

DMHF SPA Matrix 7-20-23

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-23-0011 Autism Spectrum Disorder Services; In accordance with S.B. 204, this amendment defines and provides autism services to eligible Medicaid members.	6-25-23	7-1-23	7-31-23			7-20-23
UT-23-0012 Medicaid Cost Sharing; This amendment reflects cost-sharing tracking through the new Provider Reimbursement Information System for Medicaid (PRISM).	7-16-23	7-1-23	7-31-23			7-20-23
UT-23-0013 Inpatient Payment Modifications; This amendment removes the inpatient hospitals payment reduction section that is no longer needed due to a budget neutral DRG reimbursement rebasing, which includes the effect of the 14.3% reduction factor that has historically been separately applied to provider payments.	6-25-23	7-1-23	7-17-23			7-20-23

42 CFR
440.60

ATTACHMENT 3.1-A
Attachment #6e
Page 1

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

AUTISM SPECTRUM DISORDER SERVICES

DEFINITION

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

Autism Spectrum Disorder (ASD) services are researched-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with ASD and promote, to the extent practicable, the adaptive functioning of a beneficiary.

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

LIMITATIONS

1. In accordance with 42 CFR 440.130, ASD services are covered as medically necessary based upon the recommendation and referral of a licensed physician or other qualified healthcare provider practicing within their scope of licensing, for individuals who have been diagnosed with ASD.

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

2. Evidence-based services that treat or address ASD are covered for members who meet medically necessary criteria.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

Formatted: Font: 11 pt

a. the proposed services are medically appropriate; and

Formatted: Indent: Left: 0", Hanging: 0.25", Tab stops: 0.25", Left + 0.38", Left + 0.44", Left + Not at 0.31" + 0.63"

b. the proposed services are more cost effective than alternative services.

Formatted: Underline, Font color: Red

T.N. # 23-0011

Approval Date _____

Supersedes T.N. # New

Effective Date 7-1-23

42 CFR
440.60

ATTACHMENT 3.1-B
Attachment #6e
Page 1

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

AUTISM SPECTRUM DISORDER SERVICES

DEFINITION

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

Autism Spectrum Disorder (ASD) services are researched-based behavioral intervention services that prevent or minimize the disabilities and behavioral challenges associated with ASD and promote, to the extent practicable, the adaptive functioning of a beneficiary.

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

LIMITATIONS

1. In accordance with 42 CFR 440.130, ASD services are covered as medically necessary based upon the recommendation and referral of a licensed physician or other qualified healthcare provider practicing within their scope of licensing, for individuals who have been diagnosed with ASD.

Formatted: Underline, Font color: Red

Formatted: Underline, Font color: Red

2. Evidence-based services that treat or address ASD are covered for members who meet medically necessary criteria.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

Formatted: Font: 11 pt

a. the proposed services are medically appropriate; and

Formatted: Indent: Left: 0", Hanging: 0.25", Tab stops: 0.25", Left + 0.38", Left + 0.44", Left + Not at 0.31" + 0.63"

b. the proposed services are more cost effective than alternative services.

Formatted: Underline, Font color: Red

T.N. # 23-0011

Approval Date _____

Supersedes T.N. # New

Effective Date 7-1-23



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: UT - 23 - 0012

Cost Sharing Requirements	G1
----------------------------------	-----------

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid.

- The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

- The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.
- No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).
- The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):
 - The state includes an indicator in the Medicaid Management Information System (MMIS)
 - The state includes an indicator in the Eligibility and Enrollment System
 - The state includes an indicator in the Eligibility Verification System
 - The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider
 - Other process
- Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department.

- The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:
- Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
 - Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
 - Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;



Medicaid Premiums and Cost Sharing

- Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- Provide a referral to coordinate scheduling for treatment by the alternative provider.
- The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The state identifies non-emergency services performed in the emergency department through diagnosis codes. The state has identified a list of diagnosis codes that are considered emergent in nature. When a individual seeks services from the emergency department and it is determined that their diagnosis is not on the list of approved emergent medical conditions, they are assessed cost sharing for non-emergency services being delivered in the emergency department setting.

Cost Sharing for Drugs

The state charges cost sharing for drugs.

Yes

The state has established differential cost sharing for preferred and non-preferred drugs.

No

- All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

- Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: UT - 23 - 0012

Cost Sharing Amounts - Categorically Needy Individuals	G2a
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to <u>all</u> categorically needy (Mandatory Coverage and Options for Coverage) individuals.	<input type="text" value="No"/>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: UT - 23 - 0012

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to <u>all</u> medically needy individuals.	<input type="text" value="No"/>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: UT - 23 - 0012

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	<input type="text" value="No"/>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20181119



Medicaid Premiums and Cost Sharing

State Name:

OMB Control Number: 0938-1148

Transmittal Number: UT - 23 - 0012

Cost Sharing Limitations G3

42 CFR 447.56
1916
1916A

The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
 - 133% FPL; and
 - If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- Disabled or blind individuals under age 18 eligible for the following eligibility groups:
 - SSI Beneficiaries (42 CFR 435.120).
 - Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
 - Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- An individual receiving hospice care, as defined in section 1905(o) of the Act.
- Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).



Medicaid Premiums and Cost Sharing

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.

Yes

Indicate below the age of the exemption:

- Under age 19
- Under age 20
- Under age 21
- Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specifically identified in the state plan as not being related to pregnancy.
- Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
 - The state accepts self-attestation
 - The state runs periodic claims reviews
 - The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
 - The Eligibility and Enrollment and MMIS systems flag exempt recipients



Medicaid Premiums and Cost Sharing

Other procedure

Additional description of procedures used is provided below (optional):

To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

- The MMIS system flags recipients who are exempt
- The Eligibility and Enrollment System flags recipients who are exempt
- The Medicaid card indicates if beneficiary is exempt
- The Eligibility Verification System notifies providers when a beneficiary is exempt
- Other procedure

Additional description of procedures used is provided below (optional):

Payments to Providers

- The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid.

Yes

- The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

- Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.
- The percentage of family income used for the aggregate limit is:



Medicaid Premiums and Cost Sharing

- 5%
- 4%
- 3%
- 2%
- 1%
- Other: %

The state calculates family income for the purpose of the aggregate limit on the following basis:

- Quarterly
- Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation.

Yes

Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

Managed care organization(s) track each family's incurred cost sharing, as follows:

Other process:

Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Information related to aggregate limits is maintained in the recipient's health portal identified as "MyHealthPortal". Each recipient can access this information as needed.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period.

Yes

Describe the appeals process used:

Recipients can call constituent services or customer service to request a review of their quarterly cap in relation to cost sharing and premiums.

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:



Medicaid Premiums and Cost Sharing

The provider or entity is directed to resubmit claims and the over paid cost sharing is assessed to the recipient by the provider or entity.

- Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Recipients can call constituent services or customer service to request a review of their quarterly cap in relation to cost sharing and premiums.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5).

No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

INPATIENT HOSPITAL
Section 100 Payment Methodology (Continued)

190 Exempt Hospitals -- Two categories of hospitals are exempt from DRGs:

- The State Hospital: Because of its unique patient population, the Utah State Hospital (USH) is not part of the Diagnostic Related Group (DRG) system under which inpatient hospitals are reimbursed. Instead, the State hospital receives an interim per diem rate per patient category (i.e., forensic, adult, and youth) throughout the fiscal year, and a final cost settlement is subsequently performed by comparing Medicaid service costs to the interim payments received by the hospital. Medicare regulations and the Provider Reimbursement Manual - Part 1 (CMS Pub. 15-1) are used to determine allowable costs. The State hospital's Medicare cost methodology pays an average cost per discharge. However, for purposes of measuring Medicaid costs, a separate routine per diem cost is calculated for each patient category within the State hospital and applied to Medicaid eligible hospital days. Ancillary costs are separately allocated based on patient days. Therapeutic leave days are included in the total count of Medicaid days, unless the patient was discharged. However, if a patient is admitted as an inpatient to a second hospital, the patient is deemed to be discharged from the State hospital and the days are not counted. The day count used in the Medicaid cost settlement is consistently applied for all admissions for all patient categories in establishing the State hospital's per diem costs.
- Rural Hospitals: Hospitals located in rural areas of the state are exempt from the DRG reimbursement methodology. (Urban counties are Cache, Davis, Salt Lake, Utah, Washington and Weber. Rural counties are all other Utah counties.) Rural hospitals are paid 89 percent of net covered charges. "Net covered charges" are defined on Page 4.

~~191 Payment Adjustments — Effective July 1, 2010, urban hospitals will have their calculated DRG payment reduced by 14.3 percent. This reduction to the calculated paid amount will occur after all calculated payments (base payment, outlier, etc.) and before third party liability and co-pay are applied to the payment.~~

194 Specialty Out-Of-State Hospitals -- These hospitals provide inpatient services that are not available in the State of Utah. To qualify for this special payment provision, prior authorization must be obtained from the Utah State Department of Health, Division of Health Care Financing. The payment amount will be established by direct negotiations for each approved patient. The DRG method may or may not be used depending on the negotiated payment. Typically, the Medicaid rate in the State where the hospital is located is paid.

T.N. # 15-000223-0013

Approval Date 9-17-15

Supersedes T.N. # 13-02815-0002

Effective Date 7-1-1523