. For the 2021-22 school year, the interim rates were calculated based on the LEA's reported costs from the 2019-20 school year.
    b. For the 2022-23 school year, the interim rates were calculated using the cost data for the direct service cost pools from the October-December 2021 quarterly financial submissions for the administrative claims.
    c. For the 2023-24 and subsequent years, the interim rates shall be based on the LEA's actual, certified costs identified in their most recently filed annual cost report from the prior fiscal year.
    d. For a new participating LEA, the interim rate shall be calculated based on statewide historical data.
    e. When an LEA's Total Medicaid Allowable Cost amount has been calculated following the processes defined in the following sections, the amount is then divided by 12 to arrive at a monthly rate figure. These monthly rates will be implemented to support the interim payments for the following fiscal year. Each LEA will have their own monthly rate inclusive of their Medicaid Allowable Costs for both of the direct service cost pools.
    f. The LEA is then given the option to request that the monthly amount be paid at either 80% or 90% of the total calculated amount. The percentage is applied in an effort to minimize LEA overpayments.
    g. A cost reconciliation and cost settlement is completed annually as described in Sections G and H. If an LEA's total monthly interim payments for the year exceed their costs to render services, the LEA will be invoiced the difference and the state will recoup the amount. If the total amount of monthly interim payments for the year is less than what the LEA's costs were to render services, the LEA will be reimbursed the difference.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

2. LEAs will continue to submit claims for Medicaid covered services rendered, but will not be paid for claim charges. All claims will be submitted to Medicaid with a $.00 charge. LEAs will only be paid through the monthly interim payment.

C. Data Capture for the Cost of Providing School Based Skills Development Services

Data capture for the cost of providing SDS will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
   a. SDS cost reports received from LEAs;
   b. Utah State Board of Education (USBE) Unrestricted Indirect Cost Rate (UICR);

      i. The unrestricted indirect cost rate is derived from costs having to do with administrative, overhead maintenance and other support services. Staff included on the LEA's staff pool list are not paid from these areas.

      ii. LEAs are specifically instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures. This ensures that there is no duplication of costs for indirect rates.

      iii. Some LEAs do not have a calculated USBE Unrestricted Indirect Cost Rate (UICR). For those that do not have one calculated, a de minimis rate of 10% will be charged to Medicaid. All LEAs with a calculated UICR will use their calculated rate.

   c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services) and Activity Code 10 (General Administration):

      i. Direct Medical IEP activity code is accounted for in the annual cost settlement report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

      ii. General Administration code 10 is accounted for in both the quarterly Medicaid Administrative Claim as well as the annual Cost Reconciliation and Cost Settlement.

         a. General Administrative code 10 is a General Administrative Overhead Factor and is calculated to determine the amount of time that is eligible for reimbursement in the MAC Claim. General Administration is distributed to the reimbursable code based on the percentage of total time as dictated by the Random Moment Time Study.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

b. General administrative code 10 is also accounted for in the annual cost report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

iii. The resulting direct medical service percentages will be specific to each cost pool and reflected as a statewide average.

d. LEA specific Medicaid Enrollment Ratio (MER):

i. For the purposes of the annual cost reconciliation and cost settlement process, the Medicaid Enrollment Ratio (MER) is referred to as the Medicaid IEP Ratio. This IEP Ratio is unique to each participating LEA and is used to apportion the Total Direct Medicaid Service costs between Medicaid and non-Medicaid. The ratio will be calculated based on a December 1 student count with the numerator reflecting the total number of students with a covered medical service in their IEP that are Medicaid enrolled and the denominator reflects the total number of all students with a covered medical service in their IEP.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs in Utah Administrative Code. These direct costs will be calculated on a LEA specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. These direct costs are accumulated on the annual School Based Skills Development Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been reviewed by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the State of Utah. Costs will be reported on an accrual basis.

a. Medically related purchased services include contracted services. LEAs report the amounts they pay to contracted providers as salaries. Benefits are not reported by the LEA for contracted staff.

i. The USBE's Unrestricted Indirect Cost Rate is multiplied by the sum of the LEA's total regular staff salaries and the total contracted salaries.

b. Medicaid Direct Medical Service costs are funded by the state and local dollars. Any expenditures that are fully paid for using federal funds will be removed from the cost report. Expenditures that are partially funded by federal funds will be reduced by the amount of federal funds. Only the portion of expenditures paid for with state or local funds is included in the calculation of the Medicaid Direct Medical Service costs. Providers of Medicaid Direct Medical Service costs make up this non-federally funded cost pool.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

Allowable costs for this provider pool consist of:

i. salaries;
ii. benefits;
iii. medically-related purchased services; and
iv. medically-related supplies and materials

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific Unrestricted Indirect Cost Rate (UICR) to its adjusted direct costs. Utah LEAs use predetermined fixed rates for indirect costs. Utah State Board of Education (USBE) has, in cooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by LEAs in Utah. Pursuant to the authorization in 34 CFR § 75.561(b), USBE approves unrestricted indirect cost rates for LEAs for the DOE, which is the cognizant agency for LEAs. If a LEA does not have a calculated UICR, a de minimis rate of 10% will be utilized. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

a. Apply the Utah State Board of Education Cognizant Agency UICR applicable rate for the dates of service in the rate year.
b. The UICR is the unrestricted indirect cost rate calculated by the Utah State Board of Education.

To ensure non-duplication of costs, LEAs are instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures on the annual cost report.

3. Time Study Percentages: A time study separately approved by HHS (outside the state plan process) must be approved before claiming and drawing down FFP for eligible services. This is captured by using a Random Moment Time Study (RMTS) methodology, and is used to determine the percentage of time that medical service personnel spend on IEP, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize three cost pools in total. Two cost pools are for direct medical services and one cost pool for administrative activities.

a. The first cost pool is the Direct Service cost pool and includes all eligible staff and other medical services providers except staff that primarily provide personal care and behavior modification services. These individuals are eligible to bill direct medical services. Eligible positions included in this cost pool are:

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

- Audiologist;
- Audiologist Aide;
- Certified Occupational Therapy Assistant (COTA);
- Licensed Practical Nurse;
- Occupational Therapist;
- Occupational Therapy Aide;
- Orientation and Mobility Specialist;
- Physical Therapist;
- Physical Therapy Assistant (PTA);
- Psychologist;
- Registered Nurse;
- School Counselor;
- School Social Worker;
- School Psychologist;
- School Hearing Specialist;
- Speech Language Pathologist;
- Speech Language Pathology Aide;
- Vision and Hearing Aide

b. The second cost pool is the Other Direct Service cost pool and includes staff that primarily provide personal care and behavior services. These individuals are also eligible to bill direct medical services. Eligible positions included in this cost pool are:

- Health Special Education Teachers (who supply Personal Care and Behavior Services); and
- Para Educator

c. The third cost pool is the Administrative Outreach Personnel cost pool and includes individuals whose primary duties are administrative in nature. These individuals are not eligible to bill direct medical services. Staff included in the cost pool are not included on the annual cost report and the time study results for this cost pool are not included as part of any calculations for the annual cost reconciliation and cost settlement process. Examples of staff that are eligible to be included in this cost pool are:

- Administrators;
- Diagnosticians;
- Interpreters and Interpreter Assistants;
- Program Specialists;
- Pupil Support Services Administrators;
- Pupil Support Services Technicians;
- Special Education Administrators;
- Special Education Teachers;
- Special Education Coordinators;
- School Bilingual Assistants

To ensure non-duplication of costs, LEAs are instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures on the annual cost report.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

d. Staff cannot be included in more than one cost pool. If an individual performs job duties that correspond to more than one cost pool, the individual must be added to the cost pool that corresponds with their primary job responsibilities.

e. Participants from all cost pools complete RMTS for all regular school days, with a precision level of +/- 2% and a 95% confidence level.

f. Summer vacation periods (when most students are not attending school according to the LEA calendar) will use the weighted average of the other periods to provide compensation to providers paid during this period.

g. LEAs ensure an 85% response rate to the time study moments.

h. The RMTS will generate two Direct Medical Services time study percentages; one for Direct Medical Service Cost Pool and one for the Other Direct Service Cost Pool. Each Direct Medical Services time study percentage will be statewide averages. The direct medical services costs and time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the State of Utah and CMS.

4. Medicaid IEP Ratio Determination: A Medicaid ratio will be established for each participating LEA. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid enrolled students.

a. Medicaid IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to an IEP. The names, gender, and birthdates of students with an IEP identifying a covered service will be identified from the December 1 Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid enrolled students with an IEP identifying a covered service and the denominator will be the total number of students with an IEP identifying a covered service. The IEP ratio will be calculated for each LEA participating in the SDS program on an annual basis.

5. Contracted costs: LEAs can include contracted service costs for and contracted clinicians that were included on the Staff Pool List for the RMTS process. The contracted service costs represent the amounts charged to the LEA by the contractor or contracting agency and may include the costs associated with the clinician and any overhead incurred by the contractor that is charged back to the LEA. This cost does not include any overhead or other indirect costs incurred by the LEA to support the contracted clinician.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

a. Contracted service costs for direct medical services will be a separate line item in the cost report with the application of the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.
b. Contracted service costs for direct medical services and administrative services are part of the RMTS and the allocation to direct medical and administrative percentages, the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.

c. The LEA's Unrestricted Indirect Cost Rate is applied to contracted service costs to reflect the overhead and administrative costs incurred by the LEA to support the contracted service clinician and are non-duplicative of any agency indirect costs charged to the LEA by the contractor.

6. Total Medicaid Reimbursable Cost: The previous steps will result in a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

Step 1. The Direct Service Personnel Costs (Salaries + Fringe Benefits + Contract Costs) will be added to the Direct Service Non-Personnel Costs (Materials and Supplies + Depreciation) to determine the Total Direct Services Costs

Step 2. The Total Direct Services Costs will then be multiplied by the Direct Medical Services Percentage (as determined by the RMTS and applied to the 2 Direct Medical cost pools on a statewide basis) to determine the Total Direct Medicaid Services Costs.

Step 3. The Total Direct Medical Services Costs will be multiplied by the Unrestricted Indirect Cost Rate to determine the total Indirect Costs.

Step 4. The Direct Medical Services Costs will be added to the Indirect Costs to determine the Total Allowable Costs.

Step 5. The Total allowable Costs will be multiplied by the Medicaid Enrollment IEP Ratio (calculated by each LEA) to determine the Total Medicaid Reimbursable Costs.

Step 6. Reconciliation process: The Total Medicaid Interim Payments will be subtracted from the Medicaid Reimbursable Costs to equal the Total Cost Settlement.

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

E. Certification of Funds Process

Each LEA certifies on an annual basis an amount of the interim payments received during the previous federal fiscal year. In addition, each LEA certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

LEAs are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

F. Annual Cost Report Process

Each LEA will complete an annual cost report for all SDS delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than one year after the close of the quarter ending June 30.

a. The primary purpose of the cost report is to

i. document the LEA's total Medicaid allowable scope of costs for delivering SDS, including direct costs and indirect costs, based on cost allocation methodology procedures

b. Cost reports will be subjected to a comprehensive review process prior to their use in the calculation of the interim rates.

i. The review will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SDS program are aware of federal regulations listed below for audits and documentation, and will provide documentation for MERs and any other documentation needed to support SDS claims

a. 42 CFR 431.107 Required provider agreement
b. 45 CFR 447.202 Audits
c. 45 CFR 75.302 Financial management and standards for financial management systems

MEDICALLY NECESSARY SERVICES NOT OTHERWISE PROVIDED UNDER THE STATE PLAN BUT AVAILABLE TO EPSDT (CHEC) ELIGIBLES (Continued)

c. Cost reports will be used to reconcile its interim payments to its total Medicaid-allowable scope of costs based on cost allocation methodology procedures.

i. The reconciliation will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. The annual SDS Cost Report includes a certification of funds statement to be completed, certifying the LEA's actual, incurred costs/expenditures. All filed annual SDS Cost Reports are subject to a desk review by the Division of Integrated Healthcare (DIH) or its designee.

G. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual SDS Cost Report. The total CMS-reviewed, Medicaid allowable scope of costs based on CMS-reviewed cost allocation methodology procedures are compared to the LEA's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-reviewed scope of costs, the CMS-reviewed cost allocation methodology procedures, or its time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost reporting purposes requires review from CMS prior to implementation; however, such review does not necessarily require the submission of a new state plan amendment.

H. The Cost Settlement Process

1. For services delivered for a period covering July 1st, through June 30th, the annual SDS Cost Report is due no later than one year after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than two years after the fiscal year end.

a. Actual costs will be used to determine whether or not the LEA has an under or overpayment. Actual costs will be calculated for the school year and will then be compared to the interim payments made during that same school year.

2. If an LEA's interim payments exceed the actual, certified costs of the provider for SDS to Medicaid clients, the provider will return the federal share of an amount equal to the overpayment.

3. If the actual, certified costs of a LEA for SDS exceed the interim Medicaid payments, DIH will pay the federal share of the difference to the LEA in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

a. The Division of Integrated Healthcare will issue a notice of settlement within 60 days following the completion of the settlement determination that denotes the amount due to or from the provider.

PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES

Payment for targeted case management services for EPSDT eligibles is made on a fee-for-service basis. A separate prospective rate is established for each type of targeted case management provider identified below. In accordance with Federal Office of Management and Budget Circular No. A-87 requirements, payments made to governmental service providers shall not exceed the costs of providing such services.

Independent Professional: Rates are established on the basis of the historical cost of the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider without RMS Capability: Rates are established on the basis of the historical cost for the service. To establish an initial rate, the provider's historical costs are inflated by the Consumer Price Index, Urban-All Items, published by the U. S. Department of Labor. Rate adjustments are made on the basis of periodic cost studies. Rates are based on a 15-minute unit of service.

Agency Provider with RMS Capability: Rates are based on an enrolled agency's average allowable cost to provide a monthly unit of targeted case management services to an eligible recipient. Rates will be authorized for a period of 12 months. Except for the initial period, an agency's rate will be calculated as follows:

PAYMENT FOR TARGETED CASE MANAGEMENT SERVICES FOR EPSDT ELIGIBLES (Cont.)

Compute: the Agency's actual total cost for the most recently completed 12 month period for which actual cost data exist, including (1) the salaries and benefits of case managers, their direct supervisory and support staff, and their indirect administrative staff, and (2) other operating costs including travel, supplies, telephone, and occupancy cost, and indirect administrative costs in accordance with Circular A-87. To determine the agency's "allowable costs", subtract from its total costs all personnel, operating, occupancy, and indirect administrative costs that are both unrelated to the delivery of Medicaid's scope of targeted case management services and are not allocated by the RMS.

Multiplied by: the percentage of time spent by agency personnel performing Medicaid allowable targeted case management services and related indirect activities on behalf of clients, ages birth through 20 years (regardless of the client's Medicaid eligibility) during the 12 month period. This percentage is derived from random moment time studies (RMS).

Multiplied by: the percentage of the agency's clients (regardless of Medicaid eligibility) who received a Medicaid allowable targeted case management service during the period.

Equals: total allowable costs incurred by the agency to provide and support Medicaid's scope of targeted case management services.

Divided by: 12 months.

Equals: the agency's average allowable monthly cost to provide and support Medicaid's scope of targeted case management services on behalf of individuals in the target group.

Divided by: the average monthly number of agency's clients in the target group (ages birth through 20 years regardless of Medicaid eligibility) who received a covered case management service during the period.

Equals: the agency's monthly allowable cost per targeted case management recipient in the target group. This cost equals the monthly fee for service amount that the agency will be authorized to claim for each EPSDT eligible recipient in the target group who received one or more covered targeted case management services that month. Documentation of case management services delivered will be retained in the service worker case files.

When determining an agency's initial rate, the Medicaid agency will apply the same calculations described above, but may use less than 12 months of data in calculating the rate. This initial rate may be in effect for less than a 12 month period.

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PAYMENT FOR CHIROPRACTIC SERVICES

Payments for covered chiropractic services use the physicians' fee schedule methodology described in Section D "Physicians," Page 4 of ATTACHMENT 4.19-B.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

PAYMENT FOR SERVICES

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

PAYMENT FOR SERVICES

Services provided by facilities of the Indian Health Service (IHS) which includes, at the option of the tribe, facilities operated by a tribe or tribal organization, and funded by Title I or III of the Indian Self Determination and Education Assistance Act (Public Law 93-638), are paid at the rates negotiated between the Health Care Financing Administration (HCFA) and the IHS and which are published in the Federal Register or Federal Register Notices.

A tribal health program selecting to enroll as an FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM, which is an all-inclusive rate (AIR).

Utah Medicaid will establish a Prospective Payment System (PPS) methodology for Tribal FQHCs. The PPS rate shall be the average rate of other FQHCs in the state. Annually, Utah Medicaid will compare the APM rate to the PPS rates to ensure the APM is equal to or greater than the PPS rate. A Tribal FQHC is not required to report its costs for the purposes of establishing a PPS rate.

Provider-Preventable Conditions (Continued)

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider-Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section 4.19 (B) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

For claims with dates of service on or after July 1, 2012, Utah Medicaid will not reimburse providers for any of the OPPCs indicated above. Payment will be denied for OPPCs in any health care setting identified in Attachment 4.19-B.

In compliance with 42 CFR §447.26(c):

1. No reduction in payment for a provider-preventable condition will be imposed on a provider when the condition defined as a PPC existed prior to the initiation of treatment for that patient by that provider.
2. The reductions in provider payment may be limited to the extent that the following apply:
    a. The identified provider-preventable condition would otherwise result in an increase in payment.
    b. The State can isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable condition.
3. The State provides assurance that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

In the event that individual cases are identified throughout the PPC implementation period, the State will adjust reimbursement according to the methodology above.

FREESTANDING BIRTH CENTER SERVICES

Licensed Birthing Centers -- Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The rates are effective for services on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

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1905 (a)(29) Medication-Assisted Treatment (MAT)

The agency's fee schedule rates for mental health services are effective for services provided on or after the date listed on the Attachment 4.19-B Introduction Page. These rates are published at http://health.utah.gov/stplan/lookup/CoverageLookup.php. Fee schedule payments are based on the established fee schedule unless a lower amount is billed.

The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorders will be reimbursed using the same methodology as described for prescribed drugs located in Attachment 4.1-B, Item 12-a, for drugs that are dispensed or administered.

ARPA Spending Plan Supplemental Payments

1. Based on paid data from April 1, 2021 through March 31, 2023, the agency increases payment for the providers referenced in Utah's American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan and that are listed in Appendix B., or could be listed in Appendix B., of the American Rescue Plan Act, State Medicaid Director Letter, *SMD# 21-003 Implementation of American Rescue Plan Act of 2021 Section 9817*: including:

    a. Home Health Services
    b. Private Duty Nursing – in home services only
    c. Hospice Services – in home services only
    d. Personal Care Services
    e. School Based Services
    f. Rehabilitative Services - Behavioral Health Services
    g. Early Periodic Screening Diagnosis and Treatment, Autism Spectrum Disorder Related Services

2. Temporary supplemental payments will be made based on the following criteria:

    a. Eligibility for quarterly supplemental payments require providers to attest to the following:

        i. An understanding these are time-limited payments which are anticipated to not extend beyond March 2024
        ii. An agreement that a portion of the funds will be used to address direct-care worker issues (i.e., salary/benefit increases, staff retention bonuses, employer paid training, provision of PPE, paid time to receive vaccinations, etc.)
        iii. An agreement that funds will be used to expand, enhance or strengthen their program

    b. Payments are increased through a supplemental payment:

        i. The State will make supplemental payments to qualified providers who have made an attestation per (2)(a).

        ii. The quarterly payments will equal 5 percent of the claims (fee for service based on paid date and managed care encounters based on state received date) from the previous quarter. For example, April, May and June paid claims will be used to inform the payment for that period. If $100 were paid in that period, the quarterly payment will be $5. The exact timing of payments may vary; however, the payments will be based on the example noted.

        iii. The payments are made to billing providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment specified in the chart on page 2 of this supplement. Codes appearing in the chart have the meanings defined below:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters **SP**.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in items 1 and 2 of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters **MR**.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items 1 and 2 of this attachment, for those groups and payments listed below and designated with the letters **NR**.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in items 1 and 2 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Other Medicaid Recipients	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance
Dual Eligible (QMB Plus)	Part A	SP	Deductibles	SP	Coinsurance
	Part B	SP	Deductibles	SP	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Medicaid payment for Medicare crossover claims will be limited to the patient's liability. Further, Medicaid payment for specified Medicare crossover claims will be the lower of:

(1) the allowed Medicaid payment rate less the amounts paid by Medicare and other payors; or
(2) the Medicare co-insurance and deductibles.

In the event Medicaid does not have a price for codes included on a crossover claim, the Medicaid price will be 80 percent of the Medicare price.

Following is specific information relating to certain providers:

Anesthesiologists - In order to convert to Medicaid units, the Medicare units will be multiplied by 1.25 and rounded-up to the nearest integer.

Nursing Facilities - Excluding "room and board" revenue codes from this requirement: If crossover claims do not include HCPCS codes on each claim line, then Medicaid's price is 80% of the total Medicare allowed amount for that claim.