Non-Traditional Medicaid Plan
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I. SERVICES

Non-Traditional Medicaid (NTM) provides a scope of service similar to that currently covered by the Medicaid State Plan (i.e., Traditional Medicaid) but with some additional limitations and/or reduced benefits. This Non-Traditional Medicaid Plan Provider Manual describes only the limitations and reduced benefits under NTM. If the benefits are the same for both NTM and Traditional Medicaid, this is indicated under the type of service. If there is a limitation or reduced benefits for NTM this is also described under the type of service.

Providers of NTM services are responsible to comply with all applicable federal and state laws and regulations as well as Medicaid policy and requirements set forth in the Medicaid Provider Agreement, the Utah Medicaid Provider Manuals, any attachments to specific Provider Manuals, Section I: General Information of the Utah Medicaid Provider Manual, and Medicaid Information Bulletins.

Verification

Services are based on the type of coverage a Medicaid member is eligible to receive. Medicaid members receive a Medicaid Member Card and a Benefit Letter in the mail that contains their eligibility and plan information.

For information regarding the Medicaid Member Card, including methods of verifying Medicaid eligibility, refer to Section I: General Information of the Utah Medicaid Provider Manual at: http://medicaid.utah.gov. All methods of verifying Medicaid eligibility indicate the type of coverage the member has (Non-Traditional Medicaid, Traditional Medicaid, or Primary Care Network), and any Managed Care Organization (MCO) in which the member is enrolled.

Members Enrolled in a Managed Care Organization (MCO)

Many Medicaid members are required to enroll in one or more MCOs. The Division of Medicaid and Health Financing (DMHF) contracts with MCOs to provide physical health care, behavioral health care, and dental care for most Medicaid members. DMHF pays a monthly premium for each Medicaid member enrolled in an MCO. The MCO is responsible for prior authorization, if required, and payment of all health care services specified in its contract with DMHF.

An MCO that covers physical health care is called an Accountable Care Organization (ACO); one that covers behavioral health care is called a Prepaid Mental Health Plan (PMHP); one that covers dental care is called a dental plan (however, dental services are not covered under NTM). Medicaid members enrolled in MCOs are entitled to the same Medicaid benefits as fee-for-service members. MCOs may have different prior authorization requirements than Medicaid fee-for-service.

A Medicaid member enrolled in an MCO must receive services through that MCO with some exceptions called "carve-out services." Carve-out services are services *not* included in the Medicaid contract with an MCO. DMHF pays providers directly, on a fee-for service basis, for carve-out services.

Each MCO is responsible to determine which services require prior authorization. Each MCO is also responsible to determine the process providers must use to request prior authorization of services for Medicaid members enrolled in the MCO. Medicaid does not process prior authorization requests for

services to be provided to a Medicaid member enrolled in an MCO when the services are the responsibility of the MCO. Medicaid refers providers to the MCO if the provider requests a prior authorization when the service is covered by an MCO and the member is enrolled in an MCO.

Medicaid makes every effort to provide complete and accurate information regarding a member's enrollment in an MCO. However, it is the provider's responsibility to verify eligibility and MCO enrollment for a member before providing services. *Therefore, if a Medicaid member is enrolled in an MCO, a fee-for-service claim will not be paid unless the claim is for a carve-out service.*

Medicaid members not enrolled in an MCO and not enrolled in DMHF's Restriction Program may receive services from any qualified provider who accepts Medicaid.

For more information on MCOs and the Restriction Program, refer to Section I: General Information of the Utah Medicaid Provider Manual at:

http://medicaid.utah.gov.

1 - 1 Authority

Non-Traditional Medicaid is authorized by a waiver of federal Medicaid requirements approved by the federal Centers for Medicare and Medicaid Services (CMS) and allowed under Section 1115(a) of the Social Security Act.

1 - 2 Definitions

Division of Medicaid and Health Financing (DMHF) means the organizational Division in the Utah Department of Health that administers the Medicaid program in Utah.

Fee-for-Service means Medicaid covered services that are billed directly to and paid directly by Medicaid based on an established fee schedule.

Member means the preferred term to refer to a person who is eligible for the Utah Medicaid Program. "Member" is often used interchangeably with "client," "recipient," "patient," or "enrollee" when the person is eligible for the Utah Medicaid Program.

Non-Traditional Medicaid (NTM) means a medical plan based on Traditional Medicaid but additional limitations and/or restrictions are imposed, under a waiver of federal regulations, on benefits and services of Traditional Medicaid as covered by the Medicaid State Plan. Individuals eligible for NTM include: non-pregnant adults on Family Medicaid programs (adults with dependent children) and adult caretaker relatives on Family Medicaid.

Provider means any person, individual, corporation, institution or organization qualified to perform services available under the Medicaid program and who has entered into a written contract with the Medicaid program.

Traditional Medicaid means a medical plan that will pay for many medical services for eligible individuals. Individuals eligible for Traditional Medicaid include: children; pregnant women; aged; blind

or disabled adults; and women eligible under the cancer program. Some services are available only to children and pregnant women under Traditional Medicaid.

1 - 3 Co-payments

Co-payments apply to members covered by NTM. For information on NTM co-payments, refer to the chart at: http://health.utah.gov/umb/forms/pdf/adultcomp.pdf or http://health.utah.gov/umb under "Benefits." Additional information on billing members can be found in Section I: General Information of the Utah Medicaid Provider Manual, Exception to Prohibition on Billing Patients.

2 SCOPE OF SERVICE

As stated in Chapter 1 of this manual, providers are responsible to follow general Medicaid policy and requirements set forth in the Utah Medicaid Provider Manuals for specific types of service, including any special attachments to that manual. The scope of service under NTM is similar to Traditional Medicaid but with some limitations or reduced benefits. There are limits or reduced benefits for the following types of services: hospital, home health, organ transplants, transportation, physical therapy, occupational therapy, and rehabilitative mental health and substance use disorder. The following services are not covered under NTM: speech and audiology, chiropractic, dental, and long term care.

For services covered under NTM please refer to DMHF's Coverage and Reimbursement Code Lookup Tool at:

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

All Utah Medicaid Provider Manuals can be found on the Medicaid website at:

http://medicaid.utah.gov.

2 - 1 Hospital Services (Inpatient Hospital, Outpatient Hospital, and Emergency Department)

Hospital services covered under NTM are the same as those covered under Traditional Medicaid with some revenue code exceptions. Covered and non-covered revenue codes for NTM can be found in the *Revenue Codes* attachment of the Utah Medicaid Provider Manual for Hospital Services.

2 - 2 End Stage Renal Disease - Dialysis

End state renal disease services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Hospital Services, Section 4 – End Stage Renal Disease.

2 - 3 Physician Services

Physician services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Physician Services.

2 - 4 Laboratory and Radiology Services

Laboratory and radiology services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Laboratory Services and the Utah Medicaid Provider Manual for Physician Services.

2 - 5 Family Planning Services

Family planning services covered under NTM are the same as those covered under Traditional Medicaid with the following exception:

Birth control patches are not covered under NTM.

2 - 6 Speech-Language Pathology and Audiology Services

Speech-language pathology and audiology services are not covered under NTM.

2 - 7 Podiatry Services

Podiatry services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Podiatry Services.

2 - 8 Vision Care

Vision services covered under NTM are the same as those covered under Traditional Medicaid for non-pregnant adults. Refer to the Utah Medicaid Provider Manual for Vision Care Services.

2 - 9 Home Health Services

Home health services covered under NTM are the same as those covered under Traditional Medicaid with the following exception:

Private duty nursing is not covered under NTM.

Refer to the Utah Medicaid Provider Manual for Home Health Services.

2 - 10 Hospice Services

Hospice services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Hospice Services.

2 - 11 Abortions and Sterilizations

Abortion and sterilization services covered under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Physician Services.

2 - 12 Organ Transplants

Organ transplants under NTM are limited to bone marrow, cornea, heart, kidney, liver, lung, and stem cell. In addition, these organ transplants are limited to those procedures which meet criteria listed in the Utah Administrative Code R414-10A.

For prior authorization and coverage refer to DMHF's Coverage and Reimbursement Code Lookup Tool. The tool can be found at:

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

2 - 13 Free-Standing Ambulatory Surgical Center Services

Covered services in free-standing ambulatory surgical centers under NTM are the same as those covered under Traditional Medicaid. Refer to the Utah Medicaid Provider Manual for Hospital Services, Section 5 – Free-Standing Ambulatory Surgical Center.

2 - 14 Transportation Services

1. **Emergencies:** Ambulance (ground and air) services covered for medical emergencies under NTM are the same as those covered under Traditional Medicaid.

2. **Non-emergency transportation:** Non-emergency transportation of any kind is not covered under NTM.

2 - 15 Preventive Services

Preventive services including immunizations, mammograms, Pap smears, prostate exams, diabetes self-management training, nutritional counseling, and tobacco cessation counseling covered under NTM are the same as those covered under Traditional Medicaid for non-pregnant adults with the following exception:

Immunizations are available to NTM members in a medical office, but not at the pharmacy point of sale.

Refer to the Utah Medicaid Provider Manual for Pharmacy Services and the Utah Medicaid Provider Manual for Physician Services.

2 - 16 Physical Therapy and Occupational Therapy

Physical and occupational therapy services covered under NTM are the same as those covered under Traditional Medicaid non-pregnant adults with the following limitation:

NTM is limited to a maximum of 10 visits per calendar year in any combination of physical and occupational therapy services.

Refer to the Utah Provider Manual for Physical Therapy and Occupational Therapy Services.

2 - 17 Chiropractic Services

Chiropractic services are not a covered benefit under NTM.

2 - 18 Pharmacy Services

For differences between NTM and Traditional Medicaid, refer to the *Drug Criteria and Limits* attachment of the Utah Medicaid Provider Manual for Pharmacy Services. A summary of the most notable differences are:

1. The benefit for injectable medications under NTM is limited in scope. The following injectables require prior authorization:

   a. Anti-emetics
   b. Heparin and low molecular weight heparin derivatives
   c. Antibiotics and diluents
   d. Anti-TNF agents
   e. Biologic products
   f. Erythropoetins
   g. GCSF (granulocyte colony-stimulating factor)
   h. Epinephrine Emergency Kits
   i. Medroxyprogesterone Acetate 150mg when used for family planning
   j. Insulin Pens (vials remain covered without prior authorization)

   Criteria for these prior authorizations can be found at:

   http://medicaid.utah.gov/pharmacy/pharmacy-program.

2. Compounded prescriptions are not covered under NTM.

3. Lozenges, suckers, rapid dissolve, lollipop, pellets, patches or other unique formulation delivery methodologies developed to garner "uniqueness" are not covered under NTM, except where the specific medication is unavailable in any other form (Duragesic and Actiq). Lower-cost generic alternatives may be reviewed for exception to this policy.

4. Over-the-counter drugs under NTM are limited to those on the Over-the-Counter Drug List attached to this manual.

2 - 19 Rehabilitative Mental Health and Substance Use Disorder Services

Rehabilitative Mental Health and Substance Use Disorder Services covered under NTM are the same as those covered under Traditional Medicaid with the following limitations for NTM:

1. **Outpatient:** There is a maximum of 30 outpatient days per member per year for outpatient mental health care for a mental health disorder. Targeted case management for individuals with serious mental illness also count toward the outpatient maximum. This 30-day limitation does not apply to services provided to treat substance use disorders.

2. **Inpatient:** There is also a maximum of 30 inpatient days per member per year for inpatient mental health care.

   Substitutions – Unused inpatient mental health care days, up to 30 days, can be used for additional outpatient mental health days per member per year for a mental health disorder.

Refer to the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

2 - 20 Dental Services

Dental services are not covered under NTM or Traditional Medicaid for non-pregnant adults. However, limited emergency dental services for NTM members and Traditional non-pregnant adults, although not covered under the dental program, may be recognized as a least costly alternative to a covered service.

For those procedures covered under NTM, refer to the Coverage and Reimbursement Lookup Tool at:

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

2 - 21 Interpretive Services

Interpretive services covered under NTM are the same as those covered under Traditional Medicaid. Refer to Section I: General Information of the Utah Medicaid Provider Manual.

2 - 22 Medical Supplies and Equipment

There are differences in coverage between NTM and Traditional Medicaid. For those services covered under NTM, refer to the Coverage and Reimbursement Lookup Tool at:

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

Also, refer to the Utah Medicaid Provider Manual for Medical Supplies.

2 - 23 Long Term Care

Long term care is not covered under NTM.