Table of Contents

State/Territory Name: Utah

State Plan Amendments (SPA) #: UT-CHIPSPA#13

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 S2-26-12
Baltimore, Maryland 21244-1850

AUG 0 2 2013

Michael Hales
Deputy Director
Division of Medicaid and Health Financing
Department of Health
P.O. Box 143101
Salt Lake City, UT 84114-3101

Dear Mr. Hales:

Your title XXI Children's Health Insurance Program (CHIP) State plan amendment (SPA) number 13, submitted on August 13, 2012, has been approved. However, we are concerned that the high levels of cost sharing imposed under this SPA may impair children's ability to access care. We appreciate the state's previous efforts to monitor the impact of cost sharing on beneficiaries and as described below, we request that the state continue to demonstrate compliance through an evaluation of its cost sharing on enrollment and utilization.

Utah's CHIP SPA number 13 has an effective date of July 1, 2012, and makes the following changes to the state's cost-sharing requirements:

- Increases the copayment for doctor visits from $20 to $25;
- Increases the emergency department (ED) copayment from $250 to $300;
- Increases the vision screening copayment from $35 to $40;
- Increases the hearing screening copayment from $35 to $40;
- Increases the mental health office visit from $35 to $40;
- Updates dental anesthesia services language;
- Clarifies that orthodontics are only covered if medically necessary;
- Clarifies that mental health inpatient and outpatient hospital benefits both have a co-insurance of 20 percent after the deductible;
- Clarifies the visit limitation for physical, occupational and speech therapy; and
- Clarifies the application of the deductible to inpatient, outpatient, hospital, and major diagnostic services.

As noted, although we are approving the new cost sharing, we are concerned that this may place barriers on enrollment and access to care, resulting in the provision of health assistance that is not "effective and efficient." Section 2101(a) of the Act provides that "the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low income children in an effective and efficient manner."

Based on CHIP data, Utah's program has the highest cost-sharing levels relative to all other CHIPs in the nation. These new copayment levels are in addition to a $500 deductible and quarterly premium. We are certain the state shares our concern for assessing any possible negative impact of the high cost sharing, and will work together with CMS on a plan for monitoring its impact. To this end, we will

follow up in a separate letter that describes the protocol for a monitoring plan. The monitoring elements will be targeted toward assessing the impact of high cost sharing on deterring and delaying utilization of health services.

In addition to the monitoring requirements, we want to ensure CHIP beneficiaries in Utah are not subject to cost sharing that exceeds the 5 percent cumulative cost-sharing maximum described in 42 CFR 457.560 and in preamble (Federal Register/Vol.66, No. 8/January 11, 2001). We encourage the state to review its notices and the cost sharing tracking sheet, to make sure that it is clear to the consumer that the 5 percent cumulative maximum is a *family cap* that applies to all out-of-pocket expenses incurred by all targeted low income children in the family.

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

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0721
Facsimile: (410) 786-5943
E-mail: Amy.lutzky@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lutzky and to Mr. Richard Allen, Associate Regional Administrator in our Denver Regional Office. Mr. Allen's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
Colorado State Bank Building
1600 Broadway, Suite 700
Denver, CO 80202-4367

If you have additional questions, please contact Dr. Eliot Fishman, Director, Children and Adults Health Programs Group at (410) 786-9535.

We look forward to continuing to work with you and your staff.

Sincerely,

/ Cindy Mann /

Cindy Mann
Director

cc: Richard Allen, ARA, CMS Region VIII

July 2012 CHIP State Plan Amendment
Description of Changes

Section	Proposed Changes
1.4 1.4 – TC	Entered proposed effective date and implementation date. Tribal Consultation: pending IHAB meeting July 6, 2012
6.2.17 D7 6.2.17 G12 6.2.24	Orthodontic Benefit changes: Orthodontic is only covered if medically necessary (must score 30 or greater on the Salzmann Index). Updated Dental Anesthesia Services language, per clarification from SelectHealth (current Medical benchmark). Added language clarifying that maintenance on devices, for Hearing Services, such as cochlear implants, etc., is a covered service. Also added a section at the end of 6.2.24 clarifying the responsibility of Facility Charges for Dental Procedures.
8.2.3	**Plan A & B clarifications**: Added new Orthodontic coverage terms, Clarified that Mental Health Inpatient & Outpatient Hospital are both $50 co-pays and that a Mental Health office visit is $3 co-pay per visit. Also clarified that the Therapy is relating to Physical, Occupational and Speech Therapy and the 20 visit limit is a combined limit. Under Plan A, also added clarification that enrollees with Zero income are also exempt from co-pays under the Out-of-Pocket Maximum section. **Plan C changes:** Updated co-payment and co-insurance amounts for some services: 1) $300 co-payment, after deductible, for emergency or non-emergency use of the emergency room; $300, after deductible, per visit for non-participating hospitals. 2) Surgeon & Anesthesiologist co-insurance is after deductible. 3) $25 co-pay for Physician Visits. 4) Vision and Screening $40 co-payment. 5) Updated Orthodontic coverage as only covered if the client scores 30 or greater on the Salzmann Index. 6) Clarified that Mental Health Inpatient & Outpatient Hospital both have co-insurance of 20% after deductible and that a Mental Health Office Visit is $40 co-payment per visit. 7) changed the Therapy co-pay to $40 after deductible and clarified that the Therapy is relating to Physical, Occupational and Speech Therapy and the 20 visit limit is a combined limit.
9.9.2	The FY 2013 changes will be presented to the CHIP Advisory Council on July 10, 2012. Notice of changes will be sent on June 26, 2012 to all current CHIP enrollees. In addition, public notice of benefit changes within this SPA will be

	published to the Utah State Bulletin as well as to the CHIP website on July 1, 2012.
9.10	Projected Budget FY 2013 changes

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: Michael Hales	Position/Title: Director, Medicaid and Health Financing
Name: Emma Chacon	Position/Title: CHIP Director
Name: Leigha Rodak	Position/Title: CHIP Program Specialist

***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.**

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

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

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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 Amendment 12 will be presented at the Indian Health Advisory Board meeting on July 6, 2012.

6.2.17. ☒ Dental services- (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

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Scope of Coverage

Oral examinations, diagnostic services, preventive services, oral surgery that is dental in nature, restorative services, and endodontic services are covered benefits. Oral examinations and other preventive services including cleaning and fluoride applications are limited to two per plan year.

Eligible services under the dental plan are payable in an outpatient surgical facility for children five years of age and younger or a child who is at high risk due to other medical diagnosis.

D. Limitations on Orthodontic Benefits:

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1) Payment for orthodontics is provided for a proportion of the upfront costs and then monthly thereafter.
2) Orthodontic Benefits begin with the first payment due after the person becomes covered, if treatment has begun.
3) Benefits end with the loss of eligibility. Benefits end immediately if treatment stops or if the Contract is terminated, whichever occurs first.
4) Benefits are not paid to repair or replace any Orthodontic appliance furnished, in whole or in part, under this program.
5) X-rays or extractions are not subject to the Orthodontic maximum.
6) Surgical procedures are not subject to the Orthodontic maximum.
7) Orthodontic benefits are only covered if the client scores 30 or greater on the Salzmann Index.

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G. General Exclusions

1) Charges in excess of the contracted Fee-for-Service schedule or the Reasonable and Customary rate, whichever applies.
2) Charges for any treatment program which began prior to the date the Insured is covered under the policy.
3) Services or supplies payable under any medical expense, auto or no-fault plan.
4) Conditions covered under any Worker's Compensation Act or similar law.
5) Charges for services applied without cost by any municipality, county or other political subdivision or for which there would be no charge in the absence of insurance.
6) Charges resulting from changing from one provider to another while receiving treatment, or from receiving treatment from more than one provider for one dental procedure to the extent that the total charges billed exceed the amount incurred if one provider had performed all services.
7) Hospital facility charges for any dental procedure, including but not limited to emergency room charges, surgical facility charges, hospital confinement.
8) Charges for drugs or the dispensing of drugs.
9) Charges for oral hygiene instruction; plaque control; acid etch; prescription or takehome fluoride; broken appointments; completion of a cliam form; OSHA/Sterilization fees (Occupational Safety & Health Agency); or diagnostic photographs (except for orthodontic purposes).
10) Charges for services to replace teeth that were missing (extracted or congenitally) prior to the effective date of coverage on the Plan. This limitation ends after 36 months of continuous coverage on the Plan. Abutment teeth will be reviewed for eligibility of prosthetic benefits. This exclusion does not apply if the device covers one or more natural teeth lost or extracted while covered under

the Plan, or if the prosthetic device was in place when the policy became effective.

11) Services incurred during travel or activity outside the United States.

~~11)~~12) **Dental Anesthesia Services** including local, regional, general, and/or intravenous sedation anesthesia, are not covered except for at participating facilities when members meet the following criteria:

a. The member is developmentally delayed, regardless of the chronological age of the member~~; or~~

b. The member, regardless of age, has a congenital cardiac or neurological condition and provides documentation that the dental anesthesia is needed to closely monitor the condition; or

c. The member is under five year of age, and;

i. The ~~P~~proposed dental work involves three or more teeth;

ii. The ~~D~~diagnosis is nursing bottle mouth syndrome or extreme enamel hypoplasia; and

~~i.~~iii. The ~~P~~proposed procedures are restoration or extraction for rampant decay

Cardiac/Neurologic Conditions

Consideration of coverage will be given to members ~~who~~, regardless of age, with congenital cardiac or neurological conditions. The member must provide documentation describing that the need for dental anesthesia is due to ~~their~~ an underlying medical condition and the ~~need~~ associated requirement to closely monitor this condition.

Dental anesthesia for conditions such as ADHD, situational anxiety, or fear of dentists is not covered.

Note: Remember, general anesthesia rendered with an office surgery is not covered.

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))

Hearing Services

Scope of Coverage

Screening services provided by a licensed medical professional/audiologist to test for any hearing loss.

One exam every 12 months.

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Except for cochlear implants, the purchase, fitting, or ongoing evaluation of hearing aids, appliances, auditory brain implants, bone anchored hearing aids, or any other procedure or device intended to establish or improve hearing or sounds recognition is not covered. Maintenance on the device is a covered service.

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Facility Charges for Dental Procedures

The Health Plan is responsible to pay for the cost of the facility when a member qualifies to receive dental anesthesia under 6.2.17, G, 12 above.

8.2.3. Coinsurance or copayments:

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 A Co-Payment requirements:

Hospital Services:

$50 co-payment for inpatient services.

$0 co-payment for Surgeon and Anesthesiologist services

$3 co-payment for emergency or non-emergency use of emergency department services.

$3 co-payment for outpatient hospital and urgent care center services.

Ambulance (air and ground) for medical emergencies only:

Co-insurance, 5% of total.

Physician Office Visits (includes visits to a Specialist):

$3 co-payment per visit.

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

Prescription Drugs:

$1 co-payment per prescription for generics and brand names on the approved list.

Co-insurance, 5% of total per prescription for drugs not on the approved list.

Laboratory and X-ray Services:

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

$3 co-payment for services for major diagnostic and x-rays

Vision Screening Services:

$3 co-payment, limit of one exam per plan year.

Hearing Screening Services:

$3 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.

5% co-insurance for all other covered services.

~~There is no longer a 12 month waiting period for Orthodontic care.~~ Orthodontic benefits are only covered if medically necessary. Services are deemed medically necessary if the client scores 30 or greater on the Salzmann Index.

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Mental Health Services, In-Patient & Outpatient Hospital~~Care~~:

$50 co-payment for each visit

Mental Health Services, ~~Out-Patient Care~~Office Visit:

$3 co-payment for each visit

Home Health and Hospice Care:

$3 co-payment per visit

Medical Equipment and Supplies:

$3 co-payment

Physical, Occupational and Speech Therapy:

$3 co-payment, 20 visits combined limit per child, per plan year limit.

Out-of Pocket Maximum:

The maximum out of pocket expense is 5% of a family's annual gross 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. CHIP Enrollees with zero income are exempt from co-pays and deductibles as their out-of-pocket maximum is $0.

Plan B Co-Payment requirements:

Hospital Services:

$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.

~~There is no longer a 12 month waiting period for Orthodontic care.~~
Orthodontic benefits are only covered if medically necessary. Services are deemed medically necessary if the client scores 30 or greater on the Salzmann Index.

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Mental Health Services, Inpatient & Outpatient Hospital~~Care~~:

$150 co-payment after deductible for each visit

Mental Health Services, ~~Outpatient Care~~Office Visit:

$5 co-payment for each visit

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 limit.

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

$ ~~250~~ 300co-payment for emergency or non-emergency use of the emergency room, after deductible; $ ~~250~~ 300 per visit for non participating hospitals, after deductible

$40 co-payment each urgent care center visit

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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:

$~~20~~ 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:

~~$35~~ 40 co-payment, limit of one exam per plan year.

Hearing Screening Services:

~~$35~~ 40 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).

~~There is no longer a 12 month waiting period for Orthodontic care.~~
Orthodontic benefits are only covered if medically necessary. Services are deemed medically necessary if the client scores 30 or greater on the Salzmann Index.

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Mental Health Services In-Patient & Outpatient Hospital

Co-insurance, 20% after deductible.

Mental Health Services ~~Out-Patient~~Office Visit

~~$30~~ 40 co-payment for each visit

Home Health and Hospice Care:

Co-insurance, 20% after deductible

Medical Equipment and Supplies:

Co-insurance, 20% after deductible

Physical, Occupational and Speech Therapy:

~~$20~~ 40 co-payment, 20 visits combined limit per plan year.

Out-of-Pocket Maximum

The maximum out of pocket expense is 5% of a family's annual gross 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.

Co-Insurance and Co-payment requirements for CHIP clients/enrollees who are Native American.

No co-payments or premiums are charged to CHIP enrollees who are Native American.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

CHIP uses the Utah State Administrative Rules process to notify the public when changes relating to eligibility or benefits are being considered. All proposed changes are filed with the Division of Administrative Rules who publishes a summary of the rule in the Utah State Digest. The public is given 30 days to make comments regarding the change.

On June 26, 2012, current CHIP enrollees will be sent a letter and a one page co-pay summary reflecting the benefit changes.

In addition, a public notice is scheduled to be published in the Utah State Bulletin as well as on the CHIP website on July 1, 2012.

9.9.2 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option.

State Plan Amendment #12, relating to benefit changes, will be presented at the Indian Health Advisory Board meeting on July 6, 2012.

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)

CHIP Budget

STATE: UTAH	**FFY Budget**
Federal Fiscal Year	**FFY 2013**
State's enhanced FMAP rate	
Benefit Costs	
Insurance payments	
Managed care	$79,288,000
per member/per month rate	$169.25
Fee for Service	
Health Services Initiatives	-
Cost of Proposed SPA changes	**0**
Total Benefit Costs	**$79,288,000**
(Offsetting beneficiary cost sharing payments)	$(1,804,000)
Net Benefit Costs	
Administration Costs	
Personnel	$952,000
General administration	$104,000
Contractors/Brokers	$3,940,000
Claims Processing	-
Outreach/marketing costs	-
Other	$2,600,000
Total Administration Costs	**$7,596,000**
10% Administrative Cap	$8,609,333
Federal Share	$66,983,500
State Share	$18,096,500
Total Costs of Approved CHIP Plan	**$85,080,000**

NOTE: Include the costs associated with the current SPA. There are no increased costs specifically related to the proposed SPA change in Benefits. The costs above are reflective of the FY2013 CHIP Budget.

The Source of State Share Funds: State General Funds/Tobacco Settlement Funds