DMHF SPA Matrix 2-15-24

SPA Summary	Public Notice Date	Proposed Effective Date	Target Date or Date Submitted to CMS	CMS Approval Date	CMS Approved Effective Date	MCAC Present Date
UT-24-0001 Targeted Case Management (TCM) for Individuals with Serious Mental Illness; This amendment removes reporting restrictions for TCM services delivered to individuals with serious mental illness. It will allow all licensed and certified providers to be reimbursed and will increase member access to services.	**2-25-24**	**3-1-24**	**3-29-24**			**3-21-24**
UT-24-0002 Provider-Administered Drugs; This amendment clarifies reimbursement for certain provider-administered drugs.	**2-25-24**	**3-1-24**	**3-29-24**			**3-21-24**
UT-24-0003 NF NSGO UPL and Routine Services Updates; Based on CMS guidance regarding UPL approaches given Medicare's conversion to the Patient-Driven Payment Model (PDPM), this amendment defines the scope of Utah's nursing facility benefit to include services currently considered as non-routine (i.e., physical therapy, occupational therapy, speech therapy, audiology examinations, medications, etc.	**2-25-24**	**7-1-26**	**3-15-24**			**3-21-24**
UT-24-0004 School-Based Services and Payments; This amendment updates and clarifies time study payment methodology for Medicaid school-based services.	**2-25-24**	**7-1-24**	**3-29-24**			**3-21-24**

State law (most commonly a physician assistant) and APRNs not otherwise specified above.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [**Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**
~~Qualified providers of targeted case management services to recipients in this target group are (1) employed by or under contract with a local mental health and/or substance abuse authority; or (2) employed by or under contract with a local authority's designated mental health and substance abuse services provider; 3) employed by or under contract with the Utah Department of Human Services; or 4) employed by or under contract with a program providing Medicaid-covered services, including targeted case management for individuals with serious mental illness, under 1915(a) authority. Providers authorized under 1915(a) authority provide targeted case management services only to recipients enrolled in the 1915(a) program.~~

As an integral part of the public mental health/substance abuse system, or an entity providing Medicaid-covered services under 1915(a) authority, targeted case managers understand the service systems delivering mental health/substance use disorder services and the array of services their clients need. As a member of the mental health and/or substance use disorder service delivery team, they can ensure recipients are able to access all needed services timely and in a coordinated manner.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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 the Medicaids Coverage and Reimbursement Code Look-up Tool. ~~Effective for claims adjudicated on or after April 3, 2023, covered provider-administered drugs are reimbursed in the same manner as other covered outpatient drugs in accordance with the reimbursement rules of this section, with the exception that no professional dispensing fee will be paid.~~

Investigational Drugs

Investigational drugs are not covered by Utah Medicaid.

General Reimbursement Exception

Services noted as "routine" in Attachment 4.19-D, Section 920, which are rendered by providers in this Attachment, are not reimbursable during the duration of the Medicaid member's stay in the facility. The daily rate paid to the nursing facility covers the "routine" services.

Due to differences in timing of claims submission, a provider may be reimbursed for a "routine" service from Attachment 4.19-D, which will later be denied and monies recovered.

400 ROUTINE SERVICES

410 INTRODUCTION

This section specifies the services covered in the per diem payment rate and the ancillary services that are billed separately. Because of the difficulty of defining all ~~of the~~ routine services, Section 430 specifies those services that are billed directly. Other services are covered by the routine payment rates paid to long-term care providers.

420 ROUTINE SERVICES

The Medicaid per diem payment rate covers routine services. Such routine services cover the hygienic needs of the residents. Supplies such as toothpaste, shampoo, facial tissue, disposable briefs, and other routine services and supplies specified in 42 CFR 483.10 are covered by the Medicaid payment rate and cannot be billed to the resident. The following types of items~~.~~ are considered ~~to be~~ routine for purposes of Medicaid costs reporting, even though they may be considered ancillary by the facility:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, assisting with feeding, incontinency care, tray service, and enemas.

2. Items furnished routinely and relatively uniformly to all residents, such as resident gown, water pitchers, basins, and bedpans.

3. Items stocked at nursing stations or on the floor in gross supply, such as alcohol, applicators, cotton balls, band-aids, suppositories, and tongue depressors.

4. Items used by individual residents which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable medical equipment.

5. Special dietary supplements used for tube feeding or oral feeding except as provided in Section 430.

6. Laundry services.

7. Transportation to meet the medical needs of the resident, except for emergency ambulance.

8. Medical consultants.

9. All other services and supplies that are normally provided by long-term care providers except for the non-routine services in Section 430.

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400 ROUTINE SERVICES (Continued)

~~7. Transportation to meet the medical needs of the resident, except for emergency ambulance.~~

~~8. Medical supplies and non-prescription pharmacy items. Supplies include, but are not limited to: syringes, ostomy supplies, irrigation equipment, routine dressings (i.e., band-aid, gauze, etc. - does not include specialized dressings such as negative pressure wound therapy dressings), catheters, elastic stockings, test tape, IV set-up colostomy bags, oxygen tubing /masks, CPAP/Bi-PAP supplies, etc.~~

~~9. Medical consultants.~~

~~10. All other services and supplies that are normally provided by long-term care providers except for the non-routine services in Section 430.~~

1~~0~~. ICF/IID residents only:

a. Annual dental examination.
b. Physical therapy, occupational therapy, speech therapy and audiology examinations.

1~~2~~. Nursing facility residents only:

a. Medical supplies and equipment used in the facility,
   i. except individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident as this is considered a non-routine service
b. Ambulance transportation (when other transportation would endanger member's health) to the nearest supplier of medically necessary services that aren't available at the SNF, including the return trip except as excluded by CMS in its SNF Consolidated Billing,
c. Medications except as excluded by CMS in its SNF Consolidated Billing and HIV drugs,
d. Oxygen, and
e. Physical therapy, occupational therapy, speech therapy, and audiology examinations ~~(nursing facility residents only).~~

430 NON-ROUTINE SERVICES

These services are considered ancillary for Medicaid payment. The costs of these services should not be included on the FCP. Non-routine services may be billed by either the nursing facility or the direct service provider. These services are:

~~1. Physical therapy, speech therapy, and audiology examinations (nursing facility residents only).~~

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~~a.~~

~~b.~~1. ~~2.~~ Dental services (except annual examinations for ICF/IID residents).

~~c.~~2. ~~3.~~ Oxygen (ICF/IID residents only).

3. ~~4.~~ Prescription drugs excluded by CMS in its SNF Consolidated Billing ~~(legend drugs)~~ plus antacids, insulin and total nutrition, parenteral or enteral diet given through gastrostomy, jejunostomy, IV or stomach tube. In addition, antilipemic agents and hepatic agents or high nitrogen agents are billed by pharmacies directly to Medicaid.

~~d.~~4. ~~5.~~ Prosthetic devices to include (a) artificial legs, arms, and eyes and (b) special braces for the leg, arm, back, and neck.

~~6. Physician services for direct resident care.~~

~~7. Laboratory and radiology.~~

~~8. Emergency ambulance for life threatening or emergency situations.~~

~~9. Other professional services for direct resident care, including psychologists, podiatrists, optometrists, and audiologists.~~

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400 ROUTINE SERVICES (Continued)

5. Physician services for direct resident care.

6. Laboratory and radiology.

7. Emergency ambulance for life threatening or emergency situations excluded by CMS in its SNF Consolidated Billing..

8. Other professional services for direct resident care, including psychologists, podiatrists, optometrists, and audiologists.

e.9. 10. Eyeglasses, dentures, and hearing aids.

f. 11. Special equipment approved by Medicaid for individual clients is covered. This equipment is currently limited to:

g.
h. a. air or water flotation beds (self-contained, thermal-regulated, or alarm-regulated);
i. b. mattresses and overlays specific for decubitus care;
j. c. customized (Medicaid definition) wheelchairs;
k. d. power wheelchairs;
l. e. negative pressure wound therapy (vacuum, cannister, and associated dressings); and
m. f. CPAP/Bi-PAP machine rental.
n.
10. 12. Hyperbaric Oxygen Therapy.

Medicaid criteria, applicable at the time services are rendered, applies to the above items.

431 DEFINITION OF PROSTHETIC DEVICES

Medicaid defines prosthetic devices to include (1) artificial legs, arms, and eyes; (2) special braces for the leg, arm, back, and neck; and (3) internal body organs. Specifically excluded are urinary collection and other retention systems. This definition requires catheters and other devices related to be covered by the per diem payment rate.

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942 SUPPLEMENTAL PAYMENTS TO PARTICIPATING NON-STATE GOVERNMENT OWNED (NSGO) NURSING FACILITIES

In addition to the uniform Medicaid rates for nursing facilities, any nursing facility that is owned by a non-state governmental entity and has an agreement with the Division of Medicaid and Health Financing ("Division") to participate in the supplemental payment program shall receive a supplemental payment, which shall not exceed its upper payment limit pursuant to 42 CFR 447.272.

UPL Calculation Overview

The Division shall calculate a supplemental payment amount for all non-state governmental nursing facilities that will not exceed the aggregate upper payment limit found at 42 CFR 447.272. For purposes of calculating the Medicaid nursing facility upper payment limits for non-State government owned nursing facilities, the state shall utilize nursing facility specific Medicare ~~RUG~~ rates calculated using the MDS ~~RUG~~ data. The Medicaid upper payment limits for non-state government owned nursing facilities are independently calculated. Each Medicaid upper payment limit shall be offset by nursing facility Medicaid and other third-party nursing facility payments to determine the available spending room (i.e., the gap) applicable to each Medicaid upper payment limit.

Following is the data used to calculate the UPL for each payment period:

- MDS (Minimum Data Set) from the previously completed state fiscal year
- Medicare Rate Comparison from the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities
- Medicaid revenue – Paid nursing facility claims, including third party payment amounts, client contribution to care, Medicaid payments, and quality incentives from a previously completed state fiscal year as determined by the Division

The facility-specific NSGO UPL per diem gap shall be calculated by subtracting the Medicaid weighted average per diem from the weighted average Medicare per diem the Division reasonably estimates would have been paid using Medicare payment principles. The data for the per diem gap calculation will come from the previously completed state fiscal year.

The Medicaid rate shall be adjusted to account for program differences in services between Medicaid and Medicare. A Medicaid inflation trend shall be determined based on the legislative appropriation adjustments as per Section 900 of this attachment. The appropriate trend, if any, used in the calculation shall be determined by the agency. The difference between the annual estimated Medicare per diem rate and the adjusted annual Medicaid per diem rate is the per diem rate UPL gap.

The facility-specific NSGO UPL per diem gap for facilities that were not Medicaid certified during the period of the UPL calculation shall be the weighted average per diem gap for the NSGO grouping.

900 RATE SETTING FOR NFs (CONTINUED)

Supplemental Payment Amount

The payments will be distributed to each NSGO nursing facility based on the following example:

NF	Daily Rate UPL Gap	Period of Interest Paid Days	State Fiscal Quarter UPL Gap	Amount if UPL > 0	Amount if UPL > 0 percent of Total	UPL Gap Allocation
A	($5.00)	100	($500.00)	$0.00	0.00%	$0.00
B	$80.00	200	$16,000.00	$16,000.00	21.62%	$15,891.89
C	$120.00	300	$36,000.00	$36,000.00	48.65%	$35,756.76
D	$55.00	400	$22,000.00	$22,000.00	29.73%	$21,851.35
Totals		**1,000**	**$73,500.00**	**$74,000.00**	**100%**	**$73,500.00**

Supplemental Payment Frequency

Payments will be distributed in the form of supplemental Medicaid payments to each qualifying nursing facility that is owned by a non-state governmental entity. The state shall distribute the payment to the nursing homes for each quarter.

Payments for newly approved facilities will not include service dates prior to the Division approved effective date.

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.

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.

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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 +/- 52% and a 95% confidence level.

f. The SDS RMTS sampling periods comprise of the following two periods:

i. Sample Period 1: Mid-August-December 31st

ii. Sample Period 2: January 1-June 30

g. RMTS Sample Period 3 is the summer period, beginning July 1 and ending mid-August. No time study will be generated during the summer period. The sample period will run from the day after the last regular school day until the day before the first regular school day for any participating LEA. An average of the two (2) previous sampling periods' time study results will be used to calculate claims for the summer sampling period. ~~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.

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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 followingprevious 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.