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State/Territory Name: Utah

State Plan Amendment (SPA) UT: 25-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

September 12, 2025

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 TN: 25-0015

Dear Director Jennifer Strohecker,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Utah state plan amendment (SPA) to Attachment 4.19-B UT-25-0015, which was submitted to CMS June 20, 2025. This amendment removes provisions for transitional outpatient payments as funding for these payments to providers was cut during the 2025 General Session of the Utah Legislature. Accordingly, the transition need has passed.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementation of Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July,1 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Monica Neiman at via email at monica.neiman@cms.hhs.gov

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0015

2. STATE: UT

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, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.20

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ (103,100)
b. FFY 2026 $ (412,400)

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Page 1 of ATTACHMENT 4.19-B

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Page 1 of ATTACHMENT 4.19-B
(TN 20-0011)

9. SUBJECT OF AMENDMENT
Transitional Outpatient Payments

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
[redacted]

12. TYPED NAME
Tracy S. Gruber

13. TITLE
Executive Director, Utah Dept of Health & Human Services

14. DATE SUBMITTED
June 20, 2025

15. RETURN TO
Craig Devashrayee
Department of Health & Human Services
Division of Integrated Healthcare
cdevashrayee@utah.gov

FOR CMS USE ONLY

16. DATE RECEIVED
June 20, 2025

17. DATE APPROVED
September 12, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

42 CFR
440.20

A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Effective for service end dates on or after September 1, 2011, the payment for outpatient hospital claims will be based on Medicare's Outpatient Prospective Payment System (OPPS) payment methodology. Medicare's Outpatient Code Editor and CMS pricer will be utilized for payment amounts.

   A. OPPS hospitals will be paid per applicable APC, Medicare fee schedule, or reasonable cost method (reasonable cost will be paid using the facility-specific cost-to-charge (CCR) multiplied by the line-item billed charge). A factor, rounded to four (4) decimal places, will then be applied to the rate to offset the annual Medicare inflation changes. The following example is provided for illustrative purposes only:

Year	Inflation	Change (based on $100)	Factor	Adjusted Payment
1	2.6%	$102.60	0.9747	$100.00
2	2.0%	$104.65	0.9555	$100.00

   The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

   B. Services not priced using OPPS or CAH methodology will be based on the established Medicaid fee schedule and the reimbursement policies for those services may be found in Attachment 4.19-B as follows:

   - Section C – Laboratory and Radiology Services
   - Section D – Physicians
   - Section E – Anesthesiologist/Anesthetist
   - Section F – Podiatrists
   - Section G – Optometrists
   - Section H – Eyeglasses
   - Section K – Medical Supplies and Equipment
   - Section M– Dental Services and Dentures
   - Section N– Physical and Occupational Therapy
   - Section O– Prosthetic Devices and Braces
   - Section P– Speech Pathology
   - Section Q – Audiology
   - Section S – Prescribed Drugs

   Typically, these services are not covered by Medicare.

   Except as otherwise noted in the plan, payments for these services based on state-developed fee schedule rates, are the same for both governmental and private providers. All rates are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at the web address noted on the Introduction page of this attachment.

   C. Vaccines for Children (VFC) services will be paid using the Medicaid VFC rates. Non-VFC services will be paid using Medicare's pricer. The reimbursement policies for those services may be found on Page 9a of Section 1.5.

   D. Revenue code 72[0-9], if not accompanied with procedure code detail, will be paid using the reasonable cost methodology.

   E. Transitional Outpatient Payments (TOPs) will be calculated according to Medicare principles and paid on a semi-annual basis to in-state providers only. TOPs payments will cease for services on or after July 1, 2025.

   F. Dialysis services are paid at the OPPS rate for the first encounter per member per hospital. Subsequent outpatient hospital visits for end-stage renal disease requiring dialysis treatment will reimburse, for all billed services (e.g., labs, evaluation and management, IV fluids, EKG), at the Medicare ESRD PPS Base Rate as stated in Attachment 4.19-B, Page 12a.

2. Critical Access Hospitals (CAH) will be paid 101% of costs using the facility-specific CCR.

   The CCR used will be the Medicare CCR calculated from the most recently filed Medicare Cost Report as available through the HCRIS database or the Medicare fiscal intermediary.

3. Out-of-state hospitals will be paid by hospital type (OPPS or CAH) like in-state hospitals, but will not receive any specialty payments (e.g., TOPs).

4. Billed charges shall not exceed the usual and customary charge to private pay patients.