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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-23-0028

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

April 26, 2023

Jennifer Strohecker
Medicaid Director
Director, Division of Integrated Healthcare
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Ms. Strohecker:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA), UT-23-0028, submitted on February 3, 2023, has been approved. Through SPA UT-23-0028, the state updates the CHIP out of pocket maximum member notification process. The state will use a new Provider Reimbursement Information System (PRISM) process that will track, calculate and inform members of when the 5 percent out of pocket maximum cost has been met. This approval relates only to the process for tracking cost sharing under the CHIP state plan; Medicaid processes will be analyzed separately. Additionally, this SPA clarifies Utah's disenrollment policies for non-payment of premiums. This SPA has an effective date of April 1, 2023.

Your Project Officer is Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Ms. Jordan's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: The State of Utah

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Jennifer Strohecker	Position/Title: Director, Medicaid and Health Financing
Name: Jeff Nelson	Position/Title: CHIP Director
Name: Jennifer Wiser	Position/Title: CHIP Program Manager

***Disclosure. 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 09380707. The time required to complete this information collection is estimated to average 160 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at

42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State

plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)

5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess

the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)

11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration

including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements
States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the descriptions of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Amy Lutzky
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA

may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: July 10, 1998

Implementation Date: August 1, 1998

SPA # 10 , Purpose of SPA: Rebenchmark CHIP benefits
Proposed effective date: November 19, 2011

Proposed implementation date: November 19, 2011

SPA # 11 , Purpose of SPA: Express Lane Eligibility and Presumptive Eligibility -pending
Proposed effective date: ELE- September 1, 2011; Presumptive Eligibility- April 1, 2012

Proposed implementation date: ELE- September 1, 2011; PE- April 1, 2012

SPA #_12_, Purpose of SPA: Rebenchmark CHIP benefits
Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012
Withdrawn

SPA #_13_, Purpose of SPA: Rebenchmark CHIP benefits
Proposed effective date: July 1, 2012

Proposed implementation date: July 1, 2012

SPA #_14_, Purpose of SPA: Eliminate Presumptive Eligibility for children that meet the requirements of section 1920A of the Act. (Section 2107 (e)(1)(L)); (42 CFR 457.355)
Removing references to Plan A.
Proposed effective date: November 1, 2014

Proposed implementation date: November 1, 2014

SPA# 15, Purpose of SPA: Ex Parte Reviews
Proposed effective date: February 1, 2015

Proposed implementation date: February 1, 2015

SPA# 16, Purpose of SPA: Change Reports
Proposed effective date: November 1, 2015

Proposed implementation date: November 1, 2015

SPA# 17, Purpose of SPA: Rebenchmark CHIP dental benefits
Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016
SPA# 18, Purpose of SPA: FQHC Payment Methodology
Proposed effective date: July 1, 2016

Proposed implementation date: July 1, 2016

SPA #20 Purpose of SPA: CHIP Mental Health Parity and Addiction Equity Act Analysis, Removal of Co-Payment Requirements for Residential Treatment and the Removal of Co-payment Requirements for Mental Health and Substance Use Disorder Services in an Urgent Care Clinic
Proposed effective date: July 1, 2021

Proposed implementation date: July 1, 2021

SPA# 21, Purpose of SPA: Update CHIP benefits
Proposed effective date: July 1, 2019

Proposed implementation date: July 1, 2019

SPA# 22, Purpose of SPA: Add CHIP Disaster Relief Plan
Proposed effective date: March 1, 2020

Proposed implementation date: March 1, 2020

SPA# 24, Delay timeliness requirements on ex parte renewals.

Proposed implementation date: February 1, 2021

SPA# 25, Purpose of SPA: Update CHIP Benefits

Proposed implementation date: July 1, 2021

Proposed Implementation date: July 1, 2021

SPA# UT-21-0026, Purpose of SPA: The purpose of this SPA is to demonstrate compliance with the American Rescue Plan Act provisions that require states to cover treatment (including treatment of a condition that may seriously complicate COVID-19 treatment), testing and vaccinations for COVID-19 without cost sharing in CHIP.

Proposed effective date: March 11, 2021

Proposed implementation date: March 11, 2021

SPA# UT-23-0028, Purpose of SPA: The purpose of this SPA is to update the CHIP out of pocket maximum member notification process.

Proposed effective date: April 1, 2023

Proposed implementation date: April 1, 2023

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

State Plan Amendments 10 & 11 was presented at the Indian Health Advisory Board meeting on October 7, 2011. There was no request for consultation.

State Plan Amendment 13 was presented at the Utah Indian Health Advisory Board meeting on August 3, 2012. Consultation was not requested.

State Plan Amendment 14 was presented at the Utah Indian Health Advisory Board meeting on 08/08/2014. Consultation was not requested.

State Plan Amendment 15 was presented at the Utah Indian Health Advisory Board meeting on 12/12/2014. Consultation was not requested.

State Plan Amendment 16 was presented at the Utah Indian Health Advisory Board meeting on 10/9/2015. Consultation was not requested.

State Plan Amendment 17 was presented at the Utah Indian Health Advisory Board meeting on 7/8/2016. Consultation was not requested.

State Plan Amendment 18 was presented at the Utah Indian Health Advisory Board meeting on 3/10/2017. Consultation was not requested.

State Plan Amendment 20 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2018. Consultation was not requested.

State Plan Amendment 21 was presented at the Utah Indian Health Advisory Board meeting on June 7, 2019. Consultation was not requested.

State Plan Amendment 22 in concept was presented at the Utah Indian Health Advisory Board meeting on April 10, 2020. The final SPA was presented to the board on May 8, 2020, after the SPA was submitted to CMS. To address the Federal COVID-19 public health emergency, the State received waiver approval under section 1135(b)(5) of the Act, for flexibility to modify the timeframes associated with tribal consultation, including conducting consultation after submission of the SPA. Consultation was not requested.

State Plan Amendment 24 was presented to the Utah Indian Health Advisory Board meeting on February 12, 2021, again after CMS guidance on March 12, 2021, and finally a status update on April 9, 2021. Consultation was not requested.

State Plan Amendment 25 was presented to the Utah Indian Health Advisory Board meeting on August 13, 2021. Consultation was not requested.

State Plan Amendment 26 was presented to the Utah Indian Health Advisory Board meeting on March 11, 2022. Consultation was not requested.

State Plan Amendment UT-23-0028 was presented to the Utah Indian Health Advisory Board meeting on January 13, 2023. Consultation was not requested.

8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

At application and renewal families are sent an approval notice telling them what their 5% out of pocket maximum amount will be for that certification period. Enrollees who have been verified as American Indian or Alaska Native are

exempt from the 5% out of pocket maximum cost sharing requirement, as they are not charged any cost sharing.

All new CHIP enrollee's will receive a letter with information about their CHIP benefits and instructions on how to access the CHIP Member Guide. The letter instructs the member to call the Medicaid and CHIP office to learn about their medical, pharmacy, dental and mental health benefits. The office may also provide information about how co-pays and deductibles will be tracked and applied toward their out-of-pocket maximum.

The cost sharing from premiums, and eligible medical, pharmacy and dental expenses contribute toward the 5% out of pocket maximum. The state's Provider Reimbursement Information System (PRISM) will use premiums, medical, pharmacy and dental encounters to track when the household has met their 5% maximum out of pocket. When the 5% has been met the enrollee no longer has a cost share for that certification period. PRISM will use the date the encounter was received to calculate when the out-of-pocket maximum will be met.

Once the maximum out of pocket is met, the health and dental plans will end the cost sharing requirement and the Enrollee will not billed any additional co-payments, coinsurance or deductibles for the rest of the certification period . The managed care plan will notify the enrollee that they no longer have cost sharing for the certification period and they will be sent a new identification card. Until the new card is received, the Enrollee may use the letter to show the provider that co-pays are not owed. Cost sharing paid over the 5% maximum will be refunded.

8.2.4. Other:
Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Consequences for an enrollee or applicant who does not pay copayments or coinsurance will be handled between the enrollee or applicant and the health care provider who has rendered the services.

The invoice regarding the quarterly premium is mailed to enrollees on the 1st day of the first month of the quarter."

The invoice regarding the premium notifies families when termination of coverage will occur if the family fails to pay the quarterly premium.

A family who does not pay their premium balance on time will be terminated from CHIP. The termination notice informs enrollees of their right to challenge a proposed termination of coverage for failure to pay premiums, consistent with

regulatory requirements for disenrollment protections at 42 CFR 457.570.

Approval notices sent at application and renewal inform enrollees of the amount of their quarterly premium, that they will receive a premium invoice when a premium is due, and that they will be terminated from CHIP if they do not pay the premium on time.

An invoice for payment is sent the 1st day of the 1st month of the quarter giving the enrollee until the 1st working day after the 10th of the following month to pay the premium. The family must pay the premium to keep their children enrolled. The family has a minimum grace period of at least 30 days after the beginning of the new coverage period to pay their quarterly premium. If the premium is not paid by the due date a $15.00 late fee is assessed, enrollment is terminated effective the last day of the 2nd month, and a termination notice is sent. The termination notice tells the family coverage may be reinstated if they pay the past due premium balance by the last day of the following month. Any termination notice sent to the family would be mailed out 10 days before the end of the month.

Coverage may be reinstated without a break in coverage when any of the following events occur:

- The family pays the premium balance by the last day of the 3rd month of the quarter (the month immediately following the termination.
- The family's countable income decreased to below 133% of the federal poverty level. The family will be considered for Medicaid coverage instead.
- The family's countable income decreases prior to the first month of the quarter and the family owes a lower premium amount. The new premium must be paid within 30 days.

A family who was terminated from CHIP, who reapplies within 90 days of the termination date, must pay any outstanding premium balance before the children can be re-enrolled.