State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

March 30, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Honorable Subcommittee Members:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of UCA 26-18-3(3)(a), the following is a summary of recent changes.

Presumptive Eligibility for Children

The Department has transmitted a State Plan Amendment that allows presumptive eligibility for individuals who are under 19 years of age if a qualified entity determines that they are eligible.

This amendment specifies that the Divisions of Child and Family Services or Juvenile Justice Services are qualified to determine presumptive eligibility and specifies when the presumptive eligibility period begins and ends based on when an individual files a Medicaid application.

This amendment also requires that the application be completed and signed by the child's parent or other representative and requires that the application contain other identifying information.

The Department estimates an annual cost to the state budget of about $72,656 to result from this amendment, but also expects savings to result for Medicaid recipients who become presumptively eligible. This action should be the final step in the State's obtaining approval for the CHIPRA bonus payment, subject to CMS approval. The Department's actions are consistent with the following intent language from House Bill 2 from the 2012 General Session:

The Legislature intends that the Department of Health, in conjunction with the Department of Workforce Services and the Department of Human Services, use part of their appropriations to pursue obtaining CHIPRA Performance Bonuses if the Department of Health determines that it would be in the best financial interest of the state.

UTAH DEPARTMENT OF HEALTH

288 North 1460 West • Salt Lake City, UT
Mailing Address: P.O. Box 143101 • Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 • Facsimile (801) 538-6478 • *www.health.utah.gov*

Provider Screening and Enrollment

The Department has transmitted a State Plan Amendment to assure that it complies with provider verification and enrollment procedures. The State Plan Amendment is simply an attestation that the Department is in compliance with the requirements.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Waiver Amendment – Physical Health

The Department has submitted an amendment to the 1915(b) Freedom of Choice Waiver for Utah's Choice of Health Care Delivery and Hemophilia Disease Management Program to allow a new health plan, Health Choice Utah, to enter into a contract to provide services to Medicaid enrollees in Salt Lake and Davis counties.

Waiver Amendment – Mental Health

The Department has submitted an amendment to the 1915(b) Prepaid Mental Health Plan (PMHP). Historically, Medicaid recipients have been enrolled in the PMHP for rehabilitative services for mental health disorders, while outpatient rehabilitative services for substance use disorders have been reimbursed by Medicaid on a fee-for-service basis. Effective 7/1/2012, these recipients will receive needed outpatient rehabilitative services for substance use disorders through the PMHP capitation program as well.

Home and Community Based Waiver Amendments

The Department has submitted three home and community based waiver amendments to CMS. The amendments are for the Community Supports, New Choices and Technology Dependent waivers. The collective purpose of these three amendments is to incorporate quality improvement updates, revise references within each waiver to reflect name and contact information changes, and revise cost estimates of waiver services.

The Department also substituted all instances of the term Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) with the term Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID). ICF/ID is equivalent to intermediate care facility for persons with mental retardation (ICF/MR) under Federal law.

In addition to these global changes to all three waivers, each amendment also included waiver specific adjustments.

The ***Community Supports Waiver*** amendment modifies the routine group respite service. Previously, routine group respite was only available through the Self-Administered Service (SAS) model. The amendment adjusts this service so that it may now be offered through agency based providers.

The ***New Choices Waiver*** amendment includes increasing the limit of clients served annually from 1200 to 1400, reducing the minimum age requirement from 21 to 18 years of age, and expanding special targeting criteria to take account of individuals who at the time of application are receiving assisted living facility services on an extended stay basis of 180 days or greater or have previously been enrolled in the New Choices Waiver but were disenrolled from the waiver due to receipt of a lump sum payment or other financial settlement that resulted in loss of Medicaid financial eligibility.

The proposed effective date of the waiver amendments is retroactive to July 1, 2011. All three amendments are pending CMS approval. There is no anticipated cost increase to the Community Supports or Technology Dependent waivers associated with the amendments. There is an annual increased cost of $350,766 in state funds to increase the number of clients on the New Choices Waiver. This cost is offset by the savings achieved from transitioning the clients out of nursing facilities and into the New Choices Waiver. The full HCBS waiver amendment application for each waiver can be reviewed by visiting the following site: http://health.utah.gov/ltc/

Please let me know if you have any questions on any of these State Plan and waiver changes. You can reach me at 801- 538-6689.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

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W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

June 29, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Honorable Subcommittee Members:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(3)(a), the following is a summary of recent changes.

Home and Community Based Waiver Update

New Application Submission - June 2012

The 2012 General Legislative Session passed H.B. 272, Pilot Program for Autism Spectrum Disorder Services. This bill required Medicaid to draft and submit a home and community based waiver application to CMS by July 1, 2012. The waiver was submitted earlier today. The *Medicaid Autism Waiver* is a 2-year pilot program that is intended to serve approximately 200 children ages 2 through 5 years. The bill appropriated $4.5 million to implement this pilot: $1.5 million was transferred from Department of Human Services, Division of Child and Family Services and $3 million was designated from the fiscal year 2012 Medicaid Optional Services appropriation as one-time, non-lapsing funds.

Upon submission of the application, CMS typically has 90 days to review the request. The Medicaid Autism Waiver's anticipated effective date is October 1, 2012.

Additional information about the waiver and the full application can be found at:
http://health.utah.gov/autismwaiver/

1115 Waiver Amendment

On May 29, 2011, the Division submitted an amendment to the 1115 Primary Care Network Demonstration Waiver, pursuant to H.B. 144 S4, 2012 General Session of the Utah State Legislature. The amendment requests approval to raise the eligibility income level for adults in Utah's Premium Partnership Program (UPP) from 150% of the federal poverty level (FPL) to 200% of the FPL. The requested effective date of this amendment is July 1, 2012.

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Reimbursement for Physician and Anesthesia Services

The Department has transmitted a State Plan Amendment that updates the frequency of rebasing for physician and anesthesia services and clarifies the methodology for making supplemental payments for physicians employed by the University of Utah Medical Group.

The proposed change requires the physician fee schedule to be updated annually using current relative value units and a budget neutral conversion factor to establish rates. It also proposes annual updates to the anesthesia fee schedule and a 12 % enhancement for rural anesthesia providers.
The Department anticipates an increase of $157,700 to the budget as a result of the enhancement for rural anesthesia providers.

Please note that the Legislature appropriated $2,543,300 (total funds) to increase rates for physician services; however, this SPA addresses the rebasing of rates which is a budget neutral exercise and the addition of a rural enhancement for anesthesiologists as noted above.

There is no cost shift to more expensive services for Medicaid recipients and their families as a result of this amendment.

Quality Improvement Incentive

The Department has transmitted a State Plan Amendment that updates and continues quality incentive programs for nursing facilities and Intermediate Care Facilities for Persons with Intellectual Disabilities in future State Fiscal Years and makes other clarifications.

This amendment continues quality incentive programs by updating the incentive period to be July 1st through May 31st of each state fiscal year. It also specifies the calculation of the upper bound dollar limit of the incentives. Quality incentive programs include improvements to patient shower facilities, security systems, windows, software, and dining.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Medical Education Payments

The Department has transmitted a State Plan Amendment that updates the direct graduate medical education payment pool for 2013.

This amendment rewords the payment amount and time period for the payment pool so the Department does not have to update it each year.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Federally Qualified Health Centers

The Department has transmitted a State Plan Amendment to clarify alternative payment methods for federally qualified health centers (FQHCs).

This amendment clarifies that a FQHC must calculate only covered beneficiary charges when it calculates the Ratio of Beneficiary Charges to Total Charges Applied to Allowable Cost as part of its agreement with the federal government.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Dental Services

The Department has transmitted a State Plan Amendment to restore limited emergency dental services to non-pregnant clients and to non-EPSDT clients in accordance with mandates set forth in the 2012 General Session of the Utah Legislature.

This change provides limited services that include diagnostic exams, X-rays, incision and drainage of abscess, and extractions for erupted teeth.

The Legislature directed through Intent Language that the Department fund the cost of covering emergency dental services for adults on Medicaid within existing appropriations up to $250,000 in general fund for FY 2013. That is approximately $832,224 in total funds to restore these limited dental services. The Department anticipates that increased costs to the dental program will be offset by savings through fewer emergency room visits.

The policy change is an attempt to eliminate the cost shift to more expensive emergency department services. This change will create out-of-pocket savings for non-pregnant and non-EPSDT clients who receive limited emergency dental services.

Disproportionate Share Hospital Payments

The Department has transmitted a State Plan Amendment to allow non-government hospitals that have the support of a government entity (e.g., Special Services District, County government) for the non-federal match dollars to participate in Disproportionate Share Hospital Payments (DSH) payments.

This amendment adds verbiage to allow rural private hospitals that were government-owned as of January 1, 2011, to be eligible for DSH payments under the State Plan.

The Department does not anticipate any costs to result from this amendment and there is no cost shift to more expensive services for Medicaid recipients and their families.

Reimbursement for Home Health Services

The Department has transmitted a State Plan Amendment to update the effective date of home health rates from July 1, 2007, to July 1, 2012 to reflect additional appropriations by the Legislature for this service. The Department estimates an annual cost of about $400,000 (general funds) in SFY 2013 as a result of this change. This amendment will increase provider payments for home health services and thus preserve recipient access to home health services.

Reimbursement for Optometry Services, Speech Pathology Services, Audiology Services, Chiropractic Services, Eyeglasses Services, Physical Therapy and Occupational Therapy, and Rehabilitative Mental Health Services

The Department will transmit State Plan Amendments (SPAs) for each of the services listed above to update the effective date of the agency's rates to July 1, 2012. These updates are in accordance with changes to Section D – Physician Services, and are companion filings to the SPA that describes reimbursement for physician and anesthesia services.

Please note that the Legislature appropriated $2,543,300 (total funds) to increase rates for physician services. In some cases, the providers noted in these amendments bill using the same codes as physicians and, as a result, will recognize reimbursement changes to those shared codes. An estimate of those changes is as follows: SPA for Optometry Services $23,600; SPA for Speech Pathology Services $50; SPA for Audiology Services $550; SPA for Chiropractic Services $8,500; SPA for Eyeglasses Services $70; SPA for Clinic Services $160; SPA for Physical Therapy and Occupational Therapy $380; and SPA for Rehabilitative Mental Health Services $490.

In addition, the Department's transmittal SPA for Clinic Services will propose a rebasing of rates to a percentage of Medicare's rates effective October 1, 2012.

There is no cost shift to more expensive services for Medicaid recipients and their families as a result of these amendments.

Please let me know if you have any questions on these changes to the State Plan and on the waiver update.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Director, Medicaid and Health Financing

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Lieutenant Governor

Utah Department of Health

W. David Patton, PhD
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

October 1, 2012

Members of the Social Services Appropriations Subcommittee
State Capitol
Salt Lake City, Utah 84114

Dear Subcommittee Member:

The Centers for Medicare and Medicaid Services (CMS) requires the Department of Health to update its State Plan and existing waivers for Medicaid when the State makes changes to the program. In accordance with these changes and reporting requirements of Subsection 26-18-3(3)(a), the following is a summary of recent changes.

Nursing Facility Evacuation Payments

The Department has transmitted a State Plan Amendment that defines the payment process for evacuated nursing facility residents during a declared disaster. This is a continuity of operations provision of the Medicaid State Plan that will allow the Department to reimburse for care provided to evacuated nursing home residents in a declared disaster.

The Department does not anticipate any costs to result from this amendment because this change does not affect overall payments to the nursing facility industry or to providers of intermediate care facilities for persons with intellectual disabilities (ICF/IDs).

Further, there is no cost shift to more expensive services for Medicaid recipients and their families.

1915(b) Choice of Health Care Delivery Program & Hemophilia Disease Management Program

Amendment Submission - September 2012

Senate Bill 180 passed during the 2011 General Legislative Session. This bill required the Department of Health to develop a proposal to modify the Medicaid program in a way that maximizes replacement of the fee-for-service delivery model with one or more risk-based delivery models. As previously reported, the Department prepared an 1115 waiver request that was not approved in its entirety by the Centers for Medicare and Medicaid Service (CMS). Since the provisions CMS denied were the ones requiring an 1115 waiver, CMS instructed the Department to use a 1915(b) waiver as the mechanism to implement the payment reform.

This waiver amendment provides for four full-risk capitated health plans in Weber, Davis, Salt Lake and Utah counties effective January 1, 2013. The state will no longer provide for a non-risk plan or

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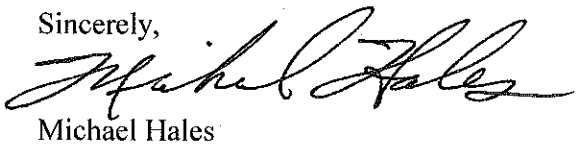
primary care case management plan in these four counties. The plans offered will be Select Health, Molina Healthcare of Utah, Healthy U and HealthChoice of Utah. In addition, effective January 1, 2013, these four plans will assume responsibility for the administration of the Medicaid pharmacy benefit for Medicaid recipients enrolled in their plan. Upon submission of this amendment, CMS has 90 days to review the request.

Please let me know if you have any questions on the change to the State Plan or the waiver amendment.

Sincerely,



Michael Hales
Deputy Director, Department of Health
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