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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-21-0025

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

November 19, 2021

Jeff Nelson
CHIP Director
Division of Medicaid and Health Financing
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Mr. Nelson:

I am pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), UT-21-0025, submitted on October 15, 2021, has been approved. Through SPA UT-21-0025, Utah adds coverage of behavioral therapy and other services for the treatment of autism spectrum disorder, including applied behavioral analysis, to its CHIP benefit package, with an effective date of July 1, 2021. This SPA also updates the CHIP state plan by removing non-substantive outdated references.

Your title XXI project officer is Ms. Joyce Jordan. She is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Jordan's contact information is as follows:

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

If you have additional questions, please contact Emily King, Deputy Director, Division of State Coverage Programs at (443) 478-6811. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky
Deputy 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: Emma Chacon	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.**

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# 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, Purpose of SPA: Delay timeliness requirements on ex parte renewals.
Proposed effective date: February 1, 2021
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

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 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.

TN No: Approval Date Effective Date _____

3.1. Delivery Standards Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

☒ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act,

including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

CHIP contracts with two managed care organizations (MCO) to provide medical care for children enrolled in CHIP:
SelectHealth
Molina Health Care of Utah

CHIP contracts with Premier Access statewide to provide dental services for children enrolled in CHIP:

These managed care organizations have extensive provider networks and include all the major hospitals, physician groups and clinics (both primary care and specialists), and specialty providers such as home health, physical therapy, and hospice. The experience of CHIP, in contracting with multiple managed care organizations, demonstrates an ability to develop and maintain provider networks. The availability of these extensive networks within the managed care organizations improves access and continuity of care provided to CHIP enrollees.

As the agency designated to implement the Utah Children's Health Insurance Program, CHIP and the DOH will offer its long-time experience in working with managed care organizations and negotiate contracts with any willing provider to serve CHIP enrollees in both urban and rural areas of the state. Offering services through more than one network of providers will give CHIP enrollee's greater access and continuity of care through a greater choice of health care providers.

The issues of language and hours of service barriers will be critical in serving CHIP enrollees. CHIP contracts require interpretive services to be provided. For example, current contracts state:

Health Plans shall provide interpretive services for languages on an as needed basis at no cost to the enrollees. These requirements shall extend to both in-person and telephone communications to ensure that enrollees are able to communicate with the Health Plan and Health Plan providers and receive covered benefits. Professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend, as interpreter is inappropriate. Family members may be used as interpreters at the enrollee's request only after the enrollee has been

notified that professional interpreters are available at no cost. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical…

Materials written in a language other than English are a contract requirement of MCOs when the non-English speaking population represents 5% of the total population.

Hours of service barriers are a general problem of the health delivery system-—public or private. CHIP and its contracting MCO's use Community Health Centers, extended hour clinics, and urgent care centers to partially address this systemic problem. In addition, divisional contracts hold the MCOs responsible for all covered emergency services 24 hours a day and 7 days a week, whether services were provided in or out of the respective managed care organization.

Standards for waiting times for appointments and office waiting times have been established with all contracting MCOs. These standards are monitored.

The described requirements and standards are part of the contracts the Department has developed with participating MCO's to serve the Children's Health Insurance Program.

All of the above areas are part of the state's MCO Quality Assurance Monitoring Plan and are monitored during annual on-site reviews. CHIP will be included in this monitoring.

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Payments from CHIP Managed Care Plans (MCPs)

The CHIP MCPs shall pay to Federally Qualified ("FQHCs") and Rural Health Clinics ("RHCs") with which it is contracted an amount not less than what it pays other similar providers that are not FQHCs and RHCs.

The CHIP MCPs shall pay an Indian health care provider that is both an FQHC and a non-participating provider at the same rate that they would pay a participating provider.

FQHC Payment by the Division of Medicaid and Health Financing

Beginning February 3, 2004, FQHCs may elect to be paid under one of two payment methods–the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). Each FQHC must elect its payment methodology

preference and give notice to the Division of Medicaid Health Financing (DMHF) on or before January 1, 2004, to be effective February 3, 2004. If an FQHC elects to change payment methods in subsequent years, an election to do so must be made no later than thirty (30) days prior to the beginning of the FQHC's fiscal year by written notice to (DMHCF).

A. Prospective Payment System (PPS).

1. Payment under PPS methodology conforms to the Federal methodology as contained in section 702 of the Benefits Improvement and Protection Act of 2001. PPS is the only approved methodology for the time period January 1, 2001 thru February 2, 2004, under the State Plan in effect for that time period.

PPS rates for each FQHC are determined on the basis of their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of services (See Section C, below). The average of the two-year costs are divided by the average number of visits for the same two-year period. The resulting prospective rate is increased on January 1 of each subsequent year by the applicable Medicare Economic Index for primary care services.

2. Regarding FQHCs which contract with CHIP Managed Care Plans (MCPs), supplemental payments will be estimated and paid quarterly to the FQHCs for the difference between amounts paid by the MCPs and amounts the FQHCs are entitled to under the PPS. Quarterly interim payments will be made no later than thirty (30) days after the end of the quarter. Annual reconciliations will be made and settled.

3. The PPS rate for newly qualified FQHCs in 2001 and later will be established by reference to PPS rates of other FQHCs in the same or adjacent areas with similar caseload, or by cost reporting methods.
4. FQHCs located out-of-state that serve Utah CHIP clients will be paid the reimbursement rate applicable to the state in which services are provided.

B. Alternative Payment Method (APM) - Ratio of Covered Beneficiary Charges to Total Charges Applied to the Allowable Cost (RCCAC)

1. Beginning February 3, 2004, an alternative payment method

(APM) was adopted and available for election. Under RCCAC, allowable costs are determined using applicable Medicare cost principles, as addressed in 42 CFR and CMS Publication 15-1, and allowable costs are allocated to CHIP using the percentage of CHIP covered billed charges to total charges for all patients. Total allowable costs are multiplied by the CHIP charge percentage to determine the amount of allowable cost to be paid by CHIP. Interim payments will be made on the basis of billed charges and valid claims processed and paid by CHIP will reduce the final settlements.

2. FQHCs participating in the alternative payment method will provide DMHF with annual cost reports and other information required by DMHF within ninety (90) days from the close of their fiscal year-end to include the provider calculations of their anticipated settlement. DMHF will review submitted cost reports and provide a preliminary payment, if applicable, to FQHCs on the basis of a desk settlement. About 6 months after the FQHC's fiscal year-end, DF will conduct a desk review or audit of submitted cost reports and perform final settlements. This will allow for the inclusion of late filed claims and adjustments processed after the submitted cost report was prepared. Claims data changes from the final settlement through one year will be added to the following year's settlement. If over-payments to the FQHC occur, pay-back to the State is required. If underpayment occurs, a payment adjustment will be made to the FQHC.

3. The alternative payment method described herein will be compared with the reimbursements calculated using the PPS methodology described in Section A. above. The greater amount will be paid to the FQHCs.

C. Scope of Service Changes

Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive an adjustment in their encounter rate. Scope changes need to be accounted for by all FQHCs because annual comparisons to APM need to be made. Actual detail cost elements need to be tracked in the general ledger accounts or otherwise to allow for verification and testing. Overstated estimated costs require pay-back. Underestimated costs will be reimbursed.

D. CHIP Managed Care Settlements

For FQHCs servicing CHIP clients, the difference between FQHC costs minus MCO/PAHP reimbursement will be determined annually and settled. The determination of cost will be on the basis of the RCCAC as noted in Section B. Quarterly estimated payments will be made to FQHCs on the basis of the most recent prior year annual reconciliation.

RHC Payment by the Division of Medicaid and Health Financing

A. Prospective Payment System (PPS)

1. Payment for Rural Health Clinic services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. All Rural Health Clinics are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001, and each succeeding year.

2. Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that fiscal year. The clinic must supply documentation to justify scope of service adjustments.

3. For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar case load, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

4. Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on July 1, 2016. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

5. RHCs located out-of-state that serve Utah CHIP clients will be paid the reimbursement rate applicable to the state in which services are provided.

B. CHIP Managed Care Settlements

In the case of any RHC which contracts with a CHIP MCP, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the MCP and the amount to which the clinic is entitled under the prospective payment system.

Cost Settlement

A. The DMHF shall perform a cost settlement of the quarterly interim payments by utilizing the following formula:

Per Encounter Prospective Payment rate multiplied by the number of Encounters included in the reconciliation period minus the amount paid by the CHIP MCP to the FQHC during this period, minus the total quarterly interim payments made by the DMHF for the reconciliation period.

B. If the Cost Settlement formula shows that the quarterly interim payments made to the FQHC exceeded the amount allowed by the cost settlement, the DMHF shall recover the overpaid amount by making proportional adjustments to future supplemental payments.

C. If the Cost Settlement formula shows the quarterly interim payments made to the FQHC were less than the amount to which the FQHC is entitled, the DMHF shall pay the FQHC the remaining amount owed.

D. The DMHF, in its sole discretion, determines the period of time which constitutes the cost settlement reconciliation period.

Cost Settlement Review Process

A. The DMHF shall review and edit the Encounter Data (or raw claims data) sent in by the CHIP MCPs. The DMHF may, at its discretion, disallow an Encounter/Claim where the Encounter/Claim:

1. was not appropriately paid by the contractor under the CHIP program;
2. was duplicative;
3. was untimely; or
4. should otherwise be disallowed per the DMHFs determination.

B. The DMHF shall provide the FQHC with an electronic file of the Encounters/Claims that it will use in the cost settlement calculation. If the FQHC determines that the Encounters/Claims are incomplete or believes the DMHF has incorrectly disallowed Encounters/Claims, the FQHC shall send to the DMHF any missing claims records that it believes should be included. The FQHC shall provide this information to the DMHF within any deadlines the DMHF sets. The DMHF shall review the FQHC's additional claims, make changes based on the FQHC's input, and shall send a final file of the Encounters/Claims that the DMHF will include as part of the Cost Settlement. If the FQHC disagrees with the final Encounter/Claim record provided by the DMHF, the FQHC may request a hearing.

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

6.2.3. ☒ **Physician services** (Section 2110(a)(3))

Scope of Coverage

Services provided directly by licensed physicians or osteopaths, or by other licensed professionals such as physician assistants, nurse practitioners, or nurse midwives under the physician's or osteopath's supervision. Includes surgery and anesthesia.

Exclusions

1. Acupuncture and acupressure
2. Services obtained for administrative purposes. Such administrative purposes include services obtained for or pursuant to legal proceedings, court orders, employment, continuing or obtaining insurance coverage, governmental licensure, home health recertification, travel, military service, school, or institutional requirements. Provider and Facility charges for completing insurance forms, duplication services, interest (except where required by Utah Administrative Code R590-192), finance charges, late fees, shipping and handling, missed appointments, and other administrative charges.
3. The following allergy test are not covered: Cytotoxic test, leukocyte histamine release test, mediator release test, passive cutaneous transfer test, provocative conjunctival test, provocative nasal test, rebuck skin window test, rinkel test, subcutaneous provocative food and chemical test, sublingual provocative food and chemical test. The following allergy treatments are not covered: allergoids, autogenous urine immunizations, LEAP therapy, medical devices (filtering air cleaner, electrostatic air cleaner, air conditioners etc.), neutralization therapy, photo-inactivated extracts, polymerized extracts, oral desensitization/ immunotherapy.
4. General anesthesia in a provider's office.
5. Cognitive or behavioral therapies for the treatment of attention deficit/hyperactivity disorder.
6. Biofeedback/neurofeedback
7. The following cancer therapies are not covered: neutron beam therapy and proton beam therapy.
8. Services or an illness, condition, accident, or injury are not covered if they occurred:
a. While the member was a voluntary participant in the commission of a felony
b. While the member was a voluntary participant in disorderly conduct, riot, or other breach of the peace
c. While the member was engaged in any conduct involving the illegal use or misuse of a firearm or other deadly weapon
d. While the member was driving or otherwise in physical control of a car, truck,

motorcycle, scooter, off-road vehicle, boat, or other motor driven vehicle if the member either had sufficient alcohol in the member's body that a subsequent test shows that the member has either a blood or breath alcohol concentration of .08 grams or greater at the time of the test or had any illegal drug or their illegal substance in the member's body to a degree that it affected the members' ability to drive or operate the vehicle

e. While the member was driving or otherwise in physical control of a car, truck, motorcycle, scooter, off road vehicle, boat, or other motor driven vehicle either without a valid driver's permit or license, if required under the circumstances or without the permission of the owner of the vehicle

f. As a complication of, or as the result of, or as follow up care for, any illness, condition, accident, or injury that is not covered as the result of this exclusion

9. Generally, claims with a date of service over one year old should be denied by the plan. Exceptions to this general rule should be addressed by the plan's policy and in its procedures.

10. Complementary, alternative and nontraditional services. Such services include acupuncture, homeopathy, homeopathic drugs, certain bioidentical hormones, massage therapies, aromatherapies, yoga, hypnosis, rolfing, and thermography

11. All services provided or ordered to treat complications of non-covered services are not covered unless stated otherwise in this document.

12. Custodial care

13. Dry needling procedures

14. Services for which the member has obtained a payment, settlement, judgment, or other recovery for future payment intended as compensation

15. Services received by a member incarcerated in a prison, jail, or other correctional facility at the time services are provided, including care provided outside of a correctional facility to a person who has been arrested or is under a court order of incarceration

16. Experimental and/or investigational services for which one or more of the following apply: it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use; it is the subject of a current investigational new drug or new device application on file with the FDA; it is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; it is being or should be delivered or provided subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS); if the predominant opinion among the appropriate experts as expressed in the peer reviewed medical literature is that further research is necessary in order to define safety, toxicity, effectiveness, or comparative effectiveness, or there is no clear medical consensus about the role

and value of the service.
17. Fitness training, conditioning, exercise equipment, and membership fees to a spa or health club.
18. Except for dietary products as defined by the Health Plan, food supplements and substitutes are not covered.
19. Gene therapy or gene based therapies
20. Services designed to create or establish function that was not previously present
21. The following immunizations are not covered: anthrax, BCG (tuberculosis), cholera, plague, typhoid, and yellow fever.
22. When a non-covered service is performed as part of the same operation or process as a covered service, only charges relating to the covered service will be considered. Allowed amounts may be calculated and fairly apportioned to exclude any charges related to the non-covered service.
23. The following pain management services are not covered: prolotherapy, radiofrequency ablation of dorsal root ganglion, acupuncture, IV pamidronate therapy for the treatment of reflex sympathetic dystrophy
24. Services for pervasive developmental disorder
25. Services provided to a member by a provider who ordinarily resides in the same household as the member
26. Service related to sexual dysfunction
27. Coverage for specific specialty services may be restricted to only those providers who are board certified or have other formal training that is considered necessary to perform those services
28. The following specific services are not covered: anodyne infrared device for any indication; auditory brain implantation; chronic intermittent insulin IV therapy/metabolic activation therapy; coblation therapy of the soft tissues of the mouth, nose, throat, or tongue; computer assisted interpretation of x-rays (except mammograms); extracorporeal shock wave therapy for musculoskeletal indications; cryoablation therapy for plantar fasciitis and Morton's neuroma; freestanding/home cervical traction; home anticoagulation or hemoglobin A1C testing; infrared light coagulation for the treatment of hemorrhoids,; interferential/neuromuscular stimulator; intimal media thickness testing to assess risk of coronary disease; lovaas therapy; magnetic source imaging; microprocessor controlled, computerized lower extremity limb prostheses; mole mapping; nonsurgical spinal decompression therapy; nucleoplasty or other forms of percutaneous disc decompression; pressure specified sensory device for neuropathy testing; prolotherapy; radiofrequency ablation for lateral epicondylitis; radiofrequency ablation of the dorsal root ganglion; secretin infusion therapy for the treatment of autism; virtual colonoscopy; whole body scanning
29. Charges for provider telephone, email, or other electronic consultations

30. Services for an illness, injury, or connected disability are not covered when caused by or arising out of an act of international or domestic terrorism, as defined by United States Code, Title 18, Section 2331, or from an accidental, negligent, or intentional release of nuclear material or nuclear byproduct material as defined by United States Code, Title 18, Section 831.
31. Costs associated with travel to a local or distant medical provider, including accommodation and meal costs, are not covered.
32. Services for an illness, injury, or connected disability are not covered when caused by or arising out of a war or an act of war (whether or not declared) or service in the armed services of any country
33. Charges prior to coverage or after termination of coverage even if illness or injury occurred while the insured is covered by CHIP
34. Charges for educational material, literature or charges made by a provider to the extent that they are related to scholastic education, vocational training, learning disabilities, behavior modification, dealing with normal living such as dies, or medication management for illnesses such as diabetes
35. Charges for services primarily for convenience, contentment or other non-therapeutic purpose
36. Charges for any service or supply not reasonable or necessary for medical care of the patient's illness or injury
37. Charges which the insured is not, in the absence of coverage, legally obligated to pay
38. Charges for services, treatments or supplies received as a result of an act of war occurring when the insured was covered by CHIP
39. Charges for any services received as a result of an industrial injury or illness, any portion of which is payable under workman's compensation or employer's liability laws
40. Charges for services or supplies resulting from participating in or in consequence of having participated in the commission of an assault or felony
41. Charges made for completion or submission of insurance forms
42. Charges for care, treatment, or surgery performed primarily for cosmetic purposes, except for expenses incurred as a result of an injury suffered in the preceding five years
43. Shipping, handling, or finance charges
44. Charges for medical care rendered by an immediate family member are subject to review by CHIP and may be determined by CHIP as ineligible
45. Charges for expenses in connection with appointments scheduled and not kept
46. Charges for telephone calls or consultations.

6.2.11. ☒ Outpatient mental health services, other than services described in

6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)

Scope of Coverage

Inpatient and outpatient services are covered. Medically necessary services from contracted hospitals, inpatient treatment centers, inpatient pain clinics, day treatment facilities or intensive outpatient programs are covered.

Effective July 2021 treatment for Autism Spectrum Disorder (ASD) for all members on CHIP with a valid ASD diagnosis. The service goal of these services is to provide counseling and treatment programs, including applied behavioral analysis (ABA) that:
(1) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual;
(2) are provided or supervised by board certified clinicians, psychologists and behavior analysts who have been trained on the use and interpretation of assessment tools, and can render an ASD diagnosis under the scope of their licensure; and
(3) diagnosis ASD by means of medically necessary assessments, evaluations, or tests that are:
(i) Performed by a clinicians, and psychologists with experience diagnosing ASD; and
(ii) necessary to diagnose whether an individual has ASD.
Coverage for the treatment of ASD includes behavioral health treatment, pharmacy care, psychiatric care and therapeutic care. Services that are part of the behavioral health treatment including ABA are not subject to cost sharing.

8.2.3. Coinsurance or Co-payments:

The following are the co-payment and co-insurance requirements for participation in CHIP. Levels of co-payments will be limited to the income groups identified in the federal enabling legislation 2103(e)(3)(A) & (B).

Plan B Co-Payment requirements:

<u>Hospital Services</u>:

-$150 co-payment after deductible for inpatient services

-Co-insurance, 5% for surgeon and anesthesiologist services

-$5 co-payment for urgent care center services and emergency use of the emergency room

-$10 co-payment for non-emergency use of the emergency room
-Co-insurance, 5% after deductible for outpatient hospital services.

Ambulance (air and ground) for medical emergencies:

-Co-insurance, 5% after deductible

Physician Office Visits (includes visits to a Specialist):

-$5 co-payment per visit

-No co-payment for well-baby care, well-child care, and immunizations.

Prescription Drugs:

-$5 co-payment per prescription for generics

-Co-insurance, 5% per prescription for brand name drugs.

Laboratory and X-ray Services:

-$0 co-payment for laboratory and x-ray services for minor diagnostic tests and x-rays

-Co-insurance, 5% after deductible for major diagnostic tests and x-rays

Vision Screening Services:

-$5 co-payment (limit of one exam per plan year)

Hearing Screening Services:

-$5 co-payment (limit of one exam per plan year)

Dental Services:

-Maximum benefit of $1,000 per person, per year

-$0 co-payment for cleanings, exams, x-rays, fluoride, and sealants

-5% co-insurance for all other covered services

-Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index

Mental Health Services, Inpatient Facility:

-$150 co-payment after deductible for each visit

Mental Health Services, Outpatient, Office Visit & Urgent Care:

-$0 co-payment for each visit

Residential Treatment:

$0 co-payment

Home Health and Hospice Care:

-Co-insurance of 5% after deductible per visit

Medical Equipment and Supplies:

-Co-insurance of 5% after deductible

Physical, Occupational and Speech Therapy:

-$5 co-payment, 20 visits combined limit per child, per plan year

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder:

-$0 co-payment

Out- of-Pocket Maximum:

-5% of a family's annual gross countable income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

Plan C Co-Insurance and Co-Payment requirements:

Hospital Services:

-Co-insurance, 20% after deductible for inpatient services

-$300 co-payment for emergency or non-emergency use of the emergency room, after deductible ; $300 per visit for non participating hospitals, after deductible

-$40 co-payment each urgent care center visit

-Co-insurance of 20% of total charges for surgeon and anesthesiologist services, after deductible.

-Co-insurance, 20% after deductible for outpatient services.

Ambulance (air and ground) for medical emergencies:

-Co-insurance, 20% after deductible

Physician office visits:

-$25 co-payment per visit (excluding visits to a Specialist)

-$40 co-payment per visit to a Specialist

-No co-payment for well-baby care, well-child care and immunizations

Prescription Drugs:

-$15 co-payment per prescription for generic drugs; Co-insurance 25% of total or brand name drugs on the approved list. Co-insurance 50% of total per prescription for brand name drugs not on the approved list

Laboratory and X-Ray Services:

-$0 co-payment for minor diagnostic tests and x-rays

-Co-insurance, 20% after deductible for major diagnostic tests and x-rays

Vision Screening Services:

-$25 co-payment, limit of one exam per plan year

Hearing Screening Services:

-$25 co-payment, limit of one exam per plan year

Dental Services:

-Maximum benefit of $1,000 per person, per year

-Plan pays 100% for cleanings, exams, x-rays, fluoride, and sealants

-Co-insurance, 20% after deductible for all other covered services

-Co-insurance, 50% after deductible for porcelain-fused crowns (not Covered for non-adult and back teeth)

-Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index

Mental Health Services In-Patient Facility

-Co-insurance, 20% after deductible.

Mental Health Services Outpatient, Office Visit & Urgent Care

-$0 co-payment for each visit

Residential Treatment

-$0 co-payment

$

Home Health and Hospice Care:

-Co-insurance, 20% after deductible

Medical Equipment and Supplies:

-Co-insurance, 20% after deductible

Physical, Occupational and Speech Therapy:

-$40 co-payment after deductible, 20 visits combined limit, per child, per plan year.

Applied Behavior Analysis for the Treatment of Autism Spectrum Disorder:

-$0 co-payment

Out-of-Pocket Maximum:

-5% of a family's annual gross countable income. Only out of pocket costs for covered services, deductibles, co-pays, and premiums will be used to calculate the maximum out of pocket limit.

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

· Planned use of funds, including:
· Projected amount to be spent on health services;
· Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
· Assumptions on which the budget is based, including cost per child and expected enrollment.
· projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

· Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
· Include a separate budget line to indicate the cost of providing coverage to pregnant women.
· States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
· Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
· Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
· Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:

- Total 1-year cost of adding prenatal coverage
- Estimate of unborn children covered in year 1

CHIP Budget

STATE: UTAH	**FFY Budget**
Federal Fiscal Year	**FFY 2022**
State's enhanced FMAP rate	23.22%
Benefit Costs	
Insurance payments	
Managed care (CHIP)	$28,041,600
Managed Care Payments (MCHIP)	$97,094,900
per member/per month rate	$184.64
Fee for Service	
Health Services Initiatives	-
Cost of Proposed SPA changes	**$2,100,000**
Total Benefit Costs	**$127,236,500**
(Offsetting beneficiary cost sharing payments)	$(9,112,400)
Net Benefit Costs	**$118,124,100**

Administration Costs	
Personnel	$532,400
General administration	$375,600
Contractors/Brokers	$2,128,300
Claims Processing	-
Outreach/marketing costs	-
Other	$2,008,000
Total Administration Costs	**$5,044,300**
10% Administrative Cap	$10,037,500
Federal Share	$94,568,700
State Share	$28,599,700
Total Costs of Approved CHIP Plan	**$123,168,400**

NOTE: Include the costs associated with the current SPA.
The Source of State Share Funds: State General Funds/Tobacco Settlement Funds