



Medicaid Administration

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

State Plan Administration Designation and Authority

A1

42 CFR 431.10

Designation and Authority

State Name:

Utah

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency:

Utah Department of Health

Type of Agency:

- Title IV-A Agency
- Health
- Human Resources
- Other

Type of Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

UCA 26-1-18

The single state agency supervises the administration of the state plan by local political subdivisions.

Yes No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

Yes No



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Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

Yes No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 02/19/14

The type of responsibility delegated is (check all that apply):

- Determining eligibility
- Conducting fair hearings
- Other

Name of state agency to which responsibility is delegated:

Department of Workforce Services

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The Department of Health, Division of Medicaid and Health Financing (DMHF) delegates authority to the Department of Workforce Services (DWS), Office of Adjudications to conduct fair hearings. DWS conducts hearings regarding all applicant and beneficiary appeals for medical assistance eligibility cases as defined in the Memorandum of Understanding with DMHF, except for decisions about disability status, issues regarding services or benefits, and foster care and subsidized adoption medical assistance eligibility. DWS agrees to conduct hearings in compliance with 42 C.F.R. section 431, subpart E, and to comply with all applicable federal and state laws, rules, regulations, policies, and guidance governing the medical assistance programs.

DMHF retains oversight of the fair hearing process, and can conduct a Superior Agency Review any time that the agency disagrees with the DWS recommended decision. DMHF retains oversight of the State Plan and has a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by Department of Workforce Services.

DMHF will ensure that every applicant and beneficiary is informed in writing of the fair hearing process, how to contact DWS, and how to obtain information about fair hearings from that agency.

The DWS Adjudication Office conducts fair hearings when an applicant or recipient requests a hearing because the individual disagrees with the DWS decision about eligibility for medical assistance. Hearings are informal and most hearings are done via telephone, unless an individual requests to have an in-person hearing. Individuals have the opportunity to present their position, and can have someone assist them in the hearing process. DWS prepares a written recommended hearing decision which is sent to the applicant and recipient, the DWS eligibility worker and the Department of Health, Bureau of Eligibility Policy (BEP). The recommended decision does not become final for 30 days, allowing either the applicant/recipient or BEP to request a Superior Agency Review. The Superior Agency Review is conducted by the DMHF Office of Formal Hearings.

The DMHF Office of Formal Hearings conducts all fair hearings regarding denials of disability status, hearings



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about foster care or subsidized adoption Medicaid cases and hearings regarding services or benefits. All of these hearings are de novo hearings. Staff from BEP and Department of Human Services attend hearings concerning foster care or subsidized adoption Medicaid cases to provide policy and regulation expertise, or case specific information.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

DWS' recommended hearing decisions are sent to the Department of Health, BEP office. The applicant or recipient receives a notice of the DWS hearing decision, and can request a Superior Agency Review from the Department of Health. All hearing decisions on medical assistance cases made by the Adjudication Office at DWS are reviewed by the Department of Health, which has the right of Superior Agency Review of those decisions before the decision is made final. BEP Program specialists review fair hearing decisions made by DWS Adjudications Officers for correct application and interpretation of rules and policy to determine if a Superior Agency Review is necessary. The specialists also determine if the DWS hearing decision considered all the available information to make an accurate decision.

The Office of Formal Hearings under the direction of the Medicaid Division Director conducts Superior Agency Reviews of decisions made by DWS. The applicant or recipient may request a Superior Agency Review or the BEP may request the Superior Agency Review. These reviews are not de novo hearings; they are a review of DWS' decision, but the applicant or beneficiary may submit a statement or additional information to the ALJ for consideration. The Medicaid Division Director makes the final decision on whether to uphold the decision made by the Administrative Law Judge under the Superior Agency Review or whether to uphold the DWS decision. The final decision under the Superior Agency Review is sent to the applicant/recipient, DWS and BEP. If an applicant or recipient still disagrees with the decision, they may file an appeal in court.

Add

- The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act



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An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

Yes No

State Plan Administration

Organization and Administration

A2

42 CFR 431.10

42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Department of Health is organized into different divisions to carry out a wide variety of public health functions. The Division of Medicaid and Health Financing is responsible for the administration of the Medicaid and CHIP programs.

The Division is divided into several bureaus to carry out the various functions of administering medical assistance programs. The bureaus include Eligibility Policy, Managed Health Care, Medicaid Operations, Financial Services, Coverage and Reimbursement Policy, and Authorization and Community-Based Services. These bureaus manage the State Medicaid Plan, the State CHIP Plan, eligibility policies, covered benefits, reimbursement rates, provider training, assurance of access to services, claims payments, reporting requirements, and coordination of long-term care services.

The Bureau of Eligibility Policy is responsible for the State Plan provisions relating to eligibility coverage groups and eligibility criteria for Medicaid. It is also responsible for all the state administrative rules relating to eligibility for Medicaid and CHIP. It develops and publishes a Medicaid Eligibility Policy manual and a CHIP Eligibility Policy manual to be used by the eligibility staff at the Department of Workforce Services as well as being available to the public. The Department of Health works closely with DWS (Department of Workforce Services) and the IT staff in charge of the client information computer system to make changes that support the eligibility determination process. The Bureau of Eligibility Policy (BEP) monitors eligibility decisions through its MEQC process. It also assures compliance with policies by reviewing DWS' training and procedure manuals. BEP also has a medical review board that makes disability determinations for Medicaid applicants. BEP Program specialists review fair hearing decisions made by DWS Adjudications Officers for correct application and interpretation of rules and policy to determine if a Superior Agency Review is necessary, which is conducted by Department of Health Administrative Law Judges.

The Bureau of Coverage and Reimbursement sets provider rates and reimbursement policies. It completes cost projections, establishes pricing strategies, policies and methodologies, as well as reviewing participant utilization, medical costs, inflationary factors and other risk factors affecting health care costs.

The Bureau of Managed Care develops and oversees contracts with Managed Health providers, determines areas of coverage for managed care, oversees the Children's Health Insurance State Plan, and the EPSDT requirements and service provision. It provides education to participants about their health care coverage under Medicaid and CHIP, and assists participants in selecting a managed care provider or other access issues.

The Bureau of Medicaid Operations is in charge of provider enrollment, processing provider claims on behalf of eligible beneficiaries. It provides training to providers about allowable Medicaid expenditures and billing practices. It publishes providers manuals and is the single point of phone contact for information about client eligibility, claims processing and general Medicaid program questions.

The Bureau of Financial Services monitors, coordinates and facilitates the Division's efforts to operate economical and cost-effective medical assistance programs. It performs budget forecasting and preparation, appropriation requests, legislative reports, administration expenditures, and federal fiscal reports.

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The Bureau of Authorization and Community-Based Services is responsible for the interpretation and implementation of quality, cost-effective long-term care services including the development and oversight of the Department's several home and community based services waivers. The bureau is also responsible for the prior authorization process required for certain Medicaid-covered services.

There is an Office of Formal Hearings under the direction of the Medicaid Division Director. This office conducts Superior Agency Reviews of cases heard by DWS either at the request of the applicant or recipient or upon request of BEP. All hearing decisions on medical assistance eligibility cases made by the Adjudication Office at DWS are reviewed by the Department of Health, which has the right of Superior Agency Review of those decisions before the decision becomes final. Individuals receive a notice of the DWS hearing decision, and can request a Superior Agency Review from the Department of Health. These reviews are not de novo hearings, they are a review of DWS' decision. The Medicaid Division Director makes the final decision on whether to uphold the decision made by the Administrative Law Judge under the Superior Agency Review or whether to uphold the DWS decision.

In addition, the DMHF Office of Formal Hearings conducts hearings for the following issues: (1) disability determinations; (2) safeguarding against unnecessary or inappropriate hospital admissions or lengths of stay; (3) denying provider claims that fail to meet medically necessary criteria; (4) prepayment and postpayment review systems to determine if utilization is reasonable or necessary; (5) preadmission certification of non-emergency admissions; (6) long-term care physical and mental health certifications; (7) alleged patient abuse in Medicare and Medicaid-certified nursing facilities; (8) issues regarding services or benefits. The Department of Health conducts fair hearings regarding denials of disability status, as well as hearings about foster care or subsidized adoption Medicaid eligibility cases. All of these hearings at the Department of Health are de novo hearings. Staff from Department of Health and Department of Human Services attend hearings concerning foster care or subsidized adoption Medicaid cases to provide policy and regulation expertise, or case specific information.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The State Executive Branch is responsible for setting up Departments within the state government to carry out the various services and functions of the state government. The Executive Department designated the Department of Health as the Single State Medicaid Agency. As a department in the state government, the Department of Health is responsible for producing and updating the State Medicaid Plan, State Administrative Rules, and policies for the implementation of Medicaid and CHIP. The Department of Health is responsible for producing provider manuals, and managing the claims and reporting functions for Medicaid and CHIP. The Executive Director of the Department is appointed by the Governor of Utah, and is responsible for reporting to the Governor's office about the activities and responsibilities of the Department of Health. The Department of Health is also responsible for working with other governmental departments providing social services and public assistance programs. This includes the Department of Human Services which is the Title IV-E agency, and the Department of Workforce Services which is the Title IV-A agency.

The Title IV-A Department, DWS, is the agency responsible for the TANF and SNAP programs, and is the agency which conducts eligibility determinations for Medicaid and CHIP programs. DWS completes medical assistance determinations for all Medicaid eligibility groups including MAGI-based coverage groups, non-MAGI-based family, child and pregnant woman groups, aged, blind and disabled groups, breast and cervical cancer group, former foster care youth, and independent living foster care group. DWS also conducts fair hearings related to eligibility for these Medicaid groups, except for hearings concerning a denial of disability by the State Medical Review Board. All fair hearing recommended decisions are reviewed by the Single State Medicaid Agency. DWS does not determine eligibility for foster care and subsidized adoption cases (both IV-E and non-IV-E.) The Department of Human Services (the Title IV-E agency) conducts eligibility determinations for foster care and subsidized adoption medical assistance cases. Fair hearings for foster care and subsidized adoption coverage groups are conducted by the Single State Medicaid Agency.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

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Remove



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Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

DWS, the Title IV-A Agency, has been designated by the Medicaid Agency under a written memorandum of agreement to determine eligibility for the Medicaid and CHIP programs for all coverage groups except foster care and subsidized adoption. DWS is the agency that does eligibility for TANF and SNAP programs, as well as Child Care Assistance. As the employment service agency of the state, DWS also works to connect people with employment or educational resources to lead to employment. The Department of Health has a Memorandum of Agreement with the Department of Workforce Services that delineates the responsibilities and requirements of completing the eligibility determinations for medical assistance programs.

Front line staff, or Eligibility Workers, determine initial and ongoing eligibility for medical assistance programs which includes answering questions and educating clients about the Medicaid and CHIP programs. They accept and process applications for medical assistance, send notices of decision and conduct fair hearings, except for hearings concerning a denial of disability status or services and benefits. DWS has an Adjudication Office which conducts the fair hearings. Hearings are informal and most hearings are done via telephone, unless an individual requests to have an in-person hearing. Individuals have the opportunity to present their position, and can have someone assist them in the hearing process. The Department of Workforce Services has a training team which provides trainings statewide for problematic areas of eligibility, policy changes and the training of new workers. In addition, they have program specialists that assist eligibility teams with policy and procedural questions. This allows for a consistent and concise message to all DWS workers. DWS also houses and maintains the eligibility determination computer system for all medical programs. It is an integrated system for public assistance programs.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

- Yes No

State Plan Administration
Assurances

A3



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42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- All requirements of 42 CFR 431.10 are met.
- There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

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.