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State/Territory Name: Utah

State Plan Amendment (SPA) #: 21-0012

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS Form 179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



August 12, 2022

Jennifer Strohecker
State Medicaid Director
Division of Integrated Healthcare
Utah Department of Health & Human Services
P O Box 144102
Salt Lake City UT 84114-4102

Re: Utah State Plan Amendment (SPA) UT-21-0012

Dear Ms. Strohecker:

We have reviewed the proposed amendment to add section 7.5 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) UT-21-0012. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the

quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Utah also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Utah also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Utah's Medicaid SPA Transmittal Number UT-21-0012 is approved effective July 1, 2021. This SPA is in addition to all previous approved Disaster Relief SPAs, and does not supersede anything approved in those SPAs.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Mandy Strom at (303) 844-7068 or by email at Mandy.Strom@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Utah and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2022.08.12
17:06:40 -04'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 1 — 0 0 1 2

2. STATE

U T

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT

XIX XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2021

5. FEDERAL STATUTE/REGULATION CITATION

Section 1902(a)(30)(A) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2021 \$ 0
b. FFY 2022 \$ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 7.5

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

9. SUBJECT OF AMENDMENT

School-Based Payments and Services

10. GOVERNOR'S REVIEW (Check One)

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

Signature: 

Email: jstrohecker@utah.gov

15. RETURN TO

Craig Devashrayee
Utah Department of Health
Division of Medicaid and Health Financing
cdevashrayee@utah.gov

13. TITLE

Medicaid Director, Utah Department of Health

14. DATE SUBMITTED

October 5, 2021*

FOR CMS USE ONLY

16. DATE RECEIVED

October 5, 2021

17. DATE APPROVED

August 12, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

July 1, 2021

19. SIGNATURE OF APPROVING OFFICIAL

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2022.08.12
17:06:55 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL

Alissa Mooney DeBoy

21. TITLE OF APPROVING OFFICIAL

On Behalf of Anne Marie Costello, Deputy Director, CMCS

22. REMARKS

* State authorized a pen & ink change in Box 14 to reflect the original submission date of the SPA.

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

The amended changes to the school-based services payment methodology in this SPA are effective July 1, 2021, through September 30, 2021.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

T.N. # 21-0012

Approval Date 8-12-22

Supersedes T.N. # New

Effective Date 7-1-21

This SPA is in addition to Utah's other Disaster Relief SPAs approved by CMS. This SPA does not supersede any disaster relief SPAs previously approved by CMS.

State/Territory: UTAH

- c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

The Department presented this SPA to the Utah Indian Health Advisory Board on September 10, 2021, as an initial step in the consultation process. The Board had questions regarding FFS reimbursement for certain rehabilitative services such as physical therapy, occupational therapy, and speech therapy. The Department responded that by federal mandate, institutions of public education provide these services to students free of charge. The Board also asked whether Native American children would be covered under the program. The Department affirmed they can be covered as long as they are enrolled in Medicaid with a school district that participates.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.
2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

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Approval Date 8-12-22

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4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

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4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

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Approval Date 8-12-22

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Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. The agency makes the following adjustments to benefits currently covered in the state plan:

Skills Development Services

EPSDT Services Provided by Local Education Agencies

A. Medicaid provides direct coverage to eligible recipients pursuant to EPSDT for services furnished in the school-setting, in accordance with section 1905(a) of the Social Security Act. Under EPSDT, the state must provide all 1905(a) coverable benefits/services to individuals under the age of twenty-one in accordance with regulations at 42 CFR 440. Services must be determined medically necessary by the state. Medicaid eligible individuals up to the age of 21, receiving covered services in a school setting, must have a valid IEP.

LEA Responsibilities

1. LEAs shall ensure that all service providers act within the requirements of proper licensure or certification.
2. LEAs shall ensure that all unlicensed/uncertified providers requiring supervision are properly supervised.
3. LEAs shall ensure that licensed/certified supervising providers assume professional liability for unlicensed/uncertified providers rendering covered Medicaid services.
4. LEAs shall ensure that proper documentation of rendered services is created and maintained to ensure that all compliance requirements are met.

Service Exclusions

1. Services are not covered when the service is educational or academic in nature.
2. Services are not covered when the service is considered to be social, vocational, or extracurricular in nature.

Service Provision

- A. Orientation and Mobility Services (O&M):

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Approval Date 8-12-22

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Effective Date 7-1-21

This SPA is in addition to Utah's other Disaster Relief SPAs approved by CMS. This SPA does not supersede any disaster relief SPAs previously approved by CMS.

1. Orientation and Mobility services are rehabilitative services recommended by a physician or other licensed practitioner related to the evaluation, diagnosis, and treatment of a student who is blind or visually impaired to attain systematic and safe orientation and movement within their environment through sensory integrative techniques. Orientation and Mobility services also include direct assistance with the selection, acquisition, training, and use of an Assistive Technology Device. The following providers may render these services:

a. Orientation and Mobility Services performed by an Orientation and Mobility Specialist with Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals.

b. Paraprofessional under the supervision of a qualified Orientation and Mobility Specialist.

B. Aural Therapy Services

1. In addition to audiologists and speech language pathologists, this rehabilitative service may also be performed by Teachers for the Deaf and Hard of Hearing who meet the qualifications of having a master's degree from an accredited college or university with a major in the Teaching of the Deaf and Hard of Hearing and are under the direction of a speech pathologist or audiologist.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

State/Territory: UTAH

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules

Effective date (enter date of change): _____

Location (list published location): _____

- b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

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Please describe criteria.

b. Payments are increased through:

- i. A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. Are not otherwise paid under the Medicaid state plan;
- b. Differ from payments for the same services when provided face to face;
- c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

- i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

- ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

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State/Territory: UTAH

Other:

4. Other payment changes:

Effective 7/1/2021, Utah's School-Based Skills Development payment model is as follows:

A. Reimbursement Methodology for School-Based Skills Development Services

School-based services, known as School-Based Skills Development Services (SDS) in Utah, are delivered by the school districts, charter schools and public K-12 educational institutions (herein after referred to as "Local Education Agencies" or "LEAs"), and include the following Medicaid 1905(a) services:

- Nursing Services;
- Personal Care Services;
- Psychology Services;
- Counseling Services;
- Social Work Services;
- Orientation, Mobility, and Vision Services;
- Speech-Language Services;
- Audiology Services;
- Occupational Therapy (OT);
- Physical Therapy (PT);

All costs described within this methodology are for Medicaid services provided by qualified personnel or qualified health care professionals who have been approved under Attachments 3.1-A and 3.1-B of the Medicaid state plan.

B. Direct Medical Payment Methodology

LEAs will be paid on a cost basis. LEAs will be reimbursed interim rates for SDS direct medical services. On an annual basis, an LEA-specific cost reconciliation and cost settlement for all over and under payments will be processed.

1. Participating SDS LEAs are reimbursed interim payments based on a monthly calculated rate. Interim payments under the SDS Program are calculated prior to the school year beginning and are divided into twelve equal monthly installments, to be paid July 1 through June 30. Interim payments shall be ties to claim submissions by the LEA.

a. For the 2021-22 school year, the interim rates were calculated based on the LEA's reported costs from the 2019-20 school year.

b. For the 2022-23 school year, the interim rates were calculated using the cost data for the direct service cost pools from the October-December 2021 quarterly financial submissions for the administrative claims.

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This SPA is in addition to Utah's other Disaster Relief SPAs approved by CMS. This SPA does not supersede any disaster relief SPAs previously approved by CMS.

c. For the 2023-24 and subsequent years, the interim rates shall be based on the LEA's actual, certified costs identified in their most recently filed annual cost report from the prior fiscal year.

d. For a new participating LEA, the interim rate shall be calculated based on statewide historical data.

e. When an LEA's Total Medicaid Allowable Cost amount has been calculated following the processes defined in the following sections, the amount is then divided by 12 to arrive at a monthly rate figure. These monthly rates will be implemented to support the interim payments for the following fiscal year. Each LEA will have their own monthly rate inclusive of their Medicaid Allowable Costs for both of the direct service cost pools.

f. The LEA is then given the option to request that the monthly amount be paid at either 80% or 90% of the total calculated amount. The percentage is applied in an effort to minimize LEA overpayments.

g. A cost reconciliation and cost settlement is completed annually as described in Sections G and H. If an LEA's total monthly interim payments for the year exceed their costs to render services, the LEA will be invoiced the difference and the state will recoup the amount. If the total amount of monthly interim payments for the year is less than what the LEA's costs were to render services, the LEA will be reimbursed the difference.

2. LEAs will continue to submit claims for Medicaid covered services rendered, but will not be paid for claim charges. All claims will be submitted to Medicaid with a \$.00 charge. LEAs will only be paid through the monthly interim payment.

C. Data Capture for the Cost of Providing School-Based Skills Development Services

Data capture for the cost of providing SDS will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:

a. SDS cost reports received from LEAs;

b. Utah State Board of Education (USBE) Unrestricted Indirect Cost Rate (UICR);

i. The unrestricted indirect cost rate is derived from costs having to do with administrative, overhead maintenance and other support services. Staff included on the LEA's staff pool list are not paid from these areas.

ii. LEAs are specifically 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. This ensures that there is no duplication of costs for indirect rates.

iii. Some LEAs do not have a calculated USBE Unrestricted Indirect Cost Rate (UICR). For those that do not have one calculated, a de minimis rate of 10% will

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be charges to Medicaid. All LEAs with a calculated UICR will use their calculated rate.

c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services) and Activity Code 10 (General Administration):

i. Direct Medical IEP activity code is accounted for in the annual cost settlement report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

ii. General Administration code 10 is accounted for in both the quarterly Medicaid Administrative Claim as well as the annual Cost Reconciliation and Cost Settlement.

a. General Administrative code 10 is a General Administrative Overhead Factor and is calculated to determine the amount of time that is eligible for reimbursement in the MAC Claim. General Administration is distributed to the reimbursable code based on the percentage of total time as dictated by the Random Moment Time Study.

b. General administrative code 10 is also accounted for in the annual cost report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

iii. The resulting direct medical service percentages will be specific to each cost pool and reflected as a statewide average.

d. LEA specific Medicaid Enrollment Ratio (MER):

i. For the purposes of the annual cost reconciliation and cost settlement process, the Medicaid Enrollment Ratio (MER) is referred to as the Medicaid IEP Ratio. This IEP Ratio is unique to each participating LEA and is used to apportion the Total Direct Medicaid Service costs between Medicaid and non-Medicaid. The ratio will be calculated based on a December 1 student count with the numerator reflecting the total number of students with a covered medical service in their IEP that are Medicaid enrolled and the denominator reflects the total number of all students with a covered medical service in their IEP.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

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1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs in the Utah Administrative Code. These direct costs will be calculated on an LEA-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. These direct costs are accumulated on the annual School-Based Skills Development Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the State of Utah. Costs will be reported on an accrual basis.

- a. Medically related purchased services include contracted services. LEAs report the amounts they pay to contracted providers as salaries. Benefits are not reported by the LEA for contracted staff.

- i. The USBE's Unrestricted Indirect Cost Rate is multiplied by the sum of the LEA's total regular staff salaries and the total contracted salaries.

- b. Medicaid Direct Medical Service costs are funded by the state and local dollars. Any expenditures that are fully paid for using federal funds will be removed from the cost report. Expenditures that are partially funded by federal funds will be reduced by the amount of federal funds. Only the portion of expenditures paid for with state or local funds is included in the calculation of the Medicaid Direct Medical Service costs. Providers of Medicaid Direct Medical Service costs make up this non-federally funded cost pool.

Allowable costs for this provider pool consist of:

- i. salaries;
- ii. benefits;
- iii. medically-related purchased services; and
- iv. medically-related supplies and materials

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific Unrestricted Indirect Cost Rate (UICR) to its adjusted direct costs. Utah LEAs use predetermined fixed rates for indirect costs. Utah State Board of Education (USBE) has, in cooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by LEAs in Utah. Pursuant to the authorization in 34 CFR §75.561(b), USBE approves unrestricted indirect cost rates for LEAs for the DOE, which is the cognizant agency for LEAs. If an LEA does not have a calculated UICR a de minimis rate of 10% will be utilized. Providers

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are permitted only to certify Medicaid-allowable costs and are not permitted to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

- a. Apply the Utah State Board of Education Cognizant Agency UICR applicable for the dates of service in the rate year.
- b. The UICR is the unrestricted indirect cost rate calculated by the Utah State Board of Education.

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.

3. Time Study Percentages: A time study separately approved by HHS (outside the state plan process) must be approved before claiming and drawing down FFP for eligible services. This is captured by using a Random Moment Time Study (RMTS) methodology, and is used to determine the percentage of time that medical service personnel spend on IEP, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize three cost pools in total. Two cost pools are for direct medical services and one cost pool for administrative activities.

a. The first cost pool is the Direct Service cost pool and includes all eligible staff and other medical services providers except staff that primarily provide personal care and behavior modification services. These individuals are eligible to bill direct medical services. Eligible positions included in this cost pool are:

- 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);
- 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.

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 +/- 2% and a 95% confidence level

f. Summer Vacation periods (when most students are not attending 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.

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4. Medicaid 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.
 - 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 result of the previous steps will be 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

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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.

E. Certification of Funds Process

Each LEA certifies on an annual basis an amount of the interim payments received during the previous federal fiscal year. In addition, each LEA certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

LEAs are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

F. Annual Cost Report Process

Each LEA will complete an annual cost report for all SDS delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than one year after the close of the quarter ending June 30.

a. The primary purpose of the cost report is to

i. document the LEA's total Medicaid allowable scope of costs for delivering SDS, including direct costs and indirect costs, based on cost allocation methodology procedures

b. Cost reports will be subjected to a comprehensive review process prior to their use in the calculation of the interim rates.

i. The review will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SDS program are

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aware of federal regulations listed below for audits and documentation, and will provide documentation for MERs and any other documentation needed to support SDS claims

- a. 42 CFR 431.107 Required provider agreement
- b. 45 CFR 447.202 Audits
- c. 45 CFR 75.302 Financial management and standards for financial management systems

c. Cost reports will be used to reconcile its interim payments to its total Medicaid-allowable scope of costs based on cost allocation methodology procedures.

i. The reconciliation will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. The annual SDS Cost Report includes a certification of funds statement to be completed, certifying the LEA's actual, incurred costs/expenditures. All filed annual SDS Cost Reports are subject to a desk review by the Division of Integrated Healthcare (DIH) or its designee.

G. The Cost Reconciliation Process

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SDS Cost Report. The total CMS-reviewed, Medicaid-allowable scope of costs based on CMS-reviewed cost allocation methodology procedures are compared to the LEA's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-reviewed scope of costs, the CMS-reviewed cost allocation methodology procedures, or its CMS-reviewed time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires review from CMS prior to implementation; however, such review does not necessarily require the submission of a new state plan amendment.

H. The Cost Settlement Process

1. For services delivered for a period covering July 1 through June 30, the annual SDS Cost Report is due no later than one year after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than two years after the fiscal year end.

a. Actual costs will be used to determine whether or not the LEA has an under or overpayment. Actual costs will be calculated for the school year and will then be compared to the interim payments made during that same school year.

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2. If an LEA's interim payments exceed the actual, certified costs of the provider for SDS to Medicaid members, the provider will return the federal share of an amount equal to the overpayment.

3. If the actual, certified costs of an LEA for SDS exceed the interim Medicaid payments, DIH will pay the federal share of the difference to the LEA in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

a. DIH will issue a notice of settlement within 60 days following the completion of the settlement determination that denotes the amount due to or from the provider.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

- a. ____ The individual's total income
- b. ____ 300 percent of the SSI federal benefit rate
- c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Medicaid State Plan /Additional 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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review

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instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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