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State/Territory Name: Utah

State Plan Amendment (SPA) #: Ut-14-0007-MM

This file contains the following documents in the order listed:

1) Approval Letter
2) Additional Companion letter (delete if not if applicable)
3) Summary Form (179)
4) Superseding Pages Notice Approved SPA Pages
5) Additional Attachments that are part of the state plan

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1600 Broadway, Suite #700
Denver, CO 80202-4967

REGION VIII - DENVER

April 2, 2014

W. David Patton, Ph.D.
Utah Department of Health
288 North 1460 West
PO Box 143102
Salt Lake City, UT 84114

RE: Utah# 14-0007-MM

Dear Dr. Patton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 14-0007-MM on January 3, 2014. This SPA implements presumptive eligibility by hospitals in accordance with the Affordable Care Act and 42 CFR 435.1110.

Please be informed this State Plan Amendment was approved April 2, 2014, with an effective date of January 1, 2014. We are enclosing the CMS- 179 and the amended plan page(s).

In addition, Utah has agreed by July 2014 to incorporate changes to Utah's single streamline application by providing better instructions to presumptive eligibility applicants on what question are required to be completed when applying for presumptive eligibility. In addition, the state will implement a paper form verifying an individual's eligibility to be given to the applicant upon determination as well as work to train doctors and pharmacies to accept this paper documentation as proof in the interim until the applicant receives the actual medical card in the mail.

If you have any questions regarding this letter, please contact Mandy Strom at (303) 844-7068 or mandy.strom@cms.hhs.gov.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid & Children's Health Operations

CC: Michael Hales, Medicaid Director, UT
Craig Devashrayee, UT
Jeff Nelson, UT
Gayle Six, UT

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Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Utah**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

UT-14-0007

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Pub. L. No. 111-148

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Presumptive Eligibility by Hospitals - The fiscal impact for this SPA is included in the fiscal impact entered for the MAGI eligibility group SPA 14-0001-MM.

Governor's Office Review

- **Governor's office reported no comment**
- **Comments of Governor's office received**
  Describe:
- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Craig Devashrayee**
Last Revision Date:	**Apr 1, 2014**
Submit Date:	**Jan 3, 2014**

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(•) Yes ( ) No

[✓] The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

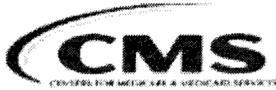
- [■] A qualified hospital is a hospital that:
  - [■] Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.
  - [■] Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

  Assists individuals in completing and submitting the full application and understanding any documentation requirements.

  (•) Yes ( ) No

- [■] The eligibility groups or populations for which hospitals determine eligibility presumptively are:
  - [■] Pregnant Women
  - [■] Infants and Children under Age 19
  - [■] Parents and Other Caretaker Relatives
  - [■] Adult Group, if covered by the state
  - [■] Individuals above 133% FPL under Age 65, if covered by the state
  - [■] Individuals Eligible for Family Planning Services, if covered by the state
  - [■] Former Foster Care Children
  - [■] Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
  - [ ] Other Family/Adult groups:
  - [ ] Eligibility groups for individuals age 65 and over
  - [ ] Eligibility groups for individuals who are blind
  - [ ] Eligibility groups for individuals with disabilities
  - [ ] Other Medicaid state plan eligibility groups
  - [ ] Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



Medicaid Eligibility

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards:

The State has set a standard for hospitals to provide 100% of all PE applications completed by the hospital site to the Department of Workforce Services (DWS). DWS enters the PE decision into the client eligibility system and issues medical assistance cards to eligible individuals.

The hospital PE application can be used to apply for ongoing assistance. Applicants only have to answer the questions required to make the PE decision and sign that paper application. The hospital staff are expected to let individuals know that they can apply for ongoing assistance using the PE application, and must offer assistance to applicants in completing the application. Individuals are encouraged, but not required to complete the full application if they want to use the PE application to apply for ongoing assistance. Applicants for PE may choose not to submit a full application at the time they are doing the PE application. The applicant may also choose to apply later using a different application process. The hospital PE application includes a question about using the PE application to apply for ongoing medical assistance.

DWS will accept the PE application as a full application for ongoing medical assistance when the applicant indicates he wants to apply for ongoing assistance. If a client does not indicate he wants to apply for ongoing assistance, DWS only enters the information about the PE decision, and issues a medical card for presumptive eligibility only.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards:

The State has set a standard that the hospital will maintain an 85% accuracy rate for its presumptive eligibility decisions based on the information provided by the applicant. The State will conduct periodic reviews of PE applications received from the various sites, and randomly select a sample of cases to review to decide if the hospital made the correct PE decision based on the information provided by the applicant. The State will conduct additional training when a site has a lower accuracy rate, and take corrective actions if needed, which may include disqualifying a site if improvement does not occur. The state will increase this standard as the hospitals have had time to learn the process, and based on the findings from reviews.

For presumptively eligible individuals who submit applications for ongoing medical assistance, the State has set a standard that 65% of those will be determined eligible for ongoing Medicaid. We have set the standard based on eligibility statistics from our Presumptive Eligibility for Pregnant Women program. We will initially use a slightly lower standard for the hospitals than the average rate of eligibility the state has seen for Pregnant Women cases because this is a new process for hospitals and it includes different populations. The state will utilize data about the number of PE cases approved and denied ongoing medical assistance to decide if a site is meeting this standard. The state may adjust the standard in the future based on its findings. from reviews.

Based on the findings from reviews, the state will schedule additional training or take other corrective actions to improve the success rate of hospitals that are not meeting these standards. If a hospital continues to be unable to meet the performance standards after corrective actions have taken place, the state can disallow the hospital from continuing to make presumptive eligibility determinations.

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

Medicaid Eligibility

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

(•) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

(•) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

( ) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

■ The presumptive eligibility determination is based on the following factors:

■ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

■ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

The Affordable Care Act

HOSPITAL PRESUMPTIVE ELIGIBILITY COMING SOON TO A HOSPITAL NEAR YOU

HEALTH

January 2014

What is Hospital Presumptive Eligibility (HPE)?

- ❑ Temporary Enrollment in Medicaid.
- ❑ Client Statement Accepted.
- ❑ Hospital Eligibility Decision Accepted

Confidentiality

- Safeguard Confidential Information
- Information that can be Identified to Particular Applicants and Recipients is Confidential Information.

Basic Eligibility Requirements

- Eligibility Begins on the Date of Approval
- Signature Required by Applicant or Authorized Representative
- Minors living with a Parent or Responsible Guardian Must Have the Parent or Responsible Guardian Sign the Application

Basic Eligibility Requirements

- ❑ U.S. Citizen or Qualified Alien
- ❑ Utah Resident
- ❑ Limit of one HPE Period per calendar year
- ❑ Must not have Received a Denial for Medicaid, CHIP, UPP, or PCN within the Past 30 Days (unless there is a change in circumstances)

Completing the Application

- ❑ Use the Most Current Application Available.
- ❑ The Shaded Areas of the Application Must Be Completed.
- ❑ For Ongoing Medicaid, Complete the Remaining Questions.
- ❑ Ensure the Client Signs the Application.

Hierarchy of HPE Program Types

- When Deciding Which Program Category to Approve for an Individual, Use the Following Hierarchy:
  - Child 0-5/Child 6-18
  - Parent/Caretaker Relative
  - Pregnant Woman
  - Former Foster Care Individual

Child Medicaid Age 0-5

- Income Under 139% FPL
- Child Under Age 6 or in Month They Turn Age 6
- Does Not Need To Live With Family

Child Medicaid Age 0-5
Household Size

- ❑ Applicant
- ❑ Applicant's Parent(s) and Step-parent(s)
- ❑ Applicant's Sibling(s) and Step-sibling(s)

Child Medicaid Age 6-18

- ❑ *Income Under 133% FPL*
- ❑ *Child Over Age 6 or in Month They Turn Age 19*
- ❑ *If 18 Year Old Lives With Parents, Parents' Income Counts.*
- ❑ *Does Not Need To Live With Family*

Child Medicaid Age 6-18
Household Size

- ❑ Applicant
- ❑ Parent(s) and Step-parent(s)
- ❑ Legal Spouse of Applicant
- ❑ Unborn Child(ren)
- ❑ Child(ren)
- ❑ Sibling(s) and Step-sibling(s)

Pregnant Woman Medicaid

- ☐ Income Under 139% FPL
- ☐ Pregnant
- ☐ If Woman Under 19 Years Old Lives With Parents, Parents' Income Counts.
- ☐ If Woman Age 19 or Over Lives With Parents, Parents' Income Does Not Count
- ☐ Only Ambulatory Prenatal Medical Services Covered
- ☐ Limit of One HPE Period Per Pregnancy

Pregnant Woman Medicaid Household Size For Women Under Age 19

- Applicant
- Legal Spouse of Applicant
- Applicant's Parent(s) (If Living with Parents)
- Applicant's Unborn Child(ren)
- Children and Step-child(ren)
- Applicant's Siblings and Step-Siblings (Who are Under Age 19)

Pregnant Woman Medicaid Household Size For Women Age 19 and Older

- ❑ Applicant
- ❑ Legal Spouse of Applicant
- ❑ Applicant's Unborn Child(ren)
- ❑ Children and Step-child(ren)

Former Foster Care Individuals Medicaid

- ❑ *No Income Test*
- ❑ *May Not Be Eligible for Another HPE Program Type*
- ❑ *Age 18-Through Month They Turn 26*
- ❑ *Concurrently Enrolled in Medicaid and Foster Care in Utah at Age 18 or Higher When Foster Care Ended.*
- ❑ *In Custody of DCFS, DHS or an Indian Tribe when Foster Care Ended.*

Former Foster Care Individuals Household Size

- Applicant

UTAH DEPARTMENT OF HEALTH

Parent/Caretaker Relative Medicaid

- See Income Chart For Income Limits
- Household Must Include a Child That is Under Age 18 or Age 18 and a Full Time Student Expecting to Graduate Before Age 19.
- Deprivation of Support Must Exist Due To a Deceased, Incapacitated, or Underemployed Parent

Parent/Caretaker Relative Medicaid Household Size

- ❑ Applicant
- ❑ Legal Spouse of Applicant
- ❑ Applicant's or Spouse's Unborn Child(ren)
- ❑ Applicant's Children and Step-Children Under Age 19
- ❑ Unborn Children of any Pregnant Child Under Age 19

Whose Income to Count

- Count the Gross Income of all included in the Household Size for the Program with the Following Exceptions
  - Don’t Count Income of a Child to another Child
  - Don’t Count Income of a Child to a Parent
  - Don’t Count Income of a Guardian to the Child(ren) that they are Taking Care of

Determining Monthly Gross Income

- Accept Applicant's Statement of their Monthly Gross Income
- When Paychecks are Received, Factor to Calculate Monthly Gross Income
- When Paychecks are Received Twice Monthly, Multiply by 2
- When Paychecks are Received Every Other Week, Multiply by 2.15
- When Paychecks are Received Weekly, Multiply by 4.3

Income Calculation Examples

- You receive one $500 (gross) paycheck and client is paid every other Friday.

  $500 x 2.15 =$1075

- You receive one $200 (gross) paycheck and client is paid every Wed. $200 x 4.3 = $860
- You receive one $500 (gross) paycheck and client is paid twice/month. $500 x 2 = $1000

UTAH DEPARTMENT OF HEALTH

Exempt Sources of Income

- Child Support and Educational Income are not Countable Sources of Income.

Next Steps

- ❑ Approve or Deny Application and Indicate Decision on the HPE cover sheet
- ❑ If Approved, Provide Paper Receipt to Customer to Show Eligibility Start Date
- ❑ If Denied, Indicate Denial Reason
- ❑ Send Application by Mail or Fax to the Dept. of Workforce Services within 5 Business Days.
- ❑ Shred the Application
- ❑ If an email is Received from DWS asking Questions, a Response is Required within 48 hrs.

Questions?

- Laurie Ocobock:801-538-9153
- Laura Belgique: 801-538-6241 (back up)
- HPEPOLICY@Utah.gov

2014

HOSPITAL PRESUMPTIVE ELIGIBILTY *Training Manual*

With Presumptive Eligibility (PE), an individual can be temporarily enrolled in Medicaid if it appears they are eligible.

State of Utah

1/1/2014

UTAH DEPARTMENT OF
HEALTH
MEDICAID

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Introduction

The Affordable Care Act[1] allows hospitals to play an increasingly important role in connecting patients to health care coverage. This new provision allows qualified hospitals to determine Presumptive Eligibility for Medicaid based on customers' preliminary information.

This manual provides guidance for the administration of the Hospital Presumptive Eligibility (HPE) program. It will outline the policy and procedures needed for an effective implementation.

Thank you for your participation in ensuring the success of this important and effective resource for the citizens of Utah.

[1] **Statute Authority and Related Federal Rules for PE Option**
Statutory Authority: Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as modified by the Health Care and Education Reconciliation Act or 2010, Public Law 111-152 (March 30, 2010), Title 2, Subtitle A, Section 2001(a) (4) (B) and Title 2, Subtitle A, Section 2202.
Federal Regulations: Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa, 42 CFR 435.1110 (2013).

HOSPITAL PRESUMPTIVE ELIGIBILITY TRAINING MANUAL

PART 1 CONTACT INFORMATION

- For Hospital Presumptive Eligibility policy or procedural questions, or to request training, contact:

  Laurie Ocobock
  Policy Specialist
  Phone: (801) 538-9153
  Fax: (801) 538-6952
  Utah Department of Health/Medicaid Health Financing
  PO Box 143107
  Salt Lake City, UT 84114-3107

  OR

  Laura Belgique (back up)
  Program Specialist
  Phone: (801) 538-6241
  Fax: (801) 538-6952
  Utah Department of Health/Medicaid and Health Financing
  PO Box 143107
  Salt Lake City, UT 84114-3107

- You may also e-mail questions to HPEpolicy@utah.gov

- To order Hospital Presumptive Eligibility applications, call (801)538-9153 or (801)538-6241.

- For questions regarding covered services, medical billing/payment, call Medicaid at (801) 538-6155 or 1-800-662-9651.

- Email completed applications to DWS at hospitalPE@utah.gov

PART 2 POLICIES AND PROCEDURES

Section 1: WHAT IS HOSPITAL PRESUMPTIVE ELIGIBILITY?

- With Hospital Presumptive Eligibility (HPE), an individual can temporarily enroll in Medicaid if it appears they are eligible based on preliminary information. Preliminary information includes information regarding the income and household size for the individual.
- The two departments that oversee the program are the Utah Department of Health (UDOH) and the Department of Workforce Services (DWS). UDOH oversees HPE policy and procedure. DWS oversees the ongoing Medicaid eligibility process.
- UDOH issues Memorandum of Agreements (MOA) between UDOH and hospitals throughout the state to administer the HPE program. Hospital staff who are trained in the HPE process determine HPE eligibility. Section 3 describes information on the HPE process.

Section 2: RULES HOSPITALS MUST COMPLY WITH

- A hospital must inform UDOH that it intends to make HPE determinations and that it agrees to follow the State's policies and procedures. UDOH will provide hospitals with information on all policies and procedures related to HPE.
- A hospital must make HPE determinations in accordance with UDOH's policies and procedures. If a hospital is not making HPE determinations in accordance with UDOH's policies and procedures, UDOH will provide the hospital with additional training or other forms of corrective action before disqualifying the hospital.
- A hospital must also comply with the proficiency standards that UDOH developed for HPE. As of January 1, 2014, UDOH has established a standard of 85 percent accuracy rate on HPE decisions. Accuracy is measured by how accurate the hospital's determination is based on the information provided by the applicant.

Section 3: SERVICES AND PAYMENT

- HPE covers an array of Medicaid eligible services including medication, lab work, inpatient and outpatient care. For questions regarding covered services, call Medicaid at 1-800-662-9651.
- During the HPE period, the client will also be able to receive treatment from other Medicaid providers after they leave the hospital.
- Hospitals will be paid at regular Medicaid rates.
- Payment for covered services is guaranteed for a hospital during an individual's presumptive eligibility period, even if the person fails to complete the full Medicaid application or is ultimately determined to be ineligible for ongoing Medicaid.
- If an HPE applicant is already covered under Medicaid, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN) or the Utah Premium Partnership (UPP) at the time of application, HPE cannot be authorized by DOH.
- States will not recoup money from the hospital for services rendered during the HPE period.

Section 4: CONFIDENTIALITY

- All confidential information must be safeguarded from unauthorized disclosure and use. Staff who fail to safeguard confidential information may be subject to both civil and criminal penalties.
- Confidential information includes identifying information about applicants and recipients, such as names, addresses, telephone numbers, social security numbers, etc. Second, it includes information used to determine eligibility, such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc. Third, it includes information about benefits and medical services provided to individual recipients.

  Information that cannot be identified to particular applicants and recipients is not confidential information. For example, information stating the total number of HPE recipients is not confidential information because no one person can be identified by the general information.

Section 5: FRAUD, WASTE AND ABUSE

- To report suspected fraud, contact the DWS Information Fraud Hotline at 1-800-955-2210 or via email at wsinv@utah.gov.
- What you need to know when reporting fraud, waste or abuse:
  - It is helpful if you can provide any of the following information when reporting fraud, waste or abuse of the HPE Program:
    - Provider or recipient name
    - Date of birth
    - Address
    - Phone number
    - Social security number
    - Other details about what you suspect may be happening that appears to be wrong
  - You may remain anonymous when reporting suspected fraud
  - You may be requested to provide your name so that the investigator can contact you if there are questions regarding your referral. However, you may request that your name is not used in conjunction with the case.

    You may find more information on reporting fraud, waste or abuse at: http://health.utah.gov/mpi/recipient.html

Section 6: ELIGIBILITY PROCESS

- Applicants can apply for HPE through any qualified hospital site.
- The eligibility begins on the date the application is approved by the hospital.
- SELF-DECLARATION IS USED FOR ALL FACTORS OF ELIGIBILITY.
- If the applicant is a minor, the applicant's parent, legal guardian, or representative must sign the application. If the minor is living independently, the minor may apply on his/her own behalf. A representative for a child may be a relative or other responsible adult living with the child.
- An applicant may assign an authorized representative to apply on his/her behalf. The applicant must sign application if possible. If the applicant is unable to sign, the authorized representative may sign the application. In general, the person who signs the application should be someone who can answer the questions on the application.
- If an applicant is unable to write, he/she must make a mark on the application and have at least one witness to the signature.
- To qualify for all HPE programs, applicants must meet the following requirements based on preliminary information provided:
    - Be a U.S. citizen or qualified alien.
        - Qualified aliens are individuals who are not U.S. citizens but have received a lawful permanent residency (LPR) status for at least five years. Ask for the month and year in which the applicant received the LPR status to determine if the applicant meets this requirement.
        - Nationalized citizens and individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa, and Swain's Island meet U.S. citizenship requirements.
            - Note: Individuals from the Marshall Islands are not considered U.S. Nationals.
    - Be a Utah resident.
    - Clients may only receive one HPE period within one calendar year and may only receive HPE once per pregnancy period.
    - ***NOTE:*** *There is no asset test.*
    - Clients must not currently receive Medicaid, CHIP, UPP, or PCN.
        - Check the applicant's eligibility status by calling Medicaid at (80)538-6155 or 1-800-662-9651. Key in the client ID number and use the HPE determination date as the date of the medical service received. If the client is eligible, the system will give the medical program type, health plan, co-pay, mental health coverage information, and TPL information.
        - If a client is open for Medicaid with a spenddown, the client is not eligible for HPE.
    - Clients must not have received a denial for Medicaid, CHIP, UPP or PCN within the past 30 days, unless household circumstances have changed. For example, if the client was denied for Medicaid because his income is too high and now the client reports that his income has changed, determine if the client is eligible for HPE.

Section 7: COMPLETING the HPE APPLICATION:

- UDOH will supply hospitals with HPE paper applications.
- General Instructions:
  - Always use the most current application available.
  - The application cover sheet will tell you which questions must be completed for HPE.
  - Ensure the applicant signs the application.
- Application Clarification:
  - Applicant's name; this is the full, legal name of applicant. A hyphenated last name is acceptable.
  - Question #3: If anyone in your household is not a U.S. Citizen or U.S. National, does he or she have a Lawful Permanent Resident card (Green Card) from U.S. Citizenship and Immigration Services?
    - If an applicant indicates they are a Lawful Permanent Resident with a Green Card and the date that he/she became a lawful permanent resident is at least five years, he/she is considered a qualified alien.
  - Question #6 What is your total gross earned and unearned income (before taxes) for your household this month?
    - Indicate applicant's total stated, gross monthly income. Make sure that educational and child support income are not included.
    - Compare this information to the income limit assigned to the household size for the HPE program type.
  - **Income guidelines may change yearly**. UDOH will e-mail HPE providers with an updated income chart each year. Please be sure you are using the most recent version. See Appendix 1 for the income chart.
  - **Page #9:** The applicant **must sign** the application. Without a signature, the application is incomplete.

Section 8: HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAID PROGRAMS

The HPE Medicaid programs and eligibility components are as follows:

- **Program Hierarchy:**
  - When choosing an eligibility program to approve, choose using the following hierarchy starting with the Child Medicaid program category.
    - Child Medicaid 0-5 or Child Medicaid 6-18
    - Parent/Caretaker Relative
    - Pregnant Woman
    - Former Foster Care Individuals
- **Child Medicaid Age 0-5:**
  - Eligibility requirements:
    - Income limit: 139% of the Federal Poverty Level (FPL).
    - A child can receive eligibility through the month in which he turns age 6.
    - A child does not have to live with a parent or specified relative.
- **Child Medicaid Age 6-18:**
  - Eligibility requirements:
    - Income limit: 133% of FPL.
    - A child can receive eligibility through the month in which he/she turns age 19.
    - If an 18 year old lives with his/her parents, the parents' income is countable.
- **Pregnant Woman:**
  - Eligibility requirements:
    - Income limit: 139% of FPL.
    - The woman must be pregnant.
    - If a pregnant woman is age 19 or older and lives with her parent(s), her parent's income is not countable. If she is under age 19 and living with her parent(s), her parents' income is countable.
- **Former Foster Care Individuals**
  - Eligibility requirements:
    - Ages 18 to 26. Eligibility runs through the month he/she turns 26.
    - Individual was concurrently enrolled in Medicaid and Foster Care in Utah at age 18 or older when Foster Care ended.
    - Individual was in the custody of DCFS, DHS or an American Indian Tribe when Foster Care ended. Persons in the custody of Juvenile Justice Services are not eligible.

    - There is no income test.
    - Was not eligible for other categories of HPE.

- **Parent/Caretaker Relative (PCR)**
  - Eligibility requirements:
    - Must have an eligible child.
      a. Household must include a child that is either under 18 or is age 18 and is a full time student and expected to graduate before the age of 19.
    - Income test: See income chart in Appendix 1
    - Deprivation of Support must exist.
      a. Deprivation of support exists if the household has:
         - ✓ A parent who is deceased.
         - ✓ A parent who is incapacitated.
         - ✓ A parent who is unemployed or employed less than 100 hours per month.
         - ✓ A parent who is absent

Section 9: DETERMINING HOUSEHOLD SIZE

Determine the household size using the following chart that applies to the coverage group:
Include only people who live together.

Child 0-5
Applicant
Applicant's parent(s) and step-parent(s)
Applicant's sibling(s) and step-sibling(s)

Child 6-18
Applicant
Parent(s) and step-parent(s)
Legal spouse of applicant(s) (not boyfriend)
Applicant's unborn child(ren)
Sibling(s) and step-sibling(s)

Note on Child Programs: *If child(ren) are living with a guardian who is not their parent, their household size includes themselves and their sibling(s). For example, household consists of grandmother, grandfather and two grandchildren. The household size for each grandchild is two.*

Pregnant Woman	
If the applicant is under age 19 (whether or not they are married)	**If the applicant is age 19 or older (whether or not they are married)**
Applicant	Applicant
Legal spouse of applicant (not boyfriend)	Legal spouse of applicant (not boyfriend)
Applicant's parent(s)	Applicant's unborn child(ren)
Applicant's unborn child(ren)	Applicant's child(ren) including step-child(ren) under age 19
Applicant's child(ren) including step-child(ren) under age 19	
Sibling(s) and step-sibling(s) that are under age 19	

Former Foster Care *(no income limit)*
Applicant

Parent Caretaker Relative
Applicant
Legal spouse of applicant(s) (not boyfriend)
Applicant's unborn child(ren) if they are in the third trimester of pregnancy
Applicant's child(ren) including step-child(ren)

Section 10: INCOME

Count the gross income (before taxes) of everyone that is included in the household size for the specific program with the following exceptions:

- Do not count the income of a child to another child (sibling)
- Do not count the income of a child to a parent
- Do not count the income of a guardian to the child(ren) that the guardian is responsible for.

Examples of whose income to count are as follows:

- Family consists of a father, mother, and two children. The child is approved for HPE.
  - The parents' income counts toward the child's HPE eligibility.
  - The income of the sibling does not count toward the child approved for HPE.

- Family consists of a father, mother, and a child. The father is approved for HPE.
  - Income of the mother counts toward the father's HPE eligibility. Income of the child doesn't count toward the father's HPE eligibility.

Educational income and child support are not countable sources of income. Do not include the income when counting the household income.

For the presumptive Former Foster Care program, there is no income limit for this program.

Note: PAYCHECK STUBS ARE NOT REQUIRED. However, if an applicant provides you with paycheck stubs to help you determine their gross monthly income, use the following procedure to calculate their income:

- When paychecks are received twice a month, multiply the gross paycheck amount by 2. If paychecks are received every other week, multiply the gross paycheck amount by 2.15. If received weekly, multiply the gross paycheck amount by 4.3.

  - Income calculation examples:
    - Johnny provides you one $500 (gross) paycheck stub and indicates he is paid every other Friday. Multiply $500 x 2.15 to determine his gross monthly income ($500 x 2.15 = $1075).
    - Mary provides you one $200 (gross) paycheck stub and indicates she is paid every Wednesday. Multiply $200 x 4.3 to determine her gross monthly income ($200 x 4.3 = $860).
    - Frankie provides you one $500 (gross) paycheck stub and indicates he is paid on the 1st and 15th of the month. Multiply $500 x 2 to determine his gross monthly income ($500 x 2 = $1000).

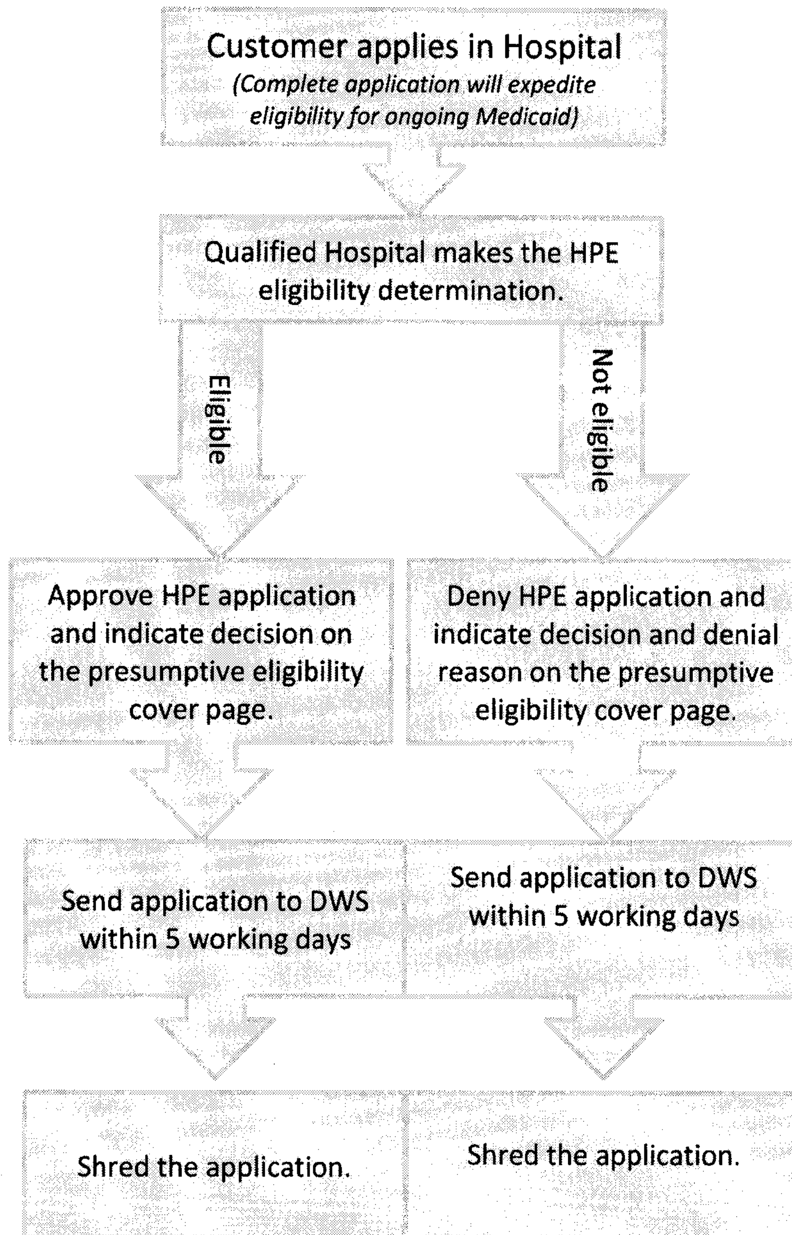
Section 11: WHAT HAPPENS NEXT AFTER AN ELIGIBILITY DETERMINATION?

- Complete the cover sheet for presumptive eligibility. Make sure to complete all fields and include the denial reason if the decision is a denial.
  - Possible denial reasons are as follows:
    - Already received HPE for the current pregnancy
    - Current CHIP, UPP, or Medicaid recipient
    - Issued HPE in the last calendar year
    - Medicaid denial in the past 30 days
    - No available HPE program
    - No deprivation
    - Not enough information to determine HPE
    - Not a U.S. citizen or eligible alien
    - Not a Utah resident
    - Over the income limit
- Hospital scans in the application and e-mails it to DWS at hospitalPE@utah.gov
  - Send the application to DWS within 5 working days.
  - **IMPORTANT**: If the application is incomplete and DWS contacts the hospital for additional information, the hospital must respond to DWS within 2 business days or HPE will not be issued.
  - Shred the paper application.
- DWS will issue the HPE card for the current month and determine eligibility for ongoing Medicaid. DWS will send the approval/denial notice and card.
  - The HPE Medicaid card is identical to a regular Medicaid card and provides the same medical coverage. Exception: For the presumptive eligibility program for pregnant women, the coverage is only for Medicaid covered ambulatory prenatal services. Delivery and inpatient services are not covered.
- HPE coverage will continue until DWS makes a decision for ongoing Medicaid. The following examples illustrate how the time frame for HPE eligibility is determined.
  - Client is approved for HPE on Jan. 15th. Ongoing Medicaid eligibility is approved or denied on Jan. 16th. Jan. 16th is before the date Feb. cards are mailed. The HPE eligibility ends on Jan. 31st. The HPE card should not be used after Jan. 15th.

  - Client is approved for HPE on Jan. 16th. Ongoing Medicaid eligibility is approved or denied on Feb. 15th. HPE eligibility continues until Feb. 28th. The HPE card should not be used after Feb. 15th.

  - Client is approved for HPE on Jan. 16th. Ongoing Medicaid eligibility is approved or denied on Mar. 15th. HPE eligibility continues until Mar. 31st. The HPE card should not be used after Mar. 15th.

Section 12: APPLICATION PROCESS



Section 13: CHECK LIST

- Make sure to do the following:
  - Help the customer complete the application *(Note: Although the customer is only required to complete the questions for HPE, completing the entire Medicaid application may expedite eligibility for ongoing Medicaid coverage).*
  - Submit the HPE application by e-mail to hospitalPE@utah.gov and subsequently destroy application
  - Educate the customer to stop using HPE card if she is approved or denied for ongoing Medicaid. If approved for ongoing Medicaid, the customer should use the new card for ongoing Medicaid.

Appendix 1: INCOME CHART (effective January 1, 2014)

HH Size	PCR	Pregnant Woman/Child 0-5	Child 6-18	Former Foster Care Individuals
		139% FPL	133% FPL	No income limit
1	438	1332	1274	
2	544	1797	1720	
3	678	2263	2165	
4	797	2729	2611	
5	912	3194	3056	
6	1012	3660	3502	
7	1072	4126	3947	
8	1132	4591	4393	
9	1196	5057	4838	
10	1257	5522	5284	

Please tear off this page and keep for your information.

Application Information

CHIP • PCN • UPP • Medicaid • PE • Private Health Insurance • APTC

What Am I Applying For?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program):** Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network):** Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance):** Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid:** Provides medical assistance for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: www.health.utah.gov/bep
- **Presumptive Eligibility (PE) for Medicaid:** Presumptive Eligibility is a program that provides temporary coverage for individuals who qualify based on preliminary information.
- **Private Health Insurance:** Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **Advanced Premium Tax Credit (APTC):** This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

What Do I Need to Do Next?

- On your application, tell us about all of your family members who live with you. If you file taxes, we need you to tell us about everyone on your tax return. (You don't need to file taxes to get health coverage). The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best coverage they can.
- We can best determine your eligibility if all questions are answered. However, for Presumptive Eligibility (PE), at a minimum you must fill out the following questions on the four pages listed below:
  - Page 1: Section A - Name, Address, Phone Number
Section B - Question 1 Only
(Student and marital statuses are optional.
  - Page 3: Section D - Questions 4 and 7
  - Page 7: Section K - All Questions
  - Page 9: Section L - Signature
- The hospital will determine PE eligibility and will forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. **If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.**
- Applying for continued medical benefits is not a requirement for presumptive eligibility. You may choose to opt out of applying for continued medical benefits by responding to question 9 on page 7 of the application.

Where Can I Get More Information?

- For questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase. If you have questions about how to complete the application or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

Information on the cHIE

- Medicaid, CHIP, UPP, and PCN recipients are automatically enrolled in the Utah Clinical Healt Information Exchange (cHIE). The cHIE provides a safe place for participating healthcare providers to share and view patient medical information.
- Recipients have the right to not participate in the cHIE or to change their participation status at any time. For more information or to opt out of the cHIE participation, visit www.mychie.org or talk to a healthcare provider.

For Presumptive Eligibility (PE) Worker Only:

Please complete this page for each presumptive eligibility application.

Name of PE Hospital: ______________________________

PE Worker Name: ______________________________

PE Decision Date: ______________

Name of Individual(s)	PE Program	Approved/Denied	Denial Reason

DOH/61HPE 1/2014
Case #: ____________

Application

CHIP • PCN • UPP • Medicaid • PE • Private Health Insurance • APTC

A Applicant Information

Name: ____
first (start with yourself) middle initial maiden last

E-mail: ____
(optional)

Home Address: ____
(Leave blank if you don't have one) street apt. # city state zip

Mailing Address: ____
(If different from home address) street apt. # city state zip

Home Phone: (_____)______________________ Cell/Other Phone: (_____)______________________

Primary Language Spoken in Your Home: ____

Would you like to receive notices in English or Spanish? ☐ English ☐ Spanish

B Household Information

1. List everyone who is living in your household and applying for benefits.

Name (first, m.i., last)	Relation to You	Social Security Number *	Birth Date mm/dd/yy	Sex M/F	Race **	Ethnicity ***	Marital Status ****	Fulltime Student Y/N	Utah Resident U.S. Citizen/ National*
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National

***Social Security Number & Citizenship** Social Security Number (SSN) and citizenship information are only needed for people applying for ongoing benefits. You are not required to provide SSN for presumptive eligibility, however, providing it may expedite your benefits. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

****Race Codes (Optional)** **WH**: White, **BL**: Black/African American, **AI**: American Indian/Alaska Native, **ASI**: Asian Indian, **CH**: Chinese, **FI**: Filipino, **JA**: Japanese, **KO**: Korean, **VI**: Vietnamese, **OA**: Other Asian, **NH**: Native Hawaiian, **SA**: Samoan, **GC**: Guamanian/Chamorro, **OPI**: Other Pacific Islander, **OT**: Other

*****Ethnicity Codes (Optional)** **N**: Not Hispanic/Latino, **M**: Mexican, **MA**: Mexican American, **CH**: Chicano/a, **PR**: Puerto Rican, **CU**: Cuban, **AH**: Another Hispanic, Latino, or Spanish Origin, **OT**: Other

******Marital Status** Single, Married, Divorced, Widowed

2. If you mark that you are an American Indian or Alaska Native above, please complete Attachment A.

☐Yes ☐No 3. If you are not a U.S. Citizen or U.S. National, do you have an eligible immigration status? *(Only answer this question for individuals who are applying for benefits.)* If yes, please complete all columns:

Name	Immigration Document Type	Alien Number	Document ID Number (if different from Alien #)	Lived in the U.S. Since 1996? (Yes/No)	Has a spouse or parent who is a veteran or an active-duty member of the U.S. military, or is himself a veteran or an active-duty member of the U.S. military. (Yes/No)

Tax Filer Information

Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimedon your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, please complete the chart* below.
**Note:* *If you are claiming more than 6 dependents on your tax return, please make a copy of this page and attach it to your application.*

Check one: ☐ **Tax Filer** **- or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: ______________________ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: ______________________ Relationship: ______________________	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: ______________________	***Dependent #1*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: ______________________ Living with tax filer: ☐Yes ☐No
Check one: ☐ **Tax Filer** **- or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: ______________________ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: ______________________ Relationship: ______________________	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: ______________________	***Dependent #1*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: ______________________ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: ______________________ Living with tax filer: ☐Yes ☐No

D General Information

Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do you want help paying any medical bills from the last 3 months?
If yes, for who:__________________ For which months:____________________

☐Yes ☐No 2. Does anyone in your household have a major medical need? This includes pregnancy, cancer, kidney disease, etc. *(Answering this question may get you extra help.)*
If yes, who:____
What is the medical need?_______________________________________

☐Yes ☐No 3 Do you live with at least one child under the age of 19, and are you the primary person taking care of this child?

☐Yes ☐No 4. Was anyone in your household in foster care on or after his/her 18th birthday?
If yes, who:____

☐Yes ☐No 5. Does anyone in your household have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:____

☐Yes ☐No 6. Has anyone in your household been in a jail, medical facility/hospital, or nursing home for 30 days or more within the last 3 months?
If yes, explain:____

☐Yes ☐No 7. Is anyone in your household currently pregnant or has been pregnant in the last 3 months?
If yes, who:_______________________________ Due date:______________
How many babies are expected during the pregnancy? ____________________
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
*(This question is for survey purposes only and does **not** affect eligibility.)*

E Income

☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (Name)	Employer Name, Address and Phone Number	Pay Rate Before Taxes ($900/mo.,$6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)
		/		
		/		
		/		

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Gross Income This Month	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain:____________________

☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:____________________

☐Yes ☐No 5. Do you or anyone in your household have/receive any of the following?

Check all that apply below:	Amount	How Often	Date Income Started	Name of Individual(s) Receiving the Income
☐ Unemployment				
☐ Pensions				
☐ Social Security				
☐ Retirement Accts.				
☐ Alimony Received				
☐ Net farming/fishing				
☐ Net rental/royalty				
☐ Other Income Type__________				

F Deductions

Check all that apply. List the amount paid and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
(*Note: You shouldn't include a cost already considered in your answer to net self- employment.)*

Check all that apply below:	Amount Paid	How Often	Name of Individual(s) Paying
☐ Alimony Paid			
☐ Student Loan Interest Paid			
☐ Other deductions: Type: ________			

G Yearly Income

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next question.

Name	**Total Income This Year**	**Total Income Next Year (if you think it would be different)**

H Health Insurance Information

☐Yes ☐No 1. Does anyone in your household currently have Medicaid, CHIP, or Medicare? If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: ______________________ ☐ CHIP: ______________

☐ Medicare: ______________________________________

☐Yes ☐No 2. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for medical services?

☐Yes ☐No 4. Is anyone in your household enrolled or eligible for COBRA coverage or continued health insurance through an employer?

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including VA Health Care System benefits, Tricare, or Peace Corps), have insurance available but not enrolled, or has had insurance in the past 6 months?

6. If you answer yes to questions 4 or 5, please complete the chart below regarding the insurance(s). *(Do not list Medicaid, Medicare, CHIP, or PCN.)*

Insurance 1

☐Enrolled, start date: ____________ ☐Not enrolled, but available ☐Ended, date ended: ____________

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: ______________________________

Name of insurance company: ______________________ Phone #: ____________

Address of insurance company: ______________________ Group#: ____________

Policyholder name: ______________________ Policy #: ____________

Policyholder birth date: ______________________ Policyholder SS#: ____________

If insurance is through an employer, list employer's name and phone #: ____________

Premium cost: $____________ Date due: ____________ How often: ____________

Type of Coverage: ☐ comprehensive ☐ limited

☐Yes ☐No Is this a retiree plan?

Insurance 2

☐Enrolled, start date: ____________ ☐Not enrolled, but available ☐Ended, date ended: ____________

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: ______________________________

Name of insurance company: ______________________ Phone #: ____________

Address of insurance company: ______________________ Group#: ____________

Policyholder name: ______________________ Policy #: ____________

Policyholder birth date: ______________________ Policyholder SS#: ____________

If insurance is through an employer, list employer's name and phone #: ____________

Premium cost: $____________ Date due: ____________ How often: ____________

Type of Coverage: ☐ comprehensive ☐ limited

☐Yes ☐No Is this a retiree plan?

Aged, Blind, Disabled, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, Refugee Medical

You are only required to answer the questions on this page if there is anyone in your household who is applying for Aged (65+), Blind, Disabled Medicaid, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, and/or Refugee Medical.

I Other Benefits, Income, and Expenses

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment or Worker's Compensation?
If yes, explain: ______________________________

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: ______________________________

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name and amount paid: ______________________________

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: ______________________________

☐Yes ☐No 5. Does anyone help you pay mortgage/rent, food, or utility bills?
If yes, explain: ______________________________

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: ______________________________

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name and amount paid: ______________________________

J Assets

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? (Check all that apply)

- ☐ Annuities
- ☐ IRA
- ☐ Stocks
- ☐ Bonds
- ☐ 401K / Retirement
- ☐ Money Market Funds
- ☐ Trust Funds
- ☐ Time Certificates
- ☐ Checking Account $ __________
- ☐ Savings Account $ __________
- ☐ Other: ______________

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? (Check all that apply)

- ☐ Land
- ☐ Home
- ☐ Tools
- ☐ Other: ________
- ☐ Cemetery Plots
- ☐ Life Insurance
- ☐ Campers / Trailers
- ☐ Mineral or Timber Rights
- ☐ Rental / Investment Property
- ☐ Burial Plans / Funds
- ☐ Life Estate
- ☐ Time Shares
- ☐ Livestock

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor homes, boats/motors, ATV's or other vehicles.

Make	Model	Year	Licensed Y/N	License Plate #	State	Owner/Joint Owners	Amount Owed

Additional Presumptive Eligibility Questions

If there is anyone in your household who is applying for presumptive eligibility (PE) for Medicaid, you are also required to answer questions on this page in addition to the specified questions on page 1 and 3. Please refer to the application coversheet to identify which specific questions on page 1 and 3 you must answer for PE. Make sure to sign the application on page 9.

K Presumptive Eligibility Questions:

☐Yes ☐No 1. If anyone in your household is not a U.S. Citizen or U.S. National, does he or she have a Lawful Permanent Resident card (Green Card) from U.S. Citizenship and Immigration Services?

If yes, please complete the chart below:

Name	Date the Individual Became a Lawful Permanent Resident (month/year)

☐Yes ☐No 2. Is anyone in the household currently on Utah Medicaid, CHIP (Children Health Insurance Program), PCN (Primary Care Network), or UPP (Utah's Premium Partnership Program) or has been approved for Utah Medicaid with a spenddown?

If yes, who:____

☐Yes ☐No 3. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?

If yes, who:____

☐Yes ☐No 4. If you answered yes to question 3, has the reason changed since the denial?

If yes, explain____

☐Yes ☐No 5. Has anyone in your household been approved for presumptive eligibility in the last calendar year, or if there is anyone pregnant, has she been approved for presumptive eligibility for pregnant women (Baby Your Baby) during this pregnancy?

If yes, who:____

6. What is your total gross earned and unearned income (before taxes) for your household this month? *(Do not include child support or educational income.)*

$____

☐Yes ☐No 7. Is there any child in the household who has any of the following? *(Check all that apply and list the child(ren)'s name(s) below.)*

- ☐ a parent who is absent from the home
- ☐ a parent who is incapacitated (meaning unable to work due to injury or illness)?
- ☐ a parent who is deceased
- ☐ a parent who receives unemployment or works less than 100 hours per month.

If yes, list the name(s) of the child(ren):______________________________

☐Yes ☐No 8. Does anyone in your household currently have health insurance? *(This information is optional.)*

If yes, complete the chart below:

Insurance

Name(s) of individual(s) covered:____

Name of insurance company:______________________________ Phone #:____________________

Address of insurance company:______________________________ Group#:____________________

Policyholder name:______________________________ Policy #:____________________

9. Applying for continued medical benefits is not a requirement for presumptive eligibility. You may choose to opt out of applying for continued medical benefits by checking the box and placing your initials below:

☐ I opt out from applying for continued medical benefits. Client Initial: ____________________

I Understand That:

***The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.**

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.
- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.
- I must report any changes in my address, phone number, household size and access to coverage by another health insurance program within 10 days.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand that I am responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.
- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The State will not report undocumented household members to USCIS.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hot Line at 1-800-275-0659.
- In the event of my death and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/ or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, QI).
- I give permission for any information provided to be verified when I apply and after I receive benefits.
- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand that these manuals may be amended without my consent or consideration.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- I must cooperate with the State in pursuing any third party responsible for medical expense. I must cooperate with the State to establish medical support for my family, if required, unless I have good cause to not cooperate.

I understand that my Social Security number will be used with the State Income and Eligiblity Verification System to make sure that my household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about my household. I must provide proof showing that my household is eligible for assistance.

I, (print name) ______________________________, have read or had someone read to me the statements on this page. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know that I may be subject to penalties under federal law if I provide false or untrue information.

____ ______________________

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form attached to this application.

M Renewal of Coverage in Future Years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

N Voter Registration Information

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O Return completed form to:

You have now completed the application. For more information please review the "Application Information" cover sheet. Please return this completed application form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear off this page and keep it for your information.

Your Rights & Responsibilities

You Have the Right to:

- Apply or re-apply any time you wish for any medical program. Some programs are only available during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days, if you claim to be disabled, unless you need more time.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  - A. Talk to your worker. Make sure you are not misunderstanding each other.
  - B. Talk to your worker's supervisor.
  - C. Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
    Note: There are not any fair hearings for presumptive eligibility programs.
  - E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 1-801-394-9431 or Salt Lake, 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 1-801-531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

Your Responsibilities:

- Verify Information. The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you are applying only for emergency Medicaid, you do not have to provide a Social Security number. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about my household. I must provide proof showing that my household is eligible for assistance.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS Help Line at 1-801-538-6872 or the Immunization Hot Line at 1-800-275-0659.
- You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.
- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.

You and your household must also follow the medical assistance program rules.

Please tear off this page and keep for your information.

Changes You Must Report

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

If you receive CHIP, PCN, UPP, or Medicaid Benefits, you must report:

- **Change in Marital Status or Living Arrangements**
  Getting married, separated, or divorced; moving in with a roommate; change of address or phone number; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; hospital stays for more than 30 days; or if anyone in your household goes to jail or prison; receiving help with your household expenses, etc.

- **Change in Insurance Coverage**
  Changes in access to insurance, coverage, or enrollment in any health coverage plan (including Medicare or VA Health Care System benefits) for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

If you receive Medicaid, you must also report:

- **Change in Source of Income**
  Getting a job, terminating a job, changing jobs, working for temporary services, obtaining educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum. Going on strike.

- **Change in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc. Change in the amount of SSI, SSA, Unemployment Compensation, etc.

- **Change in the Legal Obligation to Pay Child Support**

- **Gain or Loss of a Vehicle (Licensed or Unlicensed)**
  Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

- **Change in Any Asset(s)**
  Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

- **Change in Allowable Deductions**
  Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

Attachment A
American Indian or Alaska Native Family Member (AI/AN)

Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian Health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name ____________ ☐ No	☐ Yes If yes, tribe name ____________ ☐ No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	Amount: $____________ How often?____________	Amount: $____________ How often?____________

Attachment B

Information on Your Dependents that are Not Living With You

Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A General Information

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth	Sex M/F	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date:__________
How many babies are expected during the pregnancy? ______________________________

B Income

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone Number	Pay Rate Before Taxes ($900/mo., $6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)

☐Yes ☐No 2. Does your dependent have self-employment income?
If yes, list any self-employed income received.

Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent Company Owned	Net income this month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working few hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? (Check all that apply.)

☐ Unemployment $ ________ How often: ________ ☐ Net farming/fishing $ ________ How often: ________

☐ Pensions $ ________ How often: ________ ☐ Net rental/royalty $ ________ How often: ________

☐ Social Security $ ________ How often: ________ ☐ Other Income $ ________ How often: ________

☐ Pensions $ ________ How often: ________ Type:____________

☐ Retirement Accts. $ ________ How often: ________ ☐ Alimony Received $ ________ How often: ________

C Deductions

1. Check all that apply, and give the amount and how often your dependent gets it. If your dependent pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *Note: You shouldn't include a cost already considered in your answer to net self-employment.*

☐ Alimony Paid $ ________ How often: ________ ☐ Other deductions $ ________ How often: ________

☐ Student Loan Interest $ ________ How often: ________ Type: ________

D Yearly Income

1. Complete only if your dependent's income changes from month to month.

☐ Total income THIS year:______________________ ☐ Total income NEXT year:______________________
(If you think it will be different)

DOH/Form 116M 1/2014
Case#:____________

Attachment C

Employer's Health Insurance Information

You will need your employer or company's Human Resources representative to complete this form. Complete this form for each employed household member. You may copy this form. If you need more time to finish this form, please send us the rest of the application so that we can look at your application as soon as possible. However, in some situations, we will need the information from this form to help determine your eligibility. If you have questions regarding this form, please call 1-866-435-7414.

General Information

Employee Information

Employee name ______________________________ Employee SSN#________________
(first, m.i., last)

Employer Information

Employer Name: ____
EIN#:______________________________________ Phone #:______________________
Address:____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name:____
Phone #:_____________________________________ E-mail Address:__________________

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: ____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)________________

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled:____
____
____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): ____
If yes, when did coverage end/change? (mm/dd/yy) ______________________________

☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered **only to employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $______________
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year?
If yes, complete the following:
☐ Employer won't offer health insurance
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.
a. How much will the employee have to pay in premiums for that plan?
$________________
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

***An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)**

B Employer's Least Expensive Plan or Avenue H Default Plan

Questions below refer to the ***employer's least expensive*** plan or the ***Avenue H Default Plan***.

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)________________

3. When does the company's next open enrollment begin? (mm/dd/yy) ________

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

	Monthly Premium	
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: ________________

2. Policy number, if known: ________________

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
☐ Other, please describe:________________

8. Complete this chart only if it is different from the chart on the front page (section B). **Do not** include the cost of dental, vision or other coverage if it is separate.

	Monthly Premium	
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

☐Yes ☐No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):________________

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: ________________ Date: ________________

Name (please print): ________________

Title: ________________ Phone: ________________

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-free Fax: 1-877-313-4717

DOH/Form 114AR 10/2013

Attachment D

Authorization to Disclose Medical Information

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you're a legally appointment representative for someone on this application, submit proof with this application.

I ______________________________ hereby give ______________________________ the authority to:
(Name of Customer or Authorized Representative) (Name of individual or Organization)

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- The following date: ____________________; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Name of Authorized Representative: ______________________________

Address of Authorized Representative: ______________________________

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

______________________________ ______________________________
(Signature of Customer, Legal Guardian, or Authorized Representative) (Date)

If signed by other than the customer, description of authority to serve:

____

____

Equal Opportunity Employer Program
Auxiliary aids and services are available upon request to individuals with disabilities by calling (801) 526-9240. Individuals with speech and/or hearing impairments may call Relay Utah by dialing 711. Spanish Relay Utah: 1-888-346-3162

Strom, Mandy L. (CMS/CMCHO)

From:	Hollis, Annie R. (CMS/CMCS)
Sent:	Tuesday, April 01, 2014 12:02 PM
To:	Strom, Mandy L. (CMS/CMCHO)
Cc:	Kress, Marielle J. (CMS/CMCS)
Subject:	RE: PLEASE REPLY ASAP: UT 14-0007 Submitted

Thank you. I was out all last week so my email is a mess. No feedback to note, it looks great!

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, April 01, 2014 1:58 PM
To: Hollis, Annie R. (CMS/CMCS); Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: PLEASE REPLY ASAP: UT 14-0007 Submitted

The draft approval letter email is attached.

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Hollis, Annie R. (CMS/CMCS)
Sent: Tuesday, April 01, 2014 11:58 AM
To: Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: PLEASE REPLY ASAP: UT 14-0007 Submitted

Since I haven't been too tuned in to this SPA I defer to Marielle on final approval... I can't find the draft approval letter in my email, do you mind resending?

Thanks ☺

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, April 01, 2014 1:44 PM
To: Hollis, Annie R. (CMS/CMCS); Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: PLEASE REPLY ASAP: UT 14-0007 Submitted

I just got off the phone from the state and now I understand what they did. You are correct it is still there. They removed the opt out box and initials section from the cover page (see attached older version) because the state does not always get the cover page when an application is submitted. They added the language referring them to question 9 in appendix K regarding opting out so it is still there.

Based on this last piece of information from the state, I think we are good and ready to approve. Please let me know your concurrence. Also, any feedback on the draft approval letter I shared with Marielle yesterday afternoon?

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Hollis, Annie R. (CMS/CMCS)
Sent: Tuesday, April 01, 2014 11:32 AM
To: Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: PLEASE REPLY ASAP: UT 14-0007 Submitted

It looks like the opt out language is still there to me, according to these attachments... where do you see that?

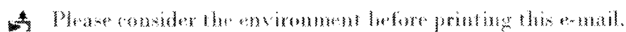
Thanks!

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, April 01, 2014 1:29 PM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: PLEASE REPLY ASAP: UT 14-0007 Submitted

Hi Marielle and Annie,
Utah has submitted its revisions in MMDL and they are attached. They have made all the required changes, but I have one question for you. They removed the opt out language from the cover page of the application, which they had added in the version Jeff shared with us on Friday. Can will still approve without that language or does it need to be added back in?

Let me know ASAP.
Thanks,
Mandy

Mandy Strom| Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | : (443) 380-6091| : Mandy.Strom@cms.hhs.gov



Strom, Mandy L. (CMS/CMCHO)

From:	Strom, Mandy L. (CMS/CMCHO)
Sent:	Tuesday, April 01, 2014 10:24 AM
To:	'Craig Devashrayee'; Gayle M. Six (gaylesix@utah.gov)
Cc:	Jeff Nelson (jeffnelson@utah.gov); Michelle Smith (michellesmith@utah.gov); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject:	ACTION REQUESTED ASAP RE: SPA 14-0007-MM Presumptive Eligibility by Hospitals
Attachments:	S21-hospital presumptive.pdf
Categories:	Follow-up

Hi Craig,
I have quickly reviewed the documents uploaded in the system and we need two revisions.

1. S21 Template: The State had submitted a revised S21 template on March 21 (attached) that included more information regarding the standards set (100%, 85%, and 65%). The new uploaded version does not reflect these revisions. Please update the March 21st version to reflect the one PE period per calendar year and upload into MMDL.
2. Training Slide Deck: The state needs to update the "Next Steps" slide to indicate the paper receipt given to the client by the hospital once PE is determined.

If you could make these two quick changes and get them uploaded into MMDL then we should be good to go.

I am unlocking the system right now.
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Craig Devashrayee [mailto:cdevashrayee@utah.gov]
Sent: Tuesday, April 01, 2014 9:31 AM
To: Strom, Mandy L. (CMS/CMCHO)
Subject: QAZ: SPA 14-0007-MM Presumptive Eligibility by Hospitals

Hi Mandy: All these items have been uploaded for CMS approval. Thanks.

Strom, Mandy L. (CMS/CMCHO)
to Jeff, me, Gayle, Amanda, Michelle, Laura, Jennifer, Marielle, Mary

One more item:

Please indicate on the subject line for fiscal impact that this SPA's fiscal impact is incorporated with 14-0001-MM.

Mandy Strom

(303) 844-7068

Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 31, 2014 2:49 PM
To: 'Jeff Nelson'; 'Craig Devashrayee (cdevashrayee@utah.gov)'
Cc: Six, Gayle M.; Yoshida, Amanda; Smith, Michelle; Laura Belgique; Jennifer Meyer-Smart; Kress, Marielle J. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject: ACTION REQUIRED ASAP: RE: Utah - HPE Next Steps - SPA 14-0007-MM
Importance: High

Hi Jeff and Craig,

Thanks for making the changes and sending the updated documents. We need you to do the following by noon tomorrow at the very latest so we can approve by COB to meet the 90th day, which is Wednesday.

- Change S21 template PE Eligibility Limit Description box to 1 PE period per calendar year and upload revised in MMDL
- Modify training slide deck "Next Step" slide to indicate a paper receipt will be provided by the hospital and upload revised version in MMDL
- Upload revised training manual
- Upload revised application

Please let me know if you have any questions or can't make the noon deadline.

Thanks,

Mandy

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Strom, Mandy L. (CMS/CMCHO)

From:	Strom, Mandy L. (CMS/CMCHO)
Sent:	Monday, March 31, 2014 4:40 PM
To:	Kress, Marielle J. (CMS/CMCS)
Cc:	Marchioni, Mary A. (CMS/WC); Allen, Richard C. (CMS/CMCHO); Hollis, Annie R. (CMS/CMCS); Cash, Judith (CMS/CMCS)
Subject:	RE: UT SPA 14-0007-MM DRAFT RAI
Attachments:	UT 14-0007 RAI DRAFT.docx
Follow Up Flag:	Follow up
Flag Status:	Completed

Marielle,
In case the state cannot get the information submitted tomorrow, I want to make sure we have a RAI ready to go. Please review the draft and let me know any suggested changes.

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 31, 2014 3:22 PM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC); Allen, Richard C. (CMS/CMCHO); Hollis, Annie R. (CMS/CMCS); Cash, Judith (CMS/CMCS)
Subject: UT SPA 14-0007-MM DRAFT APPROVAL LETTER
Importance: High

Attached is my draft approval letter. Please review and let me know what changes.
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(CMS/CMCS)
Subject: RE: NEED RESPONSE ASAP: FW: Utah - HPE Next Steps - SPA 14-0007-MM

Great. I will contact the state and send you a draft approval letter for review and edit.

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Subject: NEED RESPONSE ASAP: FW: Utah - HPE Next Steps - SPA 14-0007-MM

Hi Marielle,
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- They updated slide 12 to reflect ambulatory prenatal care coverage. Good
- They have agreed to just 1 PE period in a calendar year. This has been updated in the training manual and slide presentation. Good, but they need to update the SPA template and submit revised versions of the template and training materials in MMDL.
- They submitted a PE receipt for individuals to use to show proof of coverage during the lag of getting their actual eligibility card. The state has committed in writing to use the receipt as well as working with the pharmacy community to honor the receipt as proof of coverage. Good, but the state did not update the "next steps" slide to indicate the paper receipt.
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Next steps for approval:

- Update training slide deck "Next Step" slide with the paper receipt and upload revised version in MMDL
- Upload revised training manual
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- Does the paper receipt need to be uploaded in to MMDL?

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To: Kress, Marielle J. (CMS/CMCS); Strom, Mandy L. (CMS/CMCHO)
Cc: Six, Gayle M.; Yoshida, Amanda; Smith, Michelle; Laura Belgique; Jennifer Meyer-Smart
Subject: QAZ: Utah - HPE Next Steps - SPA 14-0007-MM

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Again we thank you for your help and we look forward to approval of this outstanding SPA.

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1600 Broadway, Suite 700
Denver, CO 80202-4967

Region VIII

April 1, 2014

Michael Hales
State Medicaid Director
Division of Health Care Financing
Utah Department of Health
P O Box 144102
Salt Lake City, UT 84114- 4102

Dear Mr. Hales:

We are reviewing the Utah State Plan Amendment (SPA) 14-0007, received in the Denver Regional Office on January 3, 2014. This MAGI SPA addresses hospital presumptive eligibility. Before we continue processing the SPA, we need additional clarifying information.

1. The state needs to explain in the subject line of the 179 that its fiscal impact is included in the fiscal impact entered for MAGI eligibility group SPA 14-0001-MM.

2. The state needs to revise the S21 template on page 3 for the Presumptive Eligibility Limit. The description box should reflect one presumptive eligibility period per calendar year. The State will need to upload the revised S21 template in MMDL with that change.

3. The State will need to revise the training slide deck attachment with the following changes and upload to MMDL:
   (i) Slide 5: Modify to reflect the one presumptive eligibility period per calendar year;
   (ii) Slide 12: Modify to reflect "ambulatory prenatal care" instead of "outpatient prenatal care" as the benefits available to pregnant women during the presumptive eligibility period; and
   (iii) Slide 23 "Next Steps": Modify to reflect a paper receipt will be provided by the hospital to the applicant upon presumptive eligibility determination.

4. The State will need to revise the training manual with the following changes and upload to MMDL:
   (i) Page 7: Modify to reflect the one presumptive eligibility period per calendar year; and
   (ii) Page 14: Modify to reflect "ambulatory prenatal care" instead of "outpatient prenatal care" as the benefits available to pregnant women during the presumptive eligibility period.

5. By July 2014, Utah should incorporate changes to Utah's single streamline application by providing better instructions to presumptive eligibility applicants on what question are required to be completed when applying for presumptive eligibility. In addition, the state will implement a paper form verifying an individual's eligibility to be given to the applicant upon determination as well as work to train doctors and pharmacies to accept this paper documentation as proof in the interim until the applicant receives the actual medical card in the mail.

Under § 1915(f) of the Social Security Act, a State plan amendment must be approved, disapproved or a request for additional information must be issued within the first 90 days of submittal; if not, a State plan amendment will be deemed approved. The 90-day period for SPA 14-0007-MM was scheduled to end on April 2, 2014. This request for additional information will stop this 90-day clock. A new 90-day time frame will start on the day when we receive your response.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer Federal financial participation (FFP) for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

We appreciate our continued dialogue as we work together to resolve the aforementioned outstanding questions. If you or your staff has questions regarding this request please contact Mandy Strom of my staff at (303) 844-7068 or by email at Mandy.Strom@cms.hhs.gov.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid & Children's Health Operations

Strom, Mandy L. (CMS/CMCHO)

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Sent: Monday, March 31, 2014 3:22 PM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC); Allen, Richard C. (CMS/CMCHO); Hollis, Annie R. (CMS/CMCS); Cash, Judith (CMS/CMCS)
Subject: UT SPA 14-0007-MM DRAFT APPROVAL LETTER
Attachments: UT 14-0007-MM Draft Approval letter.docx

Importance: High

Follow Up Flag: Follow up
Flag Status: Completed

Attached is my draft approval letter. Please review and let me know what changes.
Thanks,
Mandy

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(303) 844-7068
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From: Jeff Nelson [mailto:jeffnelson@utah.gov]
Sent: Friday, March 28, 2014 4:58 PM
To: Kress, Marielle J. (CMS/CMCS); Strom, Mandy L. (CMS/CMCHO)
Cc: Six, Gayle M.; Yoshida, Amanda; Smith, Michelle; Laura Belgique; Jennifer Meyer-Smart
Subject: QAZ: Utah - HPE Next Steps - SPA 14-0007-MM

Hello -

Thank you for all of the technical assistance you have provided for Utah on the Hospital Presumptive Eligibility SPA. We appreciate the open dialogue to discuss our concerns and explain our thoughts on how to implement the program in Utah.

We made several changes today and have included updated documents and a description of all the changes we have or will make for HPE. We tried to call out specific dates of when we think we could make those changes.

Again we thank you for your help and we look forward to approval of this outstanding SPA.

Jeff Nelson
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Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Denver Regional Office
1600 Broadway, Suite #700
Denver, CO 80202-4967

REGION VIII - DENVER

April 1, 2014

W. David Patton, Ph.D.
Utah Department of Health
288 North 1460 West
PO Box 143102
Salt Lake City, UT 84114

RE: Utah# 14-0007-MM

Dear Dr. Patton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal Number (TN) 14-0007-MM on January 3, 2014. This SPA implements presumptive eligibility by hospitals in accordance with the Affordable Care Act and 42 CFR 435.1110.

Please be informed this State Plan Amendment was approved April 1, 2014, with an effective date of January 1, 2014. We are enclosing the CMS- 179 and the amended plan page(s).

In addition, Utah has agreed by July 2014 to incorporate changes to Utah's single streamline application by providing better instructions to presumptive eligibility applicants on what question are required to be completed when applying for presumptive eligibility. In addition, the state will implement a paper form verifying an individual's eligibility to be given to the applicant upon determination as well as work to train doctors and pharmacies to accept this paper documentation as proof in the interim until the applicant receives the actual medical card in the mail.

If you have any questions regarding this letter, please contact Mandy Strom at (303) 844-7068 or mandy.strom@cms.hhs.gov.

Sincerely,

Richard C. Allen
Associate Regional Administrator
Divisions of Medicaid & Children's Health Operations

CC: Michael Hales, Medicaid Director, UT
Craig Devashrayee, UT
Jeff Nelson, UT
Gayle Six, UT

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From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 31, 2014 2:51 PM
To: 'Jeff Nelson'; 'Craig Devashrayee (cdevashrayee@utah.gov)'
Cc: 'Six, Gayle M.'; 'Yoshida, Amanda'; 'Smith, Michelle'; 'Laura Belgique'; 'Jennifer Meyer-Smart'; Kress, Marielle J. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject: REVISED: ACTION REQUIRED ASAP: RE: Utah - HPE Next Steps - SPA 14-0007-MM

Follow Up Flag: Follow up
Flag Status: Completed

One more item:
Please indicate on the subject line for fiscal impact that this SPA's fiscal impact is incorporated with 14-0001-MM.

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Subject: ACTION REQUIRED ASAP: RE: Utah - HPE Next Steps - SPA 14-0007-MM
Importance: High

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(801) 538-6471

PS. We plan to move the "opt out" bullet into the last position in the same section but had a computer glitch this afternoon.

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Strom, Mandy L. (CMS/CMCHO)

From:	Jeff Nelson <jeffnelson@utah.gov>
Sent:	Friday, March 28, 2014 4:58 PM
To:	Kress, Marielle J. (CMS/CMCS); Strom, Mandy L. (CMS/CMCHO)
Cc:	Six, Gayle M.; Yoshida, Amanda; Smith, Michelle; Laura Belgique; Jennifer Meyer-Smart
Subject:	QAZ: Utah - HPE Next Steps - SPA 14-0007-MM
Attachments:	Hospital SPA-Next steps-3-28-14.docx; HPE Powerpoint updated based on CMS' feedback.pptx; HPE TRAINING MANUAL updated per CMS feedback.docx; PE Receipt.docx; HPE App with CMS' Feedback.pdf

Hello -

Thank you for all of the technical assistance you have provided for Utah on the Hospital Presumptive Eligibility SPA. We appreciate the open dialogue to discuss our concerns and explain our thoughts on how to implement the program in Utah.

We made several changes today and have included updated documents and a description of all the changes we have or will make for HPE. We tried to call out specific dates of when we think we could make those changes.

Again we thank you for your help and we look forward to approval of this outstanding SPA.

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

PS. We plan to move the "opt out" bullet into the last position in the same section but had a computer glitch this afternoon.

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Presumptive Eligibility Receipt

Important: Any attempt to change any information on this receipt will invalidate the receipt.

ATTENTION PROVIDERS:

The Medicaid presumptive eligibility program provides temporary medical coverage for members based on preliminary information. This receipt serves as proof that the following number of members have been approved for Medicaid:

# of Members: ______________

The eligibility decision was sent to the Department of Workforce Services to enter into the eligibility system. Each member will receive a medical card with an activated medical ID# in the mail.

Eligibility Start Date

____

(MM/DD/YY)

Member Name (Last, First, M.I.)	Date of Birth (MM/DD/YY)

Important: Worker must complete all information below in order for this receipt to be valid.

Presumptive Eligibility Worker Information

Worker Office: ______________________ Phone#: ______________________

Address: ____

Worker Signature: ______________________ Date: ______________________

March 28, 2014

Hospital SPA 14-0007-MM
Utah's Response to CMS on Next Steps Needed

From today's discussion with Marielle Kress and Mandy Strom, Utah has outlined the next steps needed to finalize the HPE SPA.

1. Policy
    a. Utah will change the limit on presumptive eligibility periods from once every 6 months to one period during the calendar year on the hospital SPA template. Pregnant women will remain as one period per pregnancy. (We will also seek to amend our SPA for children to be consistent with this policy.)

2. Training
    a. Modify the training to reflect the eligibility period as mentioned above. (See p. 7 training manual, & PowerPoint slide 5)

    b. Modify the training material language to say "ambulatory prenatal care" instead of "outpatient prenatal care" as the benefits available to pregnant women during the presumptive eligibility period. (See p. 14 training manual, slide 12)

3. Application & forms
    a. Utah made proposed changes to the applications with better directions for HPE applicants. We will incorporate these changes in the next iteration expected for July 2014. (See cover and p.7)

    b. Utah created a proposed form for hospitals to give to the applicant upon determination. It verifies the individual's eligibility for presumptive Medicaid benefits.
        i. Utah will work with the pharmacy team to train pharmacies and others to accept this letter as proof of eligibility in the few days before the applicant receives their medical card by mail. Expected completion date is July 2014.

        ii. Utah will follow up with already approved hospital providers to inform them of these changes.

4. Consistency
    a. Utah will continue its work to align the presumptive processes for all PE programs. Specifically, Utah will seek to automate the eligibility system to allow for PE extensions while the actual eligibility is being determined. Until such a time that it can be automated, an interim solution will be found to extend presumptive pregnant women who apply through the clinic setting.

Strom, Mandy L. (CMS/CMCHO)

From: Allen, Richard C. (CMS/CMCHO)
Sent: Friday, March 28, 2014 10:56 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: Utah PE

Jeff was asking about other states successfully using portals with hospitals and feeds into the MMIS. Colorado has had a lot of success in this area. You may want to let Jeff know a good state contact is Antoinette Taranto. Her email address is antoinette.taranto@state.co.us

Richard C. Allen
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations,
Region VIII
Tel: 303-844-1370
Fax: 303-844-3753

Strom, Mandy L. (CMS/CMCHO)

From:	Kress, Marielle J. (CMS/CMCS)
Sent:	Friday, March 28, 2014 8:00 AM
To:	Strom, Mandy L. (CMS/CMCHO)
Cc:	Allen, Richard C. (CMS/CMCHO); Marchioni, Mary A. (CMS/WC)
Subject:	RE: Can you do 12:00 Eastern for a Utah on Hospital PE

That works perfectly. Thank you very much, Mandy!

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Friday, March 28, 2014 9:59 AM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Allen, Richard C. (CMS/CMCHO); Marchioni, Mary A. (CMS/WC)
Subject: Can you do 12:00 Eastern for a Utah on Hospital PE

Hi Marielle,
Gayle and Jeff can do 10Mountain/12 Eastern. Jeff alone might be able to meet with us later today, but Gayle is leaving early.
They are both off Monday.

Mandy Strom| Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | : (443) 380-6091| : Mandy.Strom@cms.hhs.gov

Please consider the environment before printing this e-mail.

Strom, Mandy L. (CMS/CMCHO)

From:	Kress, Marielle J. (CMS/CMCS)
Sent:	Thursday, March 27, 2014 11:46 AM
To:	Marchioni, Mary A. (CMS/WC); Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS); Cash, Judith (CMS/CMCS)
Cc:	Allen, Richard C. (CMS/CMCHO)
Subject:	Re: UT 14-0007-MM=Next Step RAI
Follow Up Flag:	Follow up
Flag Status:	Completed

It sounds like we do need to talk, but we are all unavailable today. We can regroup tomorrow morning, what time works on your end? Thanks.

From: Marchioni, Mary A. (CMS/WC)
Sent: Thursday, March 27, 2014 09:28 AM
To: Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: Re: UT 14-0007-MM=Next Step RAI

We may need to talk. Neither myself nor Richard Allen, our ARA are not supporting an RAI. Let me know if you would like a call to discuss.

We can also issue a Companion letter, assuring formal notice to the state that changes may be needed for future.

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, March 27, 2014 08:23 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: UT 14-0007-MM=Next Step RAI

Thanks Marielle. I just want to make sure I understand. Utah has indicated they will make changes, but they need some time. Are you saying that you need the changes made before you can approve the SPA or you need some type of agreement that they will make them in the future to approve the SPA? If it is the later, then what type of agreement do you need?
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Thursday, March 27, 2014 5:26 AM
To: Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: Re: UT 14-0007-MM=Next Step RAI

Thanks so much Mandy. Both Annie and I have been out of the office this week and I will get you questions tomorrow so the RAI can go out by the end of the week. We cannot approve the SPA since we do not have agreement that the state will make the changes.

Best,
Marielle

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 07:09 PM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: UT 14-0007-MM=Next Step RAI

Marielle and Annie,
I have re-reviewed everything submitted as well as spoke with the State today. Here is my analysis:

- The actual SPA template looks approvable.
- It does not look like the state made edits to the training manual or slide presentation based on our informal comments.
- As for the additional questions you sent to the state, but the state had already submitted its revisions to CMS so those changes were not incorporated. I was able to speak with Gayle today from Utah and she indicated the following:
    - The alternative single streamline application does have a * indicating below that SSN is not required for PE. The rate and ethnicity fields also have * and show optional so not sure what more you want on this piece.
    - She indicated the state is willing to make changes to the application such as adding question 3 in section D for PE, but they will not be printing revised applications to July. They are okay with some type of conditional approval requiring them to make changes.

I recommend approval for this SPA and then require changes to the training manual and application in the approval letter. Please let me know your thoughts ASAP.
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 11:08 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: UT 14-0007-MM=Next Step RAI

Hey Marielle,
I just a left you a voicemail. Just trying to connect to discuss next steps on this SPA. We are at day 82 on the clock and my management has requested to know the status. Thanks.

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 24, 2014 8:10 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)

Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: UT 14-0007-MM=Next Step RAI

Hi Annie and Marielle,
I just wanted to check back in with you on any outstanding issues you may have for the RAI for this SPA. I know Marielle had sent some comments on the application (attached) that were not addressed with Utah's latest submission of attachments. At this point, I have the following outstanding items:

1. The first page of the application indicates the questions required to be answered, but it may be easier on folks to denote the required questions on the questions themselves.
2. SSN and Race/Ethnicity cannot be required fields.
3. In section D, question 3 should also be required.
4. In section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

Let me know.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, March 18, 2014 10:16 AM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject: UT 14-0007-MM=Next Step RAI

Hi Marielle,
Regional management has directed staff to not go down to the wire on issuing RAIs close to day 90 and align with the dates in our SOP. Since we are approaching day 76 on Thursday, I think we should go the RAI route. I can draft the RAI if you send me your outstanding issues.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 12, 2014 1:37 PM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

I think it makes sense for us to try to provide another round of informal comments for the state to try to address before day 90. I will get those to you before the end of the week.

Thanks for following up!

Marielle

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 12, 2014 1:57 PM
To: Kress, Marielle J. (CMS/CMCS)

Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

Hey Marielle,
I forwarded Gayle your original email to Jeff letting her know those items were not addressed with the latest submission. I told her we would send a compiled list of outstanding items after reviewing everything and possibly have a call.

In looking at where we are on the clock, I noticed day 76 is next week. Do you anticipate providing another round of informal comments for the state to try to address before day 90 or issuing a RAI? Just trying to see what direction you would like to go since we are getting late on the clock.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Monday, March 10, 2014 11:18 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: FW: Another time

Hi Mandy, I wanted to flag this email for you since Gayle just sent us back their materials. I provided some high level feedback on the application and it appears the changes were not made. I think we will need another follow up call once we are able to re-review their submission. Just wanted to make sure you flagged this email for Gayle in case Jeff didn't get it or did not pass it along to her.

Thanks!

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 05, 2014 4:06 PM
To: 'Jeff Nelson'; Hollis, Annie R. (CMS/CMCS)
Cc: Strom, Mandy L. (CMS/CMCHO)
Subject: RE: Another time

Hi Jeff,

We had a chance to take a look at the application and we had some questions and comments for you. While we like the notation of which questions are required on the first page, it might make it easier on folks to denote the required questions on the questions themselves. In addition, we wanted to flag that SSN and race/ethnicity cannot be required fields.

In section D, question 3 should also be required. Finally, in section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

I think we are waiting for updated materials from you to re-review, but we wanted to get you some topline thoughts on the application as we are winding down our 90 days. Please let me know if you need questions answered, and we look forward to hearing from you shortly.

Best,
Marielle

From: Jeff Nelson [mailto:jeffnelson@utah.gov]
Sent: Friday, February 21, 2014 2:28 PM

To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: QAZ: Another time

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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Strom, Mandy L. (CMS/CMCHO)

From: Marchioni, Mary A. (CMS/WC)
Sent: Thursday, March 27, 2014 8:05 AM
To: Strom, Mandy L. (CMS/CMCHO); Hinojosa, Sophia A. (CMS/CMCHO); Clemens, Ann C. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

We need to discuss as an RAI doesn't seem appropriate. Is there a federal law or regulation that is being challenged via the SPA in its current form?

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, March 27, 2014 6:50 AM
To: Hinojosa, Sophia A. (CMS/CMCHO); Marchioni, Mary A. (CMS/WC); Clemens, Ann C. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

Marielle emailed and said they want to issue a RAI and I will have the questions to issue by the end of the week. See Attached.

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 5:05 PM
To: Hinojosa, Sophia A. (CMS/CMCHO); Marchioni, Mary A. (CMS/WC); Clemens, Ann C. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

Here is my summary of outstanding issues based on my re-review of everything:

- The actual SPA template looks approvable.
- It does not look like the state made edits to the training manual or slide presentation based on our informal comments.
- As for the additional questions I had listed below, the state had already submitted its revisions to CMS when they saw the additional items come via email. I was able to speak with Gayle today and she indicated the following:
  - The alternative single streamline application does have a * indicating below that SSN is not required for PE. The rate and ethnicity fields also have * and show optional so not sure what more central office wants on this piece.
  - The state is willing to make changes to the application such as adding question 3 in section D for PE, but they will not be printing revised applications to July. They are okay with some type of conditional approval requiring them to make changes.

This is a P2 SPA so the region does not have approval authority. I think we could approve the SPA and have in the approval letter the requirement for changes to the training materials and application. This is what I am going to recommend to Marielle via email.
Mandy

Mandy Strom
(303) 844-7068

Mandy.Strom@cms.hhs.gov

From: Hinojosa, Sophia A. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 10:56 AM
To: Marchioni, Mary A. (CMS/WC); Clemens, Ann C. (CMS/CMCHO); Strom, Mandy L. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

Mandy, can you please send copies of this SPA? If the PE application is not an actual part of the SPA, I think the RO could move with approval noting in the approval letter of the SPA that CMS approves the amendment with the understanding that the state will revise the PE application to meet Federal requirements. If the application questions are part of the actual SPA, I think it would be problematic for the RO to approve it as the application questions are not in line with our requirements (i.e. asking for SSN and race/ethnicity).

Mandy: have you heard from Gayle or Jeff about their reasons for not making the CMS requested changes in their hospital PE application? Was it a matter of not having time to do so or is the state really opposed to making those changes? Perhaps the state can make the requested changes before the end of the week as well and that would really address the pending questions to allow CMS to move forward with approval.

Thanks,

From: Marchioni, Mary A. (CMS/WC)
Sent: Wednesday, March 26, 2014 10:21 AM
To: Clemens, Ann C. (CMS/CMCHO); Strom, Mandy L. (CMS/CMCHO); Hinojosa, Sophia A. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

Thanks Ann,
I am not convinced that we should RAI the SPA.
This is another one of those circumstances where we are late on the clock, and sending the RAI out on the 85th – 90th day is not a recommended practice (at least it did not used to be).

Mandy, just let me know if you have success in talking with Marielle today.
If not, we may just push this one through to approval.

Thanks again everyone.
Mary

From: Clemens, Ann C. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 9:58 AM
To: Marchioni, Mary A. (CMS/WC); Strom, Mandy L. (CMS/CMCHO); Hinojosa, Sophia A. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: RE: UT 14-0007-MM -Late on Clock

Not to shirk, because you know I'll help, but I also haven't been working directly with this team and am not exactly sure what they want for final materials. Mandy's suggestions are sound, but I'm unsure if they'd want more. I just spoke with Marielle yesterday, so maybe try her again. Last time I was dealing with this type of delay with a MAGI team, I wrote the RAI, sent them the letter and said the day I'd be sending it out with a request for input before then. Luckily they responded, but it might be a tactic if they're unresponsive.

Ann Clemens / Health Insurance Specialist / Centers for Medicare & Medicaid Services, Region VIII /1600 Broadway, Suite 700 I Denver CO / 303.844.2125 / 443.380.7042 fax | Ann.Clemens@cms.hhs.gov

From: Marchioni, Mary A. (CMS/WC)
Sent: Wednesday, March 26, 2014 9:49 AM
To: Clemens, Ann C. (CMS/CMCHO); Strom, Mandy L. (CMS/CMCHO); Hinojosa, Sophia A. (CMS/CMCHO)
Cc: Allen, Richard C. (CMS/CMCHO)
Subject: FW: UT 14-0007-MM -Late on Clock

Mandy,
Thanks for informing. This may be one of those events where we consult at RO and draw upon our own expertise, and **then move without Central Office.**

Ann and Sophia,
I know I promised not to pull you into more tasks at this time, but do you have any expertise for the PE Hospital PE SPAs which we may be able to access?

Please let me know ASAP, and I can schedule some time for us to review together.

Thank you,
Mary

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 26, 2014 9:20 AM
To: Marchioni, Mary A. (CMS/WC)
Subject: UT 14-0007-MM -Late on Clock

Hi Mary,
We are on day 82 of the clock for the PE Hospital MAGI SPA. I tried to ping my CO counterparts last Tuesday before day 76 and then again Monday. Annie is out all week and she is usually responsive. I am not sure what to do. I don't have the expertise to identify all the problem issues for the RAI. I guess we can include the issues I am aware of in the RAI and then address any additional items while off the clock informally or when it is back on the clock. I will try Marielle again this week by phone and email, but wanted to make you aware.

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 24, 2014 8:10 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc: Marchioni, Mary A. (CMS/WC)
Subject: RE: UT 14-0007-MM=Next Step RAI

Hi Annie and Marielle,
I just wanted to check back in with you on any outstanding issues you may have for the RAI for this SPA. I know Marielle had sent some comments on the application (attached) that were not addressed with Utah's latest submission of attachments. At this point, I have the following outstanding items:

1. The first page of the application indicates the questions required to be answered, but it may be easier on folks to denote the required questions on the questions themselves.
2. SSN and Race/Ethnicity cannot be required fields.
3. In section D, question 3 should also be required.
4. In section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

Let me know.

Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, March 18, 2014 10:16 AM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject: UT 14-0007-MM=Next Step RAI

Hi Marielle,
Regional management has directed staff to not go down to the wire on issuing RAIs close to day 90 and align with the dates in our SOP. Since we are approaching day 76 on Thursday, I think we should go the RAI route. I can draft the RAI if you send me your outstanding issues.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 12, 2014 1:37 PM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

I think it makes sense for us to try to provide another round of informal comments for the state to try to address before day 90. I will get those to you before the end of the week.

Thanks for following up!

Marielle

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 12, 2014 1:57 PM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

Hey Marielle,
I forwarded Gayle your original email to Jeff letting her know those items were not addressed with the latest submission. I told her we would send a compiled list of outstanding items after reviewing everything and possibly have a call.

In looking at where we are on the clock, I noticed day 76 is next week. Do you anticipate providing another round of informal comments for the state to try to address before day 90 or issuing a RAI? Just trying to see what direction you would like to go since we are getting late on the clock.
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Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Monday, March 10, 2014 11:18 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: FW: Another time

Hi Mandy, I wanted to flag this email for you since Gayle just sent us back their materials. I provided some high level feedback on the application and it appears the changes were not made. I think we will need another follow up call once we are able to re-review their submission. Just wanted to make sure you flagged this email for Gayle in case Jeff didn't get it or did not pass it along to her.

Thanks!

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 05, 2014 4:06 PM
To: 'Jeff Nelson'; Hollis, Annie R. (CMS/CMCS)
Cc: Strom, Mandy L. (CMS/CMCHO)
Subject: RE: Another time

Hi Jeff,

We had a chance to take a look at the application and we had some questions and comments for you. While we like the notation of which questions are required on the first page, it might make it easier on folks to denote the required questions on the questions themselves. In addition, we wanted to flag that SSN and race/ethnicity cannot be required fields.

In section D, question 3 should also be required. Finally, in section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

I think we are waiting for updated materials from you to re-review, but we wanted to get you some topline thoughts on the application as we are winding down our 90 days. Please let me know if you need questions answered, and we look forward to hearing from you shortly.

Best,
Marielle

From: Jeff Nelson [mailto:jeffnelson@utah.gov]
Sent: Friday, February 21, 2014 2:28 PM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: QAZ: Another time

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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Strom, Mandy L. (CMS/CMCHO)

From:	Strom, Mandy L. (CMS/CMCHO)
Sent:	Monday, March 24, 2014 8:10 AM
To:	Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Cc:	Marchioni, Mary A. (CMS/WC)
Subject:	RE: UT 14-0007-MM=Next Step RAI
Attachments:	RE: Another time
Follow Up Flag:	Follow up
Flag Status:	Completed

Hi Annie and Marielle,
I just wanted to check back in with you on any outstanding issues you may have for the RAI for this SPA. I know Marielle had sent some comments on the application (attached) that were not addressed with Utah's latest submission of attachments. At this point, I have the following outstanding items:

1. The first page of the application indicates the questions required to be answered, but it may be easier on folks to denote the required questions on the questions themselves.
2. SSN and Race/Ethnicity cannot be required fields.
3. In section D, question 3 should also be required.
4. In section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

Let me know.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, March 18, 2014 10:16 AM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS); Marchioni, Mary A. (CMS/WC)
Subject: UT 14-0007-MM=Next Step RAI

Hi Marielle,
Regional management has directed staff to not go down to the wire on issuing RAIs close to day 90 and align with the dates in our SOP. Since we are approaching day 76 on Thursday, I think we should go the RAI route. I can draft the RAI if you send me your outstanding issues.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 12, 2014 1:37 PM
To: Strom, Mandy L. (CMS/CMCHO)

Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

I think it makes sense for us to try to provide another round of informal comments for the state to try to address before day 90. I will get those to you before the end of the week.

Thanks for following up!

Marielle

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Wednesday, March 12, 2014 1:57 PM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Another time

Hey Marielle,
I forwarded Gayle your original email to Jeff letting her know those items were not addressed with the latest submission. I told her we would send a compiled list of outstanding items after reviewing everything and possibly have a call.

In looking at where we are on the clock, I noticed day 76 is next week. Do you anticipate providing another round of informal comments for the state to try to address before day 90 or issuing a RAI? Just trying to see what direction you would like to go since we are getting late on the clock.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Monday, March 10, 2014 11:18 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: FW: Another time

Hi Mandy, I wanted to flag this email for you since Gayle just sent us back their materials. I provided some high level feedback on the application and it appears the changes were not made. I think we will need another follow up call once we are able to re-review their submission. Just wanted to make sure you flagged this email for Gayle in case Jeff didn't get it or did not pass it along to her.

Thanks!

From: Kress, Marielle J. (CMS/CMCS)
Sent: Wednesday, March 05, 2014 4:06 PM
To: 'Jeff Nelson'; Hollis, Annie R. (CMS/CMCS)
Cc: Strom, Mandy L. (CMS/CMCHO)
Subject: RE: Another time

Hi Jeff,

We had a chance to take a look at the application and we had some questions and comments for you. While we like the notation of which questions are required on the first page, it might make it easier on folks to denote the required questions on the questions themselves. In addition, we wanted to flag that SSN and race/ethnicity cannot be required fields.

In section D, question 3 should also be required. Finally, in section K, it appears these are PE questions while you also require other questions for PE in the rest of the application. We think the header of this section could be refined to make it clearer.

I think we are waiting for updated materials from you to re-review, but we wanted to get you some topline thoughts on the application as we are winding down our 90 days. Please let me know if you need questions answered, and we look forward to hearing from you shortly.

Best,
Marielle

From: Jeff Nelson [mailto:jeffnelson@utah.gov]
Sent: Friday, February 21, 2014 2:28 PM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: QAZ: Another time

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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Subject:	RE: Another time
Follow Up Flag:	Follow up
Flag Status:	Completed

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(303) 844-7068
Mandy.Strom@cms.hhs.gov

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Sent: Monday, March 10, 2014 11:18 AM
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Cc: Hollis, Annie R. (CMS/CMCS)
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Best,
Marielle

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Sent: Friday, February 21, 2014 2:28 PM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: QAZ: Another time

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
Utah Department of Health
(801) 538-6471

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Strom, Mandy L. (CMS/CMCHO)

From:	Strom, Mandy L. (CMS/CMCHO)
Sent:	Wednesday, March 12, 2014 11:54 AM
To:	Gayle M. Six (gaylesix@utah.gov)
Subject:	FW: Utah Hospital PE SPA materials
Attachments:	RE: Another time

Hey Gayle,
I have forwarded the materials to Marielle and Annie back in Baltimore. They did alert me that the items in the attached email were not addressed. You may not have received the email since it was only addressed to Jeff. CMS will re-review your submission and follow-up on what is outstanding. Stay tuned....

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, March 10, 2014 7:14 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: FW: Utah Hospital PE SPA materials

FYI:

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Gayle M. Six [mailto:gaylesix@utah.gov]
Sent: Friday, March 07, 2014 11:02 AM
To: Strom, Mandy L. (CMS/CMCHO); Jeff Nelson
Subject: QAZ: Hospital SPA materials

Mandy, after our phone call, we were asked to send the packet of materials for the Hospital PE SPA to CMS.

Here it is. I am not clear on who else to send this to. Can you forward the appropriate people? Let me know if anything is missing. I included the SPA as well, just in case.

Thanks, Gayle

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From: Kress, Marielle J. (CMS/CMCS)
Sent: Monday, March 10, 2014 11:18 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: FW: Another time
Attachments: 11-12-2013 HPE English eDOCs.pdf

Hi Mandy, I wanted to flag this email for you since Gayle just sent us back their materials. I provided some high level feedback on the application and it appears the changes were not made. I think we will need another follow up call once we are able to re-review their submission. Just wanted to make sure you flagged this email for Gayle in case Jeff didn't get it or did not pass it along to her.

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Subject: QAZ: Another time

Jeff Nelson
Bureau Director of Eligibility Policy
Medicaid and Health Financing
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Sent: Monday, March 10, 2014 7:14 AM
To: Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: FW: Utah Hospital PE SPA materials
Attachments: 61HPE appl.pdf; HPE Powerpoint.pptx; HPE_Manual.pdf; S21-hospital presumptive.pdf

FYI:

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

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Sent: Friday, March 07, 2014 11:02 AM
To: Strom, Mandy L. (CMS/CMCHO); Jeff Nelson
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Thanks, Gayle

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2014

HOSPITAL PRESUMPTIVE ELIGIBILTY *Training Manual*

With Presumptive Eligibility (PE), an individual can be temporarily enrolled in Medicaid if it appears they are eligible.

State of Utah

1/1/2014

UTAH DEPARTMENT OF
HEALTH
MEDICAID

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Introduction

The Affordable Care Act[1] allows hospitals to play an increasingly important role in connecting patients to health care coverage. This new provision allows qualified hospitals to determine Presumptive Eligibility for Medicaid based on customers' preliminary information.

This manual provides guidance for the administration of the Hospital Presumptive Eligibility (HPE) program. It will outline the policy and procedures needed for an effective implementation.

Thank you for your participation in ensuring the success of this important and effective resource for the citizens of Utah.

[1] **Statute Authority and Related Federal Rules for PE Option**
Statutory Authority: Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as modified by the Health Care and Education Reconciliation Act or 2010, Public Law 111-152 (March 30, 2010), Title 2, Subtitle A, Section 2001(a) (4) (B) and Title 2, Subtitle A, Section 2202.
Federal Regulations: Eligibility in the States, District of Columbia, the Northern Mariana Islands, and American Samoa, 42 CFR 435.1110 (2013).

HOSPITAL PRESUMPTIVE ELIGIBILITY TRAINING MANUAL

PART 1 CONTACT INFORMATION

- For Hospital Presumptive Eligibility policy or procedural questions, or to request training, contact:

  Laurie Ocobock
  Policy Specialist
  Phone: (801) 538-9153
  Fax: (801) 538-6952
  Utah Department of Health/Medicaid Health Financing
  PO Box 143107
  Salt Lake City, UT 84114-3107

  OR

  Laura Belgique (back up)
  Program Specialist
  Phone: (801) 538-6241
  Fax: (801) 538-6952
  Utah Department of Health/Medicaid and Health Financing
  PO Box 143107
  Salt Lake City, UT 84114-3107

- You may also e-mail questions to HPEpolicy@utah.gov

- To order Hospital Presumptive Eligibility applications, call (801)538-9153 or (801)538-6241.

- For questions regarding covered services, medical billing/payment, call Medicaid at (801) 538-6155 or 1-800-662-9651.

- Email completed applications to DWS at hospitalPE@utah.gov

PART 2 POLICIES AND PROCEDURES

Section 1: WHAT IS HOSPITAL PRESUMPTIVE ELIGIBILITY?

- With Hospital Presumptive Eligibility (HPE), an individual can temporarily enroll in Medicaid if it appears they are eligible based on preliminary information. Preliminary information includes information regarding the income and household size for the individual.
- The two departments that oversee the program are the Utah Department of Health (UDOH) and the Department of Workforce Services (DWS). UDOH oversees HPE policy and procedure. DWS oversees the ongoing Medicaid eligibility process.
- UDOH issues Memorandum of Agreements (MOA) between UDOH and hospitals throughout the state to administer the HPE program. Hospital staff who are trained in the HPE process determine HPE eligibility. Section 3 describes information on the HPE process.

Section 2: RULES HOSPITALS MUST COMPLY WITH

- A hospital must inform UDOH that it intends to make HPE determinations and that it agrees to follow the State's policies and procedures. UDOH will provide hospitals with information on all policies and procedures related to HPE.
- A hospital must make HPE determinations in accordance with UDOH's policies and procedures. If a hospital is not making HPE determinations in accordance with UDOH's policies and procedures, UDOH will provide the hospital with additional training or other forms of corrective action before disqualifying the hospital.
- A hospital must also comply with the proficiency standards that UDOH developed for HPE. As of January 1, 2014, UDOH has established a standard of 85 percent accuracy rate on HPE decisions. Accuracy is measured by how accurate the hospital's determination is based on the information provided by the applicant.

Section 3: SERVICES AND PAYMENT

- HPE covers an array of Medicaid eligible services including medication, lab work, inpatient and outpatient care. For questions regarding covered services, call Medicaid at 1-800-662-9651.
- During the HPE period, the client will also be able to receive treatment from other Medicaid providers after they leave the hospital.
- Hospitals will be paid at regular Medicaid rates.
- Payment for covered services is guaranteed for a hospital during an individual's presumptive eligibility period, even if the person fails to complete the full Medicaid application or is ultimately determined to be ineligible for ongoing Medicaid.
- If an HPE applicant is already covered under Medicaid, the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN) or the Utah Premium Partnership (UPP) at the time of application, HPE cannot be authorized by DOH.
- States will not recoup money from the hospital for services rendered during the HPE period.

Section 4: CONFIDENTIALITY

- All confidential information must be safeguarded from unauthorized disclosure and use. Staff who fail to safeguard confidential information may be subject to both civil and criminal penalties.
- Confidential information includes identifying information about applicants and recipients, such as names, addresses, telephone numbers, social security numbers, etc. Second, it includes information used to determine eligibility, such as income, assets, medical reports and data, names of persons obligated to provide financial and medical support, etc. Third, it includes information about benefits and medical services provided to individual recipients.

  Information that cannot be identified to particular applicants and recipients is not confidential information. For example, information stating the total number of HPE recipients is not confidential information because no one person can be identified by the general information.

Section 5: FRAUD, WASTE AND ABUSE

- To report suspected fraud, contact the DWS Information Fraud Hotline at 1-800-955-2210 or via email at wsinv@utah.gov.
- What you need to know when reporting fraud, waste or abuse:
  - It is helpful if you can provide any of the following information when reporting fraud, waste or abuse of the HPE Program:
    - Provider or recipient name
    - Date of birth
    - Address
    - Phone number
    - Social security number
    - Other details about what you suspect may be happening that appears to be wrong
  - You may remain anonymous when reporting suspected fraud
  - You may be requested to provide your name so that the investigator can contact you if there are questions regarding your referral. However, you may request that your name is not used in conjunction with the case.

    You may find more information on reporting fraud, waste or abuse at: http://health.utah.gov/mpi/recipient.html

Section 6: ELIGIBILITY PROCESS

- Applicants can apply for HPE through any qualified hospital site.
- The eligibility begins on the date the application is approved by the hospital.
- SELF-DECLARATION IS USED FOR ALL FACTORS OF ELIGIBILITY.
- If the applicant is a minor, the applicant's parent, legal guardian, or representative must sign the application. If the minor is living independently, the minor may apply on his/her own behalf. A representative for a child may be a relative or other responsible adult living with the child.
- An applicant may assign an authorized representative to apply on his/her behalf. The applicant must sign application if possible. If the applicant is unable to sign, the authorized representative may sign the application. In general, the person who signs the application should be someone who can answer the questions on the application.
- If an applicant is unable to write, he/she must make a mark on the application and have at least one witness to the signature.
- To qualify for all HPE programs, applicants must meet the following requirements based on preliminary information provided:
  - Be a U.S. citizen or qualified alien.
    - Qualified aliens are individuals who are not U.S. citizens but have received a lawful permanent residency (LPR) status for at least five years. Ask for the month and year in which the applicant received the LPR status to determine if the applicant meets this requirement.
    - Nationalized citizens and individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa, and Swain's Island meet U.S. citizenship requirements.
      - Note: Individuals from the Marshall Islands are not considered U.S. Nationals.
  - Be a Utah resident.
  - Clients may only receive one HPE period within a six-month period and may only receive HPE once per pregnancy period.
  - ***NOTE:*** *There is no asset test.*
  - Clients must not currently receive Medicaid, CHIP, UPP, or PCN.
    - Check the applicant's eligibility status by calling Medicaid at (80)538-6155 or 1-800-662-9651. Key in the client ID number and use the HPE determination date as the date of the medical service received. If the client is eligible, the system will give the medical program type, health plan, co-pay, mental health coverage information, and TPL information.
    - If a client is open for Medicaid with a spenddown, the client is not eligible for HPE.
  - Clients must not have received a denial for Medicaid, CHIP, UPP or PCN within the past 30 days, unless household circumstances have changed. For example, if the client was denied for Medicaid because his income is too high and now the client reports that his income has changed, determine if the client is eligible for HPE.

Section 7: COMPLETING the HPE APPLICATION:

- UDOH will supply hospitals with HPE paper applications.
- General Instructions:
  - Always use the most current application available.
  - The application cover sheet will tell you which questions must be completed for HPE.
  - Ensure the applicant signs the application.
- Application Clarification:
  - Applicant's name; this is the full, legal name of applicant. A hyphenated last name is acceptable.
  - Question #3: If anyone in your household is not a U.S. Citizen or U.S. National, does he or she have a Lawful Permanent Resident card (Green Card) from U.S. Citizenship and Immigration Services?
    - If an applicant indicates they are a Lawful Permanent Resident with a Green Card and the date that he/she became a lawful permanent resident is at least five years, he/she is considered a qualified alien.
  - Question #6 What is your total gross earned and unearned income (before taxes) for your household this month?
    - Indicate applicant's total stated, gross monthly income. Make sure that educational and child support income are not included.
    - Compare this information to the income limit assigned to the household size for the HPE program type.
  - **Income guidelines may change yearly**. UDOH will e-mail HPE providers with an updated income chart each year. Please be sure you are using the most recent version. See Appendix 1 for the income chart.
  - **Page #9:** The applicant **must sign** the application. Without a signature, the application is incomplete.

Section 8: HOSPITAL PRESUMPTIVE ELIGIBILITY MEDICAID PROGRAMS

The HPE Medicaid programs and eligibility components are as follows:

- **Program Hierarchy:**
  - When choosing an eligibility program to approve, choose using the following hierarchy starting with the Child Medicaid program category.
    - Child Medicaid 0-5 or Child Medicaid 6-18
    - Parent/Caretaker Relative
    - Pregnant Woman
    - Former Foster Care Individuals
- **Child Medicaid Age 0-5:**
  - Eligibility requirements:
    - Income limit: 139% of the Federal Poverty Level (FPL).
    - A child can receive eligibility through the month in which he turns age 6.
    - A child does not have to live with a parent or specified relative.
- **Child Medicaid Age 6-18:**
  - Eligibility requirements:
    - Income limit: 133% of FPL.
    - A child can receive eligibility through the month in which he/she turns age 19.
    - If an 18 year old lives with his/her parents, the parents' income is countable.
- **Pregnant Woman:**
  - Eligibility requirements:
    - Income limit: 139% of FPL.
    - The woman must be pregnant.
    - If a pregnant woman is age 19 or older and lives with her parent(s), her parent's income is not countable. If she is under age 19 and living with her parent(s), her parents' income is countable.
- **Former Foster Care Individuals**
  - Eligibility requirements:
    - Ages 18 to 26. Eligibility runs through the month he/she turns 26.
    - Individual was concurrently enrolled in Medicaid and Foster Care in Utah at age 18 or older when Foster Care ended.
    - Individual was in the custody of DCFS, DHS or an American Indian Tribe when Foster Care ended. Persons in the custody of Juvenile Justice Services are not eligible.

        - There is no income test.
        - Was not eligible for other categories of HPE.

- **Parent/Caretaker Relative (PCR)**
    - Eligibility requirements:
        - Must have an eligible child.
            a. Household must include a child that is either under 18 or is age 18 and is a full time student and expected to graduate before the age of 19.
        - Income test: See income chart in Appendix 1
        - Deprivation of Support must exist.
            a. Deprivation of support exists if the household has:
                - ✓ A parent who is deceased.
                - ✓ A parent who is incapacitated.
                - ✓ A parent who is unemployed or employed less than 100 hours per month.
                - ✓ A parent who is absent

Section 9: DETERMINING HOUSEHOLD SIZE

Determine the household size using the following chart that applies to the coverage group:
Include only people who live together.

Child 0-5
Applicant
Applicant's parent(s) and step-parent(s)
Applicant's sibling(s) and step-sibling(s)

Child 6-18
Applicant
Parent(s) and step-parent(s)
Legal spouse of applicant(s) (not boyfriend)
Applicant's unborn child(ren)
Sibling(s) and step-sibling(s)

Note on Child Programs: *If child(ren) are living with a guardian who is not their parent, their household size includes themselves and their sibling(s). For example, household consists of grandmother, grandfather and two grandchildren. The household size for each grandchild is two.*

Pregnant Woman	
If the applicant is under age 19 (whether or not they are married)	**If the applicant is age 19 or older (whether or not they are married)**
Applicant	Applicant
Legal spouse of applicant (not boyfriend)	Legal spouse of applicant (not boyfriend)
Applicant's parent(s)	Applicant's unborn child(ren)
Applicant's unborn child(ren)	Applicant's child(ren) including step-child(ren) under age 19
Applicant's child(ren) including step-child(ren) under age 19	
Sibling(s) and step-sibling(s) that are under age 19	

Former Foster Care *(no income limit)*
Applicant

Parent Caretaker Relative
Applicant
Legal spouse of applicant(s) (not boyfriend)
Applicant's unborn child(ren) if they are in the third trimester of pregnancy
Applicant's child(ren) including step-child(ren)

Section 10: INCOME

Count the gross income (before taxes) of everyone that is included in the household size for the specific program with the following exceptions:

- Do not count the income of a child to another child (sibling)
- Do not count the income of a child to a parent
- Do not count the income of a guardian to the child(ren) that the guardian is responsible for.

Examples of whose income to count are as follows:

- Family consists of a father, mother, and two children. The child is approved for HPE.
  - The parents' income counts toward the child's HPE eligibility.
  - The income of the sibling does not count toward the child approved for HPE.

- Family consists of a father, mother, and a child. The father is approved for HPE.
  - Income of the mother counts toward the father's HPE eligibility. Income of the child doesn't count toward the father's HPE eligibility.

Educational income and child support are not countable sources of income. Do not include the income when counting the household income.

For the presumptive Former Foster Care program, there is no income limit for this program.

Note: PAYCHECK STUBS ARE NOT REQUIRED. However, if an applicant provides you with paycheck stubs to help you determine their gross monthly income, use the following procedure to calculate their income:

- When paychecks are received twice a month, multiply the gross paycheck amount by 2. If paychecks are received every other week, multiply the gross paycheck amount by 2.15. If received weekly, multiply the gross paycheck amount by 4.3.

  - Income calculation examples:
    - Johnny provides you one $500 (gross) paycheck stub and indicates he is paid every other Friday. Multiply $500 x 2.15 to determine his gross monthly income ($500 x 2.15 = $1075).
    - Mary provides you one $200 (gross) paycheck stub and indicates she is paid every Wednesday. Multiply $200 x 4.3 to determine her gross monthly income ($200 x 4.3 = $860).
    - Frankie provides you one $500 (gross) paycheck stub and indicates he is paid on the 1st and 15th of the month. Multiply $500 x 2 to determine his gross monthly income ($500 x 2 = $1000).

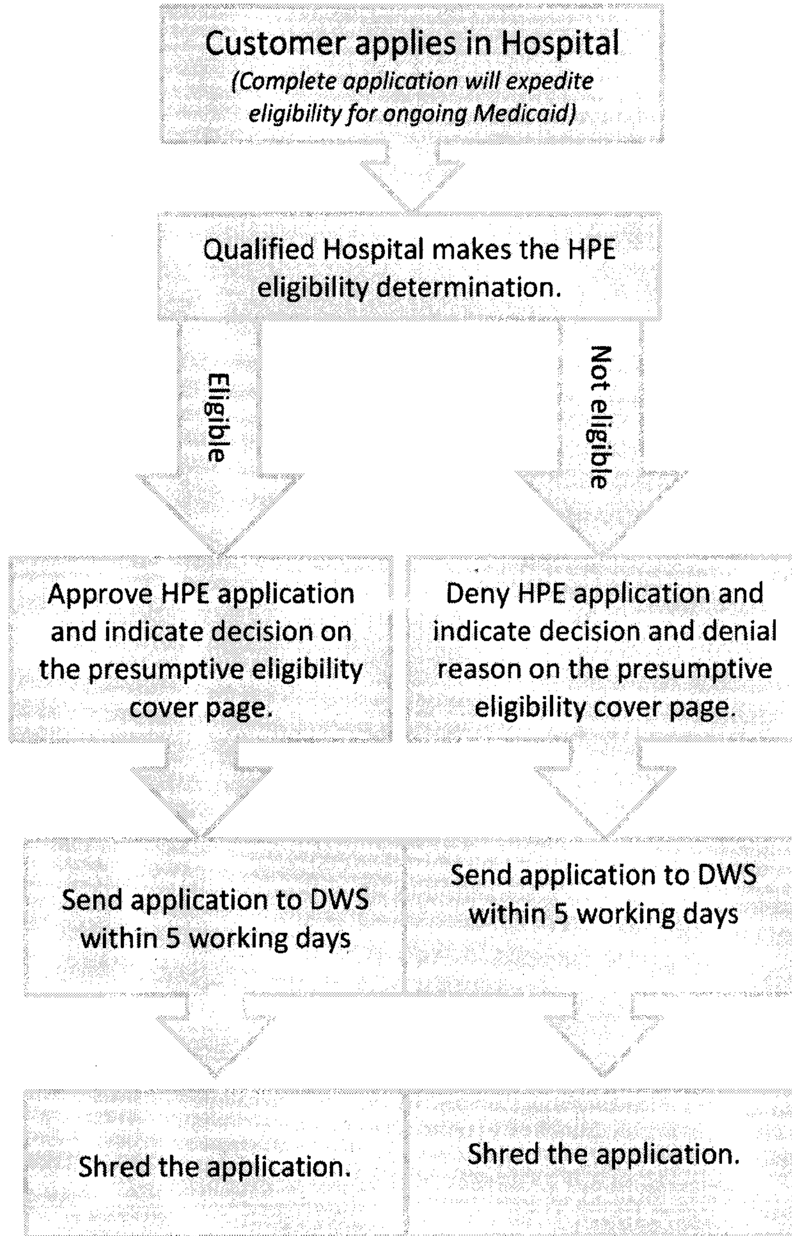
Section 11: WHAT HAPPENS NEXT AFTER AN ELIGIBILTY DETERMINATION?

- Complete the cover sheet for presumptive eligibility. Make sure to complete all fields and include the denial reason if the decision is a denial.
  - Possible denial reasons are as follows:
    - Already received HPE for the current pregnancy
    - Current CHIP, UPP, or Medicaid recipient
    - Issued HPE in the last 6 months
    - Medicaid denial in the past 30 days
    - No available HPE program
    - No deprivation
    - Not enough information to determine HPE
    - Not a U.S. citizen or eligible alien
    - Not a Utah resident
    - Over the income limit
- Hospital scans in the application and e-mails it to DWS at hospitalPE@utah.gov
  - Send the application to DWS within 5 working days.
  - **IMPORTANT**: If the application is incomplete and DWS contacts the hospital for additional information, the hospital must respond to DWS within 2 business days or HPE will not be issued.
  - Shred the paper application.
- DWS will issue the HPE card for the current month and determine eligibility for ongoing Medicaid. DWS will send the approval/denial notice and card.
  - The HPE Medicaid card is identical to a regular Medicaid card and provides the same medical coverage. Exception: For the presumptive eligibility program for pregnant women, the coverage is only for Medicaid covered pregnancy related outpatient services. Delivery and inpatient services are not covered.
- HPE coverage will continue until DWS makes a decision for ongoing Medicaid. The following examples illustrate how the time frame for HPE eligibility is determined.
  - Client is approved for HPE on Jan. 15th. Ongoing Medicaid eligibility is approved or denied on Jan. 16th. Jan. 16th is before the date Feb. cards are mailed. The HPE eligibility ends on Jan. 31st. The HPE card should not be used after Jan. 15th.

  - Client is approved for HPE on Jan. 16th. Ongoing Medicaid eligibility is approved or denied on Feb. 15th. HPE eligibility continues until Feb. 28th. The HPE card should not be used after Feb. 15th.

  - Client is approved for HPE on Jan. 16th. Ongoing Medicaid eligibility is approved or denied on Mar. 15th. HPE eligibility continues until Mar. 31st. The HPE card should not be used after Mar. 15th.

Section 12: APPLICATION PROCESS

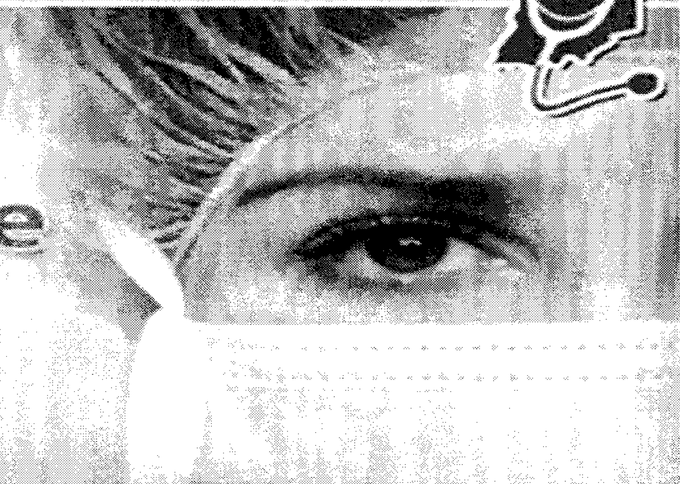


Section 13: CHECK LIST

- Make sure to do the following:
  - Help the customer complete the application *(Note: Although the customer is only required to complete the questions for HPE, completing the entire Medicaid application may expedite eligibility for ongoing Medicaid coverage).*
  - Submit the HPE application by e-mail to hospitalPE@utah.gov and subsequently destroy application
  - Educate the customer to stop using HPE card if she is approved or denied for ongoing Medicaid. If approved for ongoing Medicaid, the customer should use the new card for ongoing Medicaid.

Appendix 1: INCOME CHART (effective January 1, 2014)

HH Size	PCR	Pregnant Woman/Child 0-5	Child 6-18	Former Foster Care Individuals
		139% FPL	133% FPL	No income limit
1	438	1332	1274	
2	544	1797	1720	
3	678	2263	2165	
4	797	2729	2611	
5	912	3194	3056	
6	1012	3660	3502	
7	1072	4126	3947	
8	1132	4591	4393	
9	1196	5057	4838	
10	1257	5522	5284	



HOSPITAL PRESUMPTIVE ELIGIBILITY COMING SOON TO A HOSPITAL NEAR YOU

HEALTH

January 2014

What is Hospital Presumptive Eligibility (HPE)?

- Temporary Enrollment in Medicaid.
- Client Statement Accepted.
- Hospital Eligibility Decision Accepted

Confidentiality

- ❑ Safeguard Confidential Information
- ❑ Information that can be Identified to Particular Applicants and Recipients is Confidential Information.

Basic Eligibility Requirements

- ❑ Eligibility Begins on the Date of Approval
- ❑ Signature Required by Applicant or Authorized Representative
- ❑ Minors living with a Parent or Responsible Guardian Must Have the Parent or Responsible Guardian Sign the Application

Basic Eligibility Requirements

- ❑ U.S. Citizen or Qualified Alien
- ❑ Utah Resident
- ❑ Limit of one HPE Period Every Six Months
- ❑ Must not have Received a Denial for Medicaid, CHIP, UPP, or PCN within the Past 30 Days (unless there is a change in circumstances)

Completing the Application

- Use the Most Current Application Available.
- The Shaded Areas of the Application Must Be Completed.
- For Ongoing Medicaid, Complete the Remaining Questions.
- Ensure the Client Signs the Application.

Hierarchy of HPE Program Types

- When Deciding Which Program Category to Approve for an Individual, Use the Following Hierarchy:
  - Child 0-5/Child 6-18
  - Parent/Caretaker Relative
  - Pregnant Woman
  - Former Foster Care Individual

Child Medicaid Age 0-5

- Income Under 139% FPL
- Child Under Age 6 or in Month They Turn Age 6
- Does Not Need To Live With Family

Child Medicaid Age 0-5
Household Size

- ❑ Applicant
- ❑ Applicant's Parent(s) and Step-parent(s)
- ❑ Applicant's Sibling(s) and Step-sibling(s)

Child Medicaid Age 6-18

- ***Income Under 133% FPL***
- ***Child Over Age 6 or in Month They Turn Age 19***
- ***If 18 Year Old Lives With Parents, Parents' Income Counts.***
- ***Does Not Need To Live With Family***

Child Medicaid Age 6-18 Household Size

- ❑Applicant
- ❑Parent(s) and Step-parent(s)
- ❑Legal Spouse of Applicant
- ❑Unborn Child(ren)
- ❑Child(ren)
- ❑Sibling(s) and Step-sibling(s)

Pregnant Woman Medicaid

- Income Under 139% FPL
- Pregnant
- If Woman Under 19 Years Old Lives With Parents, Parents' Income Counts.
- If Woman Age 19 or Over Lives With Parents, Parents' Income Does Not Count
- Only Outpatient Medical Services Covered
- Limit of One HPE Period Per Pregnancy

Pregnant Woman Medicaid Household Size For Women Under Age 19

- ❑ Applicant
- ❑ Legal Spouse of Applicant
- ❑ Applicant's Parent(s) (If Living with Parents)
- ❑ Applicant's Unborn Child(ren)
- ❑ Children and Step-child(ren)
- ❑ Applicant's Siblings and Step-Siblings (Who are Under Age 19)

Pregnant Woman Medicaid Household Size For Women Age 19 and Older

- ❑Applicant
- ❑Legal Spouse of Applicant
- ❑Applicant's Unborn Child(ren)
- ❑Children and Step-child(ren)

Former Foster Care Individuals Medicaid

- *No Income Test*
- *May Not Be Eligible for Another HPE Program Type*
- *Age 18-Through Month They Turn 26*
- *Concurrently Enrolled in Medicaid and Foster Care in Utah at Age 18 or Higher When Foster Care Ended.*
- *In Custody of DCFS, DHS or an Indian Tribe when Foster Care Ended.*

Former Foster Care Individuals Household Size

- Applicant

Parent/Caretaker Relative Medicaid

- See Income Chart For Income Limits
- Household Must Include a Child That is Under Age 18 or Age 18 and a Full Time Student Expecting to Graduate Before Age 19.
- Deprivation of Support Must Exist Due To a Deceased, Incapacitated, or Underemployed Parent

Parent/Caretaker Relative Medicaid Household Size

- Applicant
- Legal Spouse of Applicant
- Applicant's or Spouse's Unborn Child(ren)
- Applicant's Children and Step-Children Under Age 19
- Unborn Children of any Pregnant Child Under Age 19

Whose Income to Count

- Count the Gross Income of all included in the Household Size for the Program with the Following Exceptions
  - Don't Count Income of a Child to another Child
  - Don't Count Income of a Child to a Parent
  - Don't Count Income of a Guardian to the Child(ren) that they are Taking Care of

Determining Monthly Gross Income

- ❑ Accept Applicant's Statement of their Monthly Gross Income
- ❑ When Paychecks are Received, Factor to Calculate Monthly Gross Income
- ❑ When Paychecks are Received Twice Monthly, Multiply by 2
- ❑ When Paychecks are Received Every Other Week, Multiply by 2.15
- ❑ When Paychecks are Received Weekly, Multiply by 4.3

Income Calculation Examples

- You receive one $500 (gross) paycheck and client is paid every other Friday.

  $500 x 2.15 =$1075

- You receive one $200 (gross) paycheck and client is paid every Wed. $200 x 4.3 = $860
- You receive one $500 (gross) paycheck and client is paid twice/month. $500 x 2 = $1000

Exempt Sources of Income

- ❑ Child Support and Educational Income are not Countable Sources of Income.

Next Steps

- ☐ Approve or Deny Application and Indicate Decision.
- ☐ If Denied, Indicate Denial Reason
- ☐ Send Application by Mail or Fax to the Dept. of Workforce Services within 5 Business Days.
- ☐ Shred the Application
- ☐ If an email is Received from DWS asking Questions, a Response is Required within 48 hrs.

Questions?

- Laurie Ocobock:801-538-9153
- Laura Belgique: 801-538-6241 (back up)
- HPEPOLICY@Utah.gov

Please tear off this page and keep for your information.

Application Information

CHIP • PCN • UPP • Medicaid • PE • Private Health Insurance • APTC

What Am I Applying For?

Health coverage is important for you and your family to get the medical care you need. When you submit this application, you will be considered for all medical programs that are now open for enrollment, including:

- **CHIP (Children's Health Insurance Program)**: Provides medical and dental insurance for uninsured children in families who qualify based on family size and income. For more information, visit: www.health.utah.gov/chip
- **PCN (Primary Care Network)**: Provides primary preventive health coverage for uninsured adults who qualify based on family size and income. For more information, visit: www.health.utah.gov/pcn
- **UPP (Utah's Premium Partnership for Health Insurance)**: Provides a monthly premium reimbursement when a previously uninsured individual or family enrolls in their employer's health plan or COBRA. For more information, visit: www.health.utah.gov/upp
- **Medicaid**: Provides medical assistance for low-income families, children, pregnant women, and disabled, blind and elderly individuals. For more information, visit: www.health.utah.gov/bep
- **Presumptive Eligibility (PE) for Medicaid**: Presumptive Eligibility is a program that provides temporary coverage for individuals who qualify based on preliminary information.
- **Private Health Insurance**: Provides comprehensive coverage to help you stay well. This is offered through the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov
- **Advanced Premium Tax Credit (APTC)**: This is a tax credit that can immediately help pay your premiums for health coverage in the Federally Facilitated Marketplace (FFM). For more information, visit: www.healthcare.gov

What Do I Need to Do Next?

- On your application, tell us about all of your family members who live with you. If you file taxes, we need you to tell us about everyone on your tax return. (You don't need to file taxes to get health coverage). The program you qualify for depends on the number of people in your family and their income. This information helps us make sure everyone gets the best coverage they can.
- We can best determine your eligibility if all questions are answered. However, for Presumptive Eligibility (PE), at a minimum you must fill out the following questions on the four pages listed below:
  - Page 1: Section A - Name, Address, Phone Number
Section B - Question 1 Only
(Student and marital statuses are optional.)
  - Page 3: Section D - Questions 4 and 7
  - Page 7: Section K - All Questions
  - Page 9: Section L - Signature
- Return this application to a qualified hospital that determines PE eligibility. The hospital will determine PE eligibility and will also forward your application to the Department of Workforce Services (DWS) to determine continued medical benefits. DWS will notify you of your eligibility decision.
- If more information is needed to determine your eligibility for benefits, an eligibility worker from DWS will contact you. **If you have not heard from DWS within 10 days, please call toll-free 1-866-435-7414.**

Where Can I Get More Information?

- For questions about how to complete the application, your application status, or to find out if you qualify, please access your information online at www.jobs.utah.gov/mycase. If you have questions about how to complete the application or you are unable to access the website, please call DWS at 1-866-435-7414.
- For general questions about the health care services covered by Medicaid or PCN, call the Medicaid hotline at 1-800-662-9651.
- For general questions about CHIP, PCN or UPP, call the Health Information Hotline at 1-888-222-2542.

Information on the cHIE

- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). The cHIE provides a safe place for participating healthcare providers to share and view patient medical information.
- Once your consent status has been set to PARTICIPATE, it will remain in effect for five years or until a minor turns 18. Recipients have the right to not participate in the cHIE or to change their consent status at any time. For more information or to opt out of the cHIE participation, visit www.mychie.org or talk to a healthcare provider.

For Presumptive Eligibility (PE) Worker Only:

Please complete this page for each presumptive eligibility application.

Name of PE Hospital: ______________________________

PE Worker Name: ______________________________

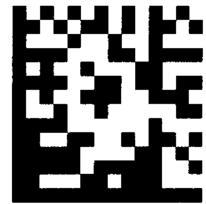
PE Decision Date: ______________

Name of Individual(s):	PE Medical Program	Approved/Denied

DOH/61HPE 1/2014
Case #: ___________

Application

CHIP • PCN • UPP • Medicaid • PE • Private Health Insurance • APTC



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A Applicant Information

Name: ____
first (start with yourself) middle initial maiden last

E-mail: ____
(optional)

Home Address: ____
(Leave blank if you don't have one) street apt. # city state zip

Mailing Address: ____
(If different from home address) street apt. # city state zip

Home Phone: (_____)__________________ Cell/Other Phone: (_____)__________________

Primary Language Spoken in Your Home: ______________________________

Would you like to receive notices in English or Spanish? ☐ English ☐ Spanish

B Household Information

1. List everyone who is living in your household and applying for benefits.

Name (first, m.i., last)	Relation to You	Social Security Number *	Birth Date mm/dd/yy	Sex M/F	Race **	Ethnicity ***	Marital Status ****	Fulltime Student Y/N	Utah Resident U.S. Citizen/ National*
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National
									☐Utah Resident ☐U.S. Citizen/ National

***Social Security Number & Citizenship** Social Security Number (SSN) and citizenship information are only needed for people applying for ongoing benefits. You are not required to provide SSN for presumptive eligibility, however, providing it may expedite your benefits. If someone needs help getting a SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

****Race Codes (Optional)** **WH**: White, **BL**: Black/African American, **AI**: American Indian/Alaska Native, **ASI**: Asian Indian, **CH**: Chinese, **FI**: Filipino, **JA**: Japanese, **KO**: Korean, **VI**: Vietnamese, **OA**: Other Asian, **NH**: Native Hawaiian, **SA**: Samoan, **GC**: Guamanian/Chamorro, **OPI**: Other Pacific Islander, **OT**: Other

*****Ethnicity Codes (Optional)** **N**: Not Hispanic/Latino, **M**: Mexican, **MA**: Mexican American, **CH**: Chicano/a, **PR**: Puerto Rican, **CU**: Cuban, **AH**: Another Hispanic, Latino, or Spanish Origin, **OT**: Other

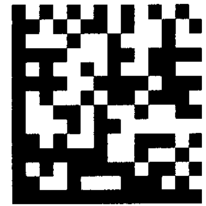
******Marital Status** Single, Married, Divorced, Widowed

2. If you mark that you are an American Indian or Alaska Native above, please complete Attachment A.

☐Yes ☐No 3. If you are not a U.S. Citizen or U.S. National, do you have an eligible immigration status? *(Only answer this question for individuals who are applying for benefits.)* If yes, please complete all columns:

Name	Immigration Document Type	Alien Number	Document ID Number (if different from Alien #)	Lived in the U.S. Since 1996? (Yes/No)	Has a spouse or parent who is a veteran or an active-duty member of the U.S. military, or is himself a veteran or an active-duty member of the U.S. military. (Yes/No)

Tax Filer Information



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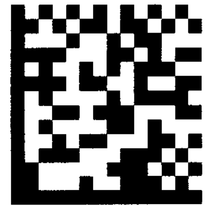
Please answer the following questions to help us select the program for your household. In addition to the questions below, please complete Attachment B of this application for all dependents that are not living with you, but are claimedon your tax return.

☐Yes ☐No 1. Do you plan to file a federal income tax return next year or will you be claimed as a dependent on someone's tax return next year?
If yes, please complete the chart* below.
Note: *If you are claiming more than 6 dependents on your tax return, please make a copy of this page and attach it to your application.*

Check one: ☐ **Tax Filer** **- or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: ________________ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: ________________ Relationship: ________________	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: ________________	***Dependent #1*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: ________________ Living with tax filer: ☐Yes ☐No
Check one: ☐ **Tax Filer** **- or-** ☐ **Tax Dependent**	**Filing Jointly with Spouse:** *(Applicable to Tax Filer Only)*	**Dependents Listed on Your Tax Return:** *(Applicable to Tax Filer Only)*
First & Last Name: ________________ Will you be claimed as a dependent on someone's tax return? ☐Yes ☐No If yes, list name of tax filer and your relationship to the tax filer: Name: ________________ Relationship: ________________	Are you filing jointly with your spouse? ☐Yes ☐No If yes, name of spouse: ________________	***Dependent #1*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #2*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #3*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #4*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #5*** Name: ________________ Living with tax filer: ☐Yes ☐No ***Dependent #6*** Name: ________________ Living with tax filer: ☐Yes ☐No

D General Information



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Please answer the following questions for anyone in your household that is applying for benefits. This will help us select the right medical program.

☐Yes ☐No 1. Do you want help paying any medical bills from the last 3 months?
If yes, for who:____________________ For which months:____________________

☐Yes ☐No 2. Does anyone in your household have a major medical need? This includes pregnancy, cancer, kidney disease, etc. *(Answering this question may get you extra help.)*
If yes, who:____________________
What is the medical need?____________________

☐Yes ☐No 3 Do you live with at least one child under the age of 19, and are you the primary person taking care of this child?

☐Yes ☐No 4. Was anyone in your household in foster care on or after his/her 18th birthday?
If yes, who:____________________

☐Yes ☐No 5. Does anyone in your household have a disability (a physical, mental, or emotional health condition that causes limitations in activities like bathing, dressing, daily chores, etc.)?
If yes, who:____________________

☐Yes ☐No 6. Has anyone in your household been in a jail, medical facility/hospital, or nursing home for 30 days or more within the last 3 months?
If yes, explain:____________________

☐Yes ☐No 7. Is anyone in your household currently pregnant or has been pregnant in the last 3 months?
If yes, who:____________________ Due date:____________________
How many babies are expected during the pregnancy? ____________________
Has she smoked or used tobacco in the past 6 months? ☐Yes ☐No
*(This question is for survey purposes only and does **not** affect eligibility.)*

E Income

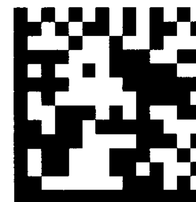
☐Yes ☐No 1. Does anyone in your household have earned income?
If yes, list any earned income received by all people who live in your home.

Employed Person (Name)	Employer Name, Address and Phone Number	Pay Rate Before Taxes ($900/mo.,$6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)
		/		
		/		
		/		

☐Yes ☐No 2. Does anyone in your household have self-employment income?
If yes, list any self-employment income received by all people who live in your home.

Self-Employed Person (name)	Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent of Company Owned	Gross Income This Month	Net Income This Month (profit once business expenses are paid)

☐Yes ☐No 3. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain:______________________________



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☐Yes ☐No 4. In the past year, did anyone in your household change jobs, stop working or start working fewer hours?
If yes, who:______________________________

☐Yes ☐No 5. Do you or anyone in your household have/receive any of the following? *(Check all that apply.)*

☐ Unemployment	$ ________	How often: ________	Date Income Started _______
☐ Pensions	$ ________	How often: ________	Date Income Started _______
☐ Social Security	$ ________	How often: ________	Date Income Started _______
☐ Retirement Accts.	$ ________	How often: ________	Date Income Started _______
☐ Alimony Received	$ ________	How often: ________	Date Income Started _______
☐ Net farming/fishing	$ ________	How often: ________	Date Income Started _______
☐ Net rental/royalty	$ ________	How often: ________	Date Income Started _______
☐ Other Income	$ ________	How often: ________	Date Income Started _______

Type____________

F Deductions

Check all that apply. List the amount paid and how often you get it. If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.
(*Note: You shouldn't include a cost already considered in your answer to net self- employment.)*

☐ Alimony Paid	$ _________	How often: _________
☐ Student Loan Interest Paid	$ _________	How often: _________
☐ Other deductions:	$ _________	How often: _________

Type: _________

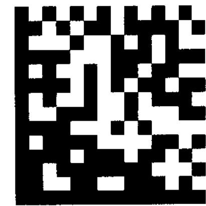
G Yearly Income

Complete only if your income changes from month to month. If you don't expect changes from month to month, skip to the next question.

☐ Total income THIS year: ____________________

☐ Total income NEXT year: ____________________
(If you think it will be different)

Health Insurance Information



D05914000500516

☐Yes ☐No 1. Does anyone in your household currently have Medicaid, CHIP, or Medicare? If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.

☐ Medicaid: ______________ ☐ CHIP: ______________

☐ Medicare: ______________

☐Yes ☐No 2. Has anyone in your household been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for medical services?

☐Yes ☐No 4. Is anyone in your household enrolled or eligible for COBRA coverage or continued health insurance through an employer?

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including VA Health Care System benefits, Tricare, or Peace Corps), have insurance available but not enrolled, or has had insurance in the past 6 months?

6. If you answer yes to questions 4 or 5, please complete the chart below regarding the insurance(s). *(Do not list Medicaid, Medicare, CHIP, or PCN.)*

Insurance 1

☐Enrolled, start date: ______________ ☐Not enrolled, but available ☐Ended, date ended: ______________

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: ______________

Name of insurance company: ______________ Phone #: ______________

Address of insurance company: ______________ Group#: ______________

Policyholder name: ______________ Policy #: ______________

Policyholder birth date: ______________ Policyholder SS#: ______________

If insurance is through an employer, list employer's name and phone #: ______________

Premium cost: $______________ Date due: ______________ How often: ______________

Type of Coverage: ☐ comprehensive ☐ limited

☐Yes ☐No Is this a retiree plan?

Insurance 2

☐Enrolled, start date: ______________ ☐Not enrolled, but available ☐Ended, date ended: ______________

*(If you check that your insurance status is **Not enrolled, but available** and this insurance is offered through either your job or someone else's job, such as a parent or spouse, please also complete Attachment C - Employer's Health Insurance Information Form attached to this application.)*

Name(s) of individual(s) covered: ______________

Name of insurance company: ______________ Phone #: ______________

Address of insurance company: ______________ Group#: ______________

Policyholder name: ______________ Policy #: ______________

Policyholder birth date: ______________ Policyholder SS#: ______________

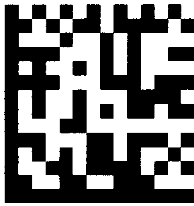
If insurance is through an employer, list employer's name and phone #: ______________

Premium cost: $______________ Date due: ______________ How often: ______________

Type of Coverage: ☐ comprehensive ☐ limited

☐Yes ☐No Is this a retiree plan?

Aged, Blind, Disabled, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, Refugee Medical



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You are only required to answer the questions on this page if there is anyone in your household who is applying for Aged (65+), Blind, Disabled Medicaid, Nursing Home, Waiver, or Spenddown Medicaid, Medicare Cost Sharing, and/or Refugee Medical.

I Other Benefits, Income, and Expenses

☐Yes ☐No 1. Has anyone in your household applied for, received, or been denied Social Security Income, VA, Unemployment or Worker's Compensation?
If yes, explain: ______

☐Yes ☐No 2. Has anyone in your household been determined disabled by Social Security?
If yes, who: ______

☐Yes ☐No 3. Does anyone in your household that has been determined disabled by Social Security pay child support or alimony?
If yes, list name and amount paid: ______

☐Yes ☐No 4. If employed, do you expect any changes in earnings or in the number of hours worked?
If yes, explain: ______

☐Yes ☐No 5. Does anyone help you pay mortgage/rent, food, or utility bills?
If yes, explain: ______

☐Yes ☐No 6. Does anyone in the household work in exchange for mortgage/rent, food, or utility bills?
If yes, explain: ______

☐Yes ☐No 7. Does anyone in the household pay for dependent care so he/she can go to work?
If yes, list name and amount paid: ______

J Assets

☐Yes ☐No 1. Do you or anyone in your household have any of the following financial assets? (Check all that apply)

☐ Annuities ☐ 401K / Retirement ☐ Checking Account $ ______
☐ IRA ☐ Money Market Funds ☐ Savings Account $ ______
☐ Stocks ☐ Trust Funds ☐ Other: ______
☐ Bonds ☐ Time Certificates

☐Yes ☐No 2. Do you or anyone in your household have any of the following assets? (Check all that apply)

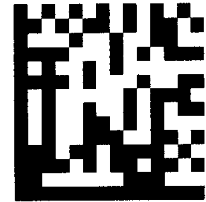
☐ Land ☐ Cemetery Plots ☐ Mineral or Timber Rights ☐ Life Estate
☐ Home ☐ Life Insurance ☐ Rental / Investment Property ☐ Time Shares
☐ Tools ☐ Campers / Trailers ☐ Burial Plans / Funds ☐ Livestock
☐ Other: ______

☐Yes ☐No 3. Do you own any vehicles?
If yes, using the chart below, list any vehicles that are owned by you and anyone who lives with you. Type of vehicle includes all cars, trucks, vans, snowmobiles, motorcycles, motor homes, boats/motors, ATV's or other vehicles.

Make	Model	Year	Licensed Y/N	License Plate #	State	Owner/Joint Owners	Amount Owed

Presumptive Eligibility

You are only required to answer the questions on this page if there is anyone in your household who is applying for presumptive eligibility (PE) for Medicaid.



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K Presumptive Eligibility Questions:

☐Yes ☐No 1. If anyone in your household is not a U.S. Citizen or U.S. National, does he or she have a Lawful Permanent Resident card (Green Card) from U.S. Citizenship and Immigration Services?
If yes, please complete the chart below:

Name	Date the Individual Became a Lawful Permanent Resident (month/year)

☐Yes ☐No 2. Is anyone in the household currently on Utah Medicaid, CHIP (Children Health Insurance Program), PCN (Primary Care Network), or UPP (Utah's Premium Partnership Program) or has been approved for Utah Medicaid with a spenddown?
If yes, who:______________________________

☐Yes ☐No 3. Has anyone in your household been denied Utah Medicaid, CHIP, PCN, or UPP in the last 30 days?
If yes, who:______________________________

☐Yes ☐No 4. If you answered yes to question 3, has the reason changed since the denial?
If yes, explain______________________________

☐Yes ☐No 5. Has anyone in your household been approved for presumptive eligibility in the last 6 months, or if there is anyone pregnant, has she been approved for presumptive eligibility for pregnant women (Baby Your Baby) during this pregnancy?
If yes, who:______________________________

6. What is your total gross earned and unearned income (before taxes) for your household this month? *(Do not include child support or educational income.)*
$______________________________

☐Yes ☐No 7. Is there any child in the household who has any of the following? *(Check all that apply and list the child(ren)'s name(s) below.)*

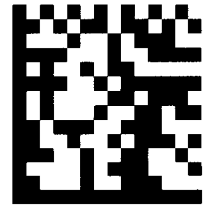
- ☐ a parent who is absent from the home
- ☐ a parent who is incapacitated (meaning unable to work due to injury or illness)?
- ☐ a parent who is deceased
- ☐ a parent who receives unemployment or works less than 100 hours per month.

If yes, list the name(s) of the child(ren):______________________________

☐Yes ☐No 8. Does anyone in your household currently have health insurance? *(This information is optional.)*
If yes, complete the chart below:

Insurance
Name(s) of individual(s) covered:______________________________
Name of insurance company:____________________ Phone #:____________
Address of insurance company:____________________ Group#:____________
Policyholder name:____________________ Policy #:____________

I Understand That:



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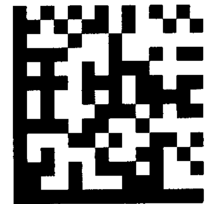
The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file
- My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.
- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.
- I must report any changes in my address, phone number, household size and access to coverage by another health insurance program within 10 days.
- The Utah Clinical Health Information Exchange (cHIE) is an electronic system that gathers my medical history from participating cHIE healthcare providers. The cHIE provides a safe place for my healthcare providers to share my medical information. For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.
- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand that I am responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- If I receive a medical card, I will allow only the people named on the medical card to use the card.
- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.
- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). The State will not report undocumented household members to USCIS.
- The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hot Line at 1-800-275-0659.
- In the event of my death and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/ or Medicaid at any time while I am 55 years of age or older. The state does not have the right to recover from my estate those costs paid as a benefit of eligibility for a Medicare cost-sharing program (QMB, SLMB, QI).
- I give permission for any information provided to be verified when I apply and after I receive benefits.
- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand that these manuals may be amended without my consent or consideration.
- I may ask for a fair hearing if I disagree with the decision made on this application.
- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.
- I must cooperate with the State in pursuing any third party responsible for medical expense. I must cooperate with the State to establish medical support for my family, if required, unless I have good cause to not cooperate.

I understand that my Social Security number will be used with the State Income and Eligiblity Verification System to make sure that my household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about my household. I must provide proof showing that my household is eligible for assistance.



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I, (print name) ______________________________, have read or had someone read to me the statements on this page. I understand and agree to those statements. Under penalty of perjury, I swear that the answers I give on this application are complete and correct. I am the person represented by the signature on this document. I know that I may be subject to penalties under federal law if I provide false or untrue information.

____ ____________________

Signature (check one): ☐ Applicant ☐ Authorized Representative Date

☐Yes ☐No Would you like someone to act as an authorized representative and have access to the information regarding your case? If yes, please complete Attachment D - Authorization to Disclose Medical Eligibility Information form attached to this application.

M Renewal of Coverage in Future Years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Marketplace to use income data, including information from tax returns. I also agree to allow the Department of Workforce Services, the Department of Human Services and the Department of Health to use information from tax returns. I can opt out at any time. The Marketplace will send me a notice and let me make changes.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year

☐ Don't use information from tax returns to renew my coverage.

N Voter Registration Information

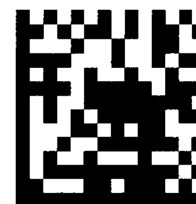
☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

O Return completed form to:

You have now completed the application. For more information please review the "Application Information" cover sheet. Please return this completed application form to:

Department of Workforce Services
PO Box 143245
SLC, UT 84114-3245
Fax: 1-801-526-9505
Toll-free Fax: 1-888-522-9505

Please tear off this page and keep it for your information.



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Your Rights & Responsibilities

You Have the Right to:

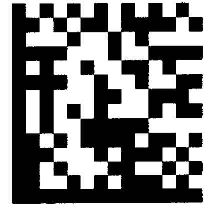
- Apply or re-apply any time you wish for any medical program. Some programs are only available during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision. For medical assistance, we have 30 days to process your application. We have 90 days, if you claim to be disabled, unless you need more time.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances, we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  - A. Talk to your worker. Make sure you are not misunderstanding each other.
  - B. Talk to your worker's supervisor.
  - C. Talk to Constituent Services: 1-801-526-4390 or call toll-free 1-800-331-4341
  - D. Request a Fair Hearing within 90 days of the decision; 10 days to get benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process. *Note: There are not any fair hearings for presumptive eligibility programs.*
  - E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 1-801-394-9431 or Salt Lake, 1-801-328-8891. The toll-free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 1-801-531-9075.
- Look at information in your case. Information about you and your case is confidential. We may give information to other agencies to administer a program to help you.

Your Responsibilities:

- Verify Information. The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you are applying only for emergency Medicaid, you do not have to provide a Social Security number. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with the Department of Workforce Services, Department of Health, Department of Human Services, Department of Homeland Security, Social Security, Internal Revenue Service, and/or a consumer reporting agency. These agencies may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about my household. I must provide proof showing that my household is eligible for assistance.
- Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS Help Line at 1-801-538-6872 or the Immunization Hot Line at 1-800-275-0659.
- You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a 'good cause' claim. Your worker can explain this procedure.
- Medical assistance (Medicaid, CHIP, UPP, PCN) recipients are automatically enrolled in the Utah Clinical Health Information Exchange (cHIE). For more information or to opt out of the cHIE participation, visit www.mychie.org or contact your health care provider.

You and your household must also follow the medical assistance program rules.

Please tear off this page and keep for your information.



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Changes You Must Report

Remember that **YOU** are required to report changes in your situation **WITHIN 10 DAYS** of the day you learn of the change. Do not delay reporting changes. Changes can affect your eligibility. If you receive benefits which you are not eligible to receive, you will have to repay that amount. To report changes, contact DWS online at www.jobs.utah.gov/mycase or call 1-866-435-7414.

If you receive CHIP, PCN, UPP, or Medicaid Benefits, you must report:

- **Change in Marital Status or Living Arrangements**
  Getting married, separated, or divorced; moving in with a roommate; change of address or phone number; absent parent moves in; birth of a baby or end of a pregnancy; household member moves in or out; death of a household member; hospital stays for more than 30 days; or if anyone in your household goes to jail or prison; receiving help with your household expenses, etc.

- **Change in Insurance Coverage**
  Changes in access to insurance, coverage, or enrollment in any health coverage plan (including Medicare or VA Health Care System benefits) for anyone in the household. You must also report accidents or injuries which may be payable by a third party.

If you receive Medicaid, you must also report:

- **Change in Source of Income**
  Getting a job, terminating a job, changing jobs, working for temporary services, obtaining educational income, SSI, SSA, or unemployment compensation, etc. Receiving a lump sum. Going on strike.

- **Change in Amount of Earned or Unearned Gross Monthly Income**
  Working more OR less hours, overtime, getting a raise, etc. Change in the amount of SSI, SSA, Unemployment Compensation, etc.

- **Change in the Legal Obligation to Pay Child Support**

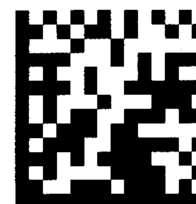
- **Gain or Loss of a Vehicle (Licensed or Unlicensed)**
  Car, truck, van, motorcycle, camper, trailer, recreational vehicle, etc.

- **Change in Any Asset(s)**
  Report changes in ownership or value of stocks, bonds, property, vehicles, life insurance, trust funds, burial plans, cash, opening and closing of bank accounts, etc. for all household members. (Includes joint ownership of any asset with spouse, parents, children, etc.)

- **Change in Allowable Deductions**
  Child care expenses, health insurance expenses, etc. If you are age 65 or over, blind, or disabled, you must also report changes in alimony or child support paid by a spouse or parent and work related expenses.

Attachment A

American Indian or Alaska Native Family Member (AI/AN)



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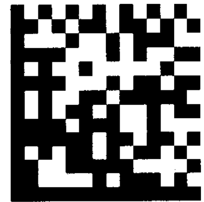
Complete this attachment if you or a family member are American Indian or Alaska Native. Submit this with your application. If you have more people to include, make a copy of this page and attach it to your application.

Tell us about your American Indian or Alaska Native family member(s).
American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian Health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN Person 1	AI/AN Person 2
1. Name	First Middle Last	First Middle Last
2. Member of a federally recognized tribe?	☐ Yes If yes, tribe name ____________ ☐ No	☐ Yes If yes, tribe name ____________ ☐ No
3. Has this person ever received a service from the Indian Health Service, a tribal health program, or urban Indian Health program, or through a referral from one of these programs?	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No	☐ Yes ☐ No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian Health programs, or through a referral from one of these programs? ☐ Yes ☐ No
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: • Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties • Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian Trust Land by the Department of Interior (including reservations and former reservations) • Money from selling things that have cultural significance	Amount: $____________ How often?____________	Amount: $____________ How often?____________

Attachment B

Information on Your Dependents that are Not Living With You



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Complete this attachment for all dependents that ARE NOT living with you, but are claimed on your tax return. If you have more dependents that are not living with you, but are claimed on your tax return, please make a copy of this page and attach it to your application.

A General Information

Complete the following chart for your dependent:

Name of Dependent (first, m.i., last)	Relationship to You	Date of Birth	Sex M/F	SSN# (optional)

☐Yes ☐No 1. Is your dependent currently pregnant or has been pregnant in the last 3 months?
If yes, due date:__________
How many babies are expected during the pregnancy? ____________________

B Income

☐Yes ☐No 1. Does your dependent have earned income? If yes, complete the chart below:

Employer Name, Address and Phone Number	Pay Rate Before Taxes ($900/mo., $6/hr.)	Hours Worked Weekly	How Often Paid (weekly, monthly)

☐Yes ☐No 2. Does your dependent have self-employment income?
If yes, list any self-employed income received.

Company Name	Type of Business (Ex. LLC, S-Corp, etc.)	Business Start Date	Percent Company Owned	Net income this month (profit once business expenses are paid)

☐Yes ☐No 3. In the past year, did your dependent change jobs, stop working or start working few hours?

☐Yes ☐No 4. Does your dependent have/receive any of the following? (Check all that apply.)

☐ Unemployment $ ________ How often: ________ ☐ Net farming/fishing $ ________ How often: ________

☐ Pensions $ ________ How often: ________ ☐ Net rental/royalty $ ________ How often: ________

☐ Social Security $ ________ How often: ________ ☐ Other Income $ ________ How often: ________

☐ Pensions $ ________ How often: ________ Type:__________

☐ Retirement Accts. $ ________ How often: ________ ☐ Alimony Received $ ________ How often: ________

C Deductions

1. Check all that apply, and give the amount and how often your dependent gets it. If your dependent pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower. *Note: You shouldn't include a cost already considered in your answer to net self-employment.*

☐ Alimony Paid $ ________ How often: ________ ☐ Other deductions $ ________ How often: ________

☐ Student Loan Interest $ ________ How often: ________ Type: ________

D Yearly Income

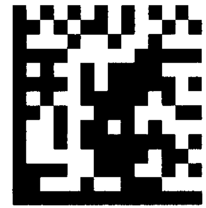
1. Complete only if your dependent's income changes from month to month.

☐ Total income THIS year:____________________ ☐ Total income NEXT year:____________________
(If you think it will be different)

DOH/Form 116M 10/2013
Case#:____________

Attachment C

Employer's Health Insurance Information



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- *This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.*
- *A form must be completed for each employed household member. You may copy this form.*
- *If you have general questions about this form or the medical programs, please call 1-866-435-7414.*

A General Information

Employee Information

Employee name ______________________________ Employee SSN#____________________
(first, m.i., last)

Employer Information

Employer Name: ____
EIN#:______________________________________ Phone #:____________________
Address:____
street apt.# city state zip

Who can we contact about employee health coverage at this job?

Contact Name:____
Phone #:______________________________________ E-mail Address:____________________

☐Yes ☐No 1. Does your company offer health insurance? If no, skip to section D. Sign and return the form.

☐Yes ☐No 2. Is your health insurance a state employee benefit plan?

☐Yes ☐No 3. Is your health insurance offered through Avenue H?

☐Yes ☐No 4. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: ____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy)____________________

☐Yes ☐No 5. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of person(s) enrolled:______________________________________
____
____

☐Yes ☐No 6. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): ____
If yes, when did coverage end/change? (mm/dd/yy) ____________________________

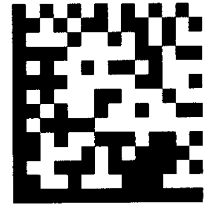
☐Yes ☐No 7. Does the employer offer a health plan that meets the *minimum value standard?

8. For the lowest-cost plan that meets the *minimum value standard offered **only to employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on the wellness programs:
a. How much would the employee have to pay in premiums for that plan? $________________
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

☐Yes ☐No 9. Do you know what change the employer will make for the new plan year?
If yes, complete the following:
☐ Employer won't offer health insurance
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the *minimum value standard. (Premium should not reflect the discount for wellness programs. See question 8.
a. How much will the employee have to pay in premiums for that plan?
$________________
b. How often? ☐ weekly ☐ every 2 weeks ☐ twice a month ☐ quarterly ☐ yearly

***An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)**

B Employer's Least Expensive Plan or Avenue H Default Plan


D05914000501516

Questions below refer to the ***employer's least expensive*** plan or the ***Avenue H Default Plan***.

☐Yes ☐No 1. Does the employee have to enroll in order to add their dependent(s)?

2. When will/did coverage begin? (mm/dd/yy)____________________________

3. When does the company's next open enrollment begin? (mm/dd/yy) ______________

4. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

	Monthly Premium	
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

C Employee's Health Plan Choice

Questions below refer to the plan that the employee has selected. Questions 3-7 refer to "in-network" benefits.

1. Insurance company and plan name: ____________________________________

2. Policy number, if known: ____

☐Yes ☐No 3. Is the deductible $2,500 or less per individual?

☐Yes ☐No 4. Is the lifetime maximum benefit $1,000,000 or more?

☐Yes ☐No 5. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

6. What benefits are covered under this plan? (Check all that apply.)
☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx

☐Yes ☐No 7. Does the plan cover abortion services?
If yes, under what circumstances:
☐ Only in the case where the life of the mother would be endangered if the fetus were carried to term or in the case of incest or rape
☐ Other, please describe:____

8. Complete this chart only if it is different from the chart on the front page (section B). **Do not** include the cost of dental, vision or other coverage if it is separate.

	Monthly Premium	
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

☐Yes ☐No 9. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):____________________________________

D Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: ____________________________________ Date: ____________________

Name (please print): ____

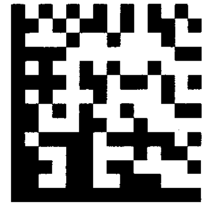
Title: ______________________________________ Phone: ____________________

Please return completed form to:

Department of Workforce Services, PO Box 143245, SLC, UT 84114-3245
Fax: 1-801-526-9500 Toll-free Fax: 1-877-313-4717

DOH/Form 114AR 10/2013

Attachment D



D05914000501616

Authorization to Disclose Medical Information

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you're a legally appointment representative for someone on this application, submit proof with this application.

I ______________________________ hereby give ______________________________ the authority to:
(Name of Customer or Authorized Representative) (Name of individual or Organization)

(check only one box)

☐ Receive Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed to whichever of the following occurs first:

- The following date: ____________________; or
- The medical application is denied*; or
- 30 days from the month the medical program is closed*.

**If the application is denied or the case is closed, information disclosure will continue throughout the fair hearing process.*

☐ Speak or act on my behalf as an authorized representative, which includes receiving Medicaid, CHIP, UPP, PCN or Buyout eligibility information regarding my current application, ongoing case or a recent case denial or closure. This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services.

Name of Authorized Representative: ____

Address of Authorized Representative: ____

- I understand that I may revoke this authorization at any time by sending a written notification to the Department of Workforce Services (DWS). I understand that a revocation is not effective to the extent that the Utah Department of Health, through its Division of Medicaid and Health Financing (DMHF) or the DWS has relied on the disclosed health information.
- I understand my rights and responsibilities described in the Notice of Privacy Practices. For a duplicate Notice of Privacy Practices, access the following URL - http://health.utah.gov/hipaa/privacy.htm.
- I understand that I may refuse to sign this authorization. I also understand that the DWS cannot deny eligibility for benefits if I refuse to sign this authorization.
- I understand that giving an individual authorized representative power allows them to act on my behalf, which includes making changes to my medical case and any changes that they make, I may be liable for if an overpayment is incurred.
- I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and could be disclosed by the person or agency that receives it.
  Note: DMHF and DWS will not disclose controlled documents without the consent of their Legal Departments.
- By signing this form, I acknowledge I have been provided a copy of this signed authorization.

____ ____________________
(Signature of Customer, Legal Guardian, or Authorized Representative) (Date)

If signed by other than the customer, description of authority to serve:

____

____

Strom, Mandy L. (CMS/CMCHO)

From:	Hollis, Annie R. (CMS/CMCS)
Sent:	Tuesday, February 25, 2014 6:30 AM
To:	Strom, Mandy L. (CMS/CMCHO)
Cc:	Kress, Marielle J. (CMS/CMCS)
Subject:	RE: UT 14-0007-MM

Hi Mandy!

Thanks for checking in.

The call went well in that they were very nice and understanding about the issues that we raised. Unfortunately, we are running into some systems issues with them automating a full Medicaid app whether or not the person is willing and able to or not...

Marielle, correct me if I'm wrong, but I think we are waiting to hear back from them on some sort of mitigation plan for that issue...

Thanks!
A.

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, February 24, 2014 3:56 PM
To: Hollis, Annie R. (CMS/CMCS)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: UT 14-0007-MM

Hey Annie,
How did the call go with Utah on Friday?

Mandy Strom| Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | : (443) 380-6091| : Mandy.Strom@cms.hhs.gov

Please consider the environment before printing this e-mail.

Strom, Mandy L. (CMS/CMCHO)

From: Repasch, Lee A.(CMS/CMCHO)
Sent: Thursday, February 20, 2014 11:58 AM
To: Frandson, Renee L.(CMS/CMCS); Jones, Lisa Y. (CMS/CMCS); Mills, Michelle (CMS/CMCS); Ryan, Jennifer (CMS/CMCS); Costello, Anne Marie (CMS/CMCS); Kress, Marielle J. (CMS/CMCS)
Cc: Sheer, Jennifer L. (CMS/CMCS); Burch Mack, Rebecca M.(CMS/CMCHO); Strom, Mandy L. (CMS/CMCHO)
Subject: RE: [SOTA-UT] SOTA Call

Good afternoon, while on this hospital PE call, I was reminded that Utah asked me to report that they began hospital presumptive eligibility yesterday. As of today, 50% of hospitals are on board, and many more contracts are currently in process.
They will have the majority of hospitals on by month's end.

They wanted to note this on the SOTA call yesterday but forgot and asked if I could send on word.

Thanks,

Lee

-----Original Appointment-----
From: Frandson, Renee L.(CMS/CMCS)
Sent: Tuesday, August 27, 2013 8:16 PM
To: Frandson, Renee L.(CMS/CMCS); Allen, Richard C. (CMS/CMCHO); Anderson, Alvin F. (CMS/CMCS); Aretakis, Nicolas J. (CMS/CMCHO); Calhoun, Yolande M. (CMS/OIS); Cash, Judith (CMS/CMCS); Cohen Ross, Donna (CMS/CMCS); Cummins, Susan K. (CMS/CMCHO); Curry, Elliot M. (CMS/CMCHO); Greene, Deanna K. (CMS/CMCS); Holmes, William J. (CMS/WC); Hughes, Ruth A. (CMS/CMCHO); Jones, Lisa Y. (CMS/CMCS); Kress, Marielle J. (CMS/CMCS); Lutzky, Amy (CMS/CMCS); Maiden, Diana (CMS/CMCHO); Manning, Scott (CMS/CMCS); Matthews, Elizabeth A. (CMS/CMCS); Melendez, Ricardo (CMS/CMCHO); Mills, Michelle (CMS/CMCS); Pedneau, Emily S. (CMS/CCIIO); Preston, Robin A. (CMS/CMCS); Repasch, Lee A.(CMS/CMCHO); Richards, Barbara K. (CMS/CMCS); Schmidt, Donna W. (CMS/OIS); Strecker, Betty L. (CMS/WC); Sweet, Jocelyn A. (CMS/CCIIO); Tibbals, Erica (CMS/CCIIO); Strom, Mandy L. (CMS/CMCHO)
Cc: Sheer, Jennifer L. (CMS/CMCS); Burch Mack, Rebecca M.(CMS/CMCHO); Kahn, Jessica (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: [SOTA-UT] SOTA Call
When: Wednesday, February 19, 2014 1:30 PM-2:00 PM (UTC-05:00) Eastern Time (US & Canada).
Where: Jen's Office and Call-in Below

<< File: UT_SOTA_Agenda_21 Call 2-19-14.doc >>
Please contact Lisa Jones (Lisa.Jones@cms.hhs.gov) if you have any questions.

Renee Frandson invites you to an online meeting using WebEx.

Meeting Number: 994 751 267
Meeting Password: This meeting does not require a password.

Audio conference information

----

1. Please call the following number:
WebEx: 1-877-267-1577
2. Follow the instructions you hear on the phone.
Your WebEx Meeting Number: 994 751 267

To join from a Cisco VoIP enabled CMS Region or from CMS Central Office

----

1. Dial ext. 63100
2. Enter the Meeting Number: 994 751 267

To join this meeting online

----

1. Go to https://cms.webex.com/cms/j.php?J=994751267
2. If requested, enter your name and email address.
3. If a password is required, enter the meeting password: This meeting does not require a password.
4. Click "Join".
5. Follow the instructions that appear on your screen.

Strom, Mandy L. (CMS/CMCHO)

From:	Strom, Mandy L. (CMS/CMCHO)
Sent:	Wednesday, February 19, 2014 6:53 AM
To:	Hollis, Annie R. (CMS/CMCS)
Cc:	Kress, Marielle J. (CMS/CMCS)
Subject:	RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Hi Annie,
I have sent an appointment with a call-in line for Friday from 2-2:30 Eastern. As I mentioned, I am off on Friday so I will not be able to make the call. I am going to give you some Utah contact information in case you need to cancel the call on Friday or need to get in touch with the State and I am out.

Gayle Six: gaylesix@utah.gov or 801-538-6895
Jeff Nelson: jeffnelson@utah.gov or 801-538-6471

Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Hollis, Annie R. (CMS/CMCS)
Sent: Wednesday, February 19, 2014 6:16 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Hi Mandy,

Let's try for Friday from 2-2:30... Marielle, not sure if that works for you, but Monday looked worse for you than Friday does.

Thanks much,
Annie

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Tuesday, February 18, 2014 5:57 PM
To: Hollis, Annie R. (CMS/CMCS)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Hi Annie,
I spoke with Utah. They are struggling to find a time for the three critical people that need to be on this call, Gayle, Jeff, and Amanda. They have just a few times that currently work.
Tomorrow-Wednesday, 2/19 from 2:00-2:30 Eastern
Friday, 2/21 from 2-2:30 Eastern
Monday, 2/24 from 11:30-12 or 12-12:30 Eastern

Do any of these times work for you? I am out of the office tomorrow and Friday at those times so I will not be able to make them, but I am fine with you meeting with the state without me since everyone is so busy and time is critical at this point.

Let me know.
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Hollis, Annie R. (CMS/CMCS)
Sent: Tuesday, February 18, 2014 9:39 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Thank you for following up! Let me know if/when you hear. Today is day 46 for UT, just FYI.

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, February 13, 2014 4:20 PM
To: Hollis, Annie R. (CMS/CMCS)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Hi Annie,
I just wanted to follow-up with you. I have left Gayle Six in Utah two voicemails regarding scheduling a call to discuss your comments. I still haven't heard back from her, but will let you know as soon as I do. When I do get her on the phone, I will make sure to get some times so we can move this call forward.

I also have alerted her to the fact that we are trying to get all MAGI SPAs approved by end of March. I know she has a lot on her plate, but hopefully things will start moving soon on this SPA.
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Hollis, Annie R. (CMS/CMCS)
Sent: Monday, February 10, 2014 7:45 AM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Kress, Marielle J. (CMS/CMCS)
Subject: RE: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

Hi Mandy,

Have you heard back from the state about a call to discuss this SPA?

Thanks,
Annie

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, January 30, 2014 5:14 PM

To: Gayle M. Six (gaylesix@utah.gov)
Cc: Jeff Nelson (jeffnelson@utah.gov); Craig Devashrayee (cdevashrayee@utah.gov); Michelle Smith (michellesmith@utah.gov); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments

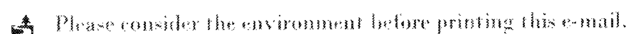
Hi Gayle,
Attached are CMS' comments to Utah's MAGI PE Hospital SPA. In addition to the comments attached, I have one more related to the 179 that Craig and I had discussed. The 179 shows $0 fiscal impact, but also needs to reference that the fiscal impact is included with 14-0001-MM SPA.

Once you have had a chance to look over the attached comments, CMS would like to schedule a call to discuss. Let me know what your availability is over the next couple of weeks and I will work to try to get something scheduled.

Let me know if you have questions.
Mandy

P.S. I have unlocked the SPA in MMDL.

Mandy Strom| Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | : (443) 380-6091| Mandy.Strom@cms.hhs.gov



Strom, Mandy L. (CMS/CMCHO)

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, January 30, 2014 3:14 PM
To: Gayle M. Six (gaylesix@utah.gov)
Cc: Jeff Nelson (jeffnelson@utah.gov); 'Craig Devashrayee (cdevashrayee@utah.gov)'; Michelle Smith (michellesmith@utah.gov); Kress, Marielle J. (CMS/CMCS); Hollis, Annie R. (CMS/CMCS)
Subject: UT 14-0007-MM PE Hospital SPA=CMS Informal Comments
Attachments: Comments-to-UT 1-30-14.pdf

Hi Gayle,
Attached are CMS' comments to Utah's MAGI PE Hospital SPA. In addition to the comments attached, I have one more related to the 179 that Craig and I had discussed. The 179 shows $0 fiscal impact, but also needs to reference that the fiscal impact is included with 14-0001-MM SPA.

Once you have had a chance to look over the attached comments, CMS would like to schedule a call to discuss. Let me know what your availability is over the next couple of weeks and I will work to try to get something scheduled.

Let me know if you have questions.
Mandy

P.S. I have unlocked the SPA in MMDL.

Mandy Strom | Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | ℻: (443) 380-6091 | ✉: Mandy.Strom@cms.hhs.gov

Please consider the environment before printing this e-mail.

Utah State Plan Amendment (SPA) S21 – Hospital Presumptive Eligibility
CMS Comments for SPA Submission

The Centers for Medicare & Medicaid Services (CMS) is reviewing State plan amendment (SPA) S21 submitted by the Utah Department of Health. This SPA proposes to enact changes related to hospital presumptive eligibility (HPE).

Thank you for the opportunity to review this SPA. In this document, CMS provides comments for this SPA for the State's consideration and to facilitate future discussion. Please note that we may have further questions, pending the State's responses. We are available to discuss these at the State's request.

General Questions

1. Please provide a copy of the single streamlined application with the required fields noted that the state will use to determine HPE.
2. Please provide a copy of the application cover sheet that identifies the necessary fields for HPE, as referenced in the training materials.

Page 2 of 3

3. The state has indicated that it is establishing standards for qualified hospitals making eligibility determinations.
   a. The state has written that it will require hospitals to assist applicants in completing a full Medicaid application and the hospital will submit these applications to the Department of Workforce Services for 100% of the individuals completing an application for a presumptive eligibility decision.
      i. Please note that a full Medicaid application cannot be a requirement of an HPE determination.
      ii. Please describe how the state arrived at the 100% standard.
   b. The state has written that it will require that the hospital will maintain an 85% accuracy rate for its presumptive eligibility determinations. Does the state plan to review every HPE determination made for accuracy?
   c. The state has selected that it will require a standard of 65% of individuals who are determined presumptively eligible are determined eligible for full Medicaid. Please briefly describe how the state selected this 65% standard.
   d. Please provide a description of how the state will retrain hospitals and institute corrective action for underperforming hospitals.

Attachment: HPE Training Manual

4. There are additional immigration statuses that are considered eligible immigration statuses for purposes of Medicaid eligibility. It may help hospitals to provide this list and say that the individual must be a "U.S. Citizen or have eligible immigration status". The list can be found here: https://www.healthcare.gov/immigration-status-and-the-marketplace/.
5. On page 9, please either include the five percent disregard for each of the eligibility levels, or direct the hospitals to subtract five percent from each individual's FPL found from their gross income.

6. On page 13, it may make sense to include the questions that ascertain which group the individual may be eligible for. For example, the state should include a question on whether the individual was in foster care at age 18, or whether they are a parent or caretaker relative with a dependent child under age 19.

7. On page 15, the training materials state that "DWS will issue the HPE card for the current month and determine eligibility for ongoing Medicaid. DWS will send the approval/denial notice and card."

    a. Please note that a full Medicaid application cannot be a requirement of an HPE determination.

        i. Please describe the state's process to ensure an opt-out mechanism for individuals who cannot or do not want to file a full Medicaid application.

        ii. If only the sections necessary for HPE are completed and the information is transmitted to DWS, will this result in a denial for full Medicaid based on a submission of incomplete information? This could have the unintended consequence of ending an HPE period earlier than the period that the individual is entitled to, regardless of whether or not the individual files a full Medicaid application.

    b. Please add information clarifying the HPE coverage in the event that an individual does not complete a full Medicaid application. If a full Medicaid application is not filed by the last day of the month following the month in which HPE eligibility was determined, then HPE coverage ends on the last day of the month following the month in which HPE eligibility was determined.

Attachment: HPE Training Powerpoint

8. On slide 12, please clarify that for pregnant women, only ambulatory prenatal care is covered during an HPE period.

Strom, Mandy L. (CMS/CMCHO)

From: Kress, Marielle J. (CMS/CMCS)
Sent: Thursday, January 30, 2014 3:04 PM
To: Strom, Mandy L. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: Re: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Perfect, thank you very much!

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Thursday, January 30, 2014 05:00 PM
To: Kress, Marielle J. (CMS/CMCS)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Hi Marielle,
I do not have any additional questions except for the fiscal impact modification to the 179 that I mentioned in my earlier email. I will go ahead and get the questions sent to the State and work to get a call set up.
Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

From: Kress, Marielle J. (CMS/CMCS)
Sent: Thursday, January 30, 2014 12:28 PM
To: Strom, Mandy L. (CMS/CMCHO)
Cc: Hollis, Annie R. (CMS/CMCS)
Subject: RE: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Hi Mandy,

Attached please find our review of Utah's S21 SPA and questions and comments for the state. Let us know if you have anything to add/any questions.

We would like to discuss with the state, so could you work on getting a call on the calendar? Let us know if you need us to provide specific times or would want to reach out to get the state's availability first.

Many thanks,
Marielle

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, January 27, 2014 4:05 PM
To: Kress, Marielle J. (CMS/CMCS)
Subject: RE: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Hi Marielle,

I just wanted to follow-up with you on Utah 14-0007-MM PE SPA. Have you had a chance to review it? I have looked over the template and training materials and it looked pretty good to me, but I am also not a PE expert. The one comment I did have is below:

- Utah needs to add a note as to why fiscal impact is $0 and reference 14-0001-MM. The State could not break out its fiscal impact for all the different MAGI SPAs so they plan to include the full impact in 14-0001-MM and just put $0 for the others and reference back to 0001.

Thanks,
Mandy

Mandy Strom
(303) 844-7068
Mandy.Strom@cms.hhs.gov

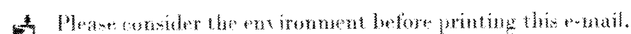
From: Corddry, Mary C. (CMS/CMCS)
Sent: Monday, January 06, 2014 2:39 PM
To: Strom, Mandy L. (CMS/CMCHO); Clemens, Ann C. (CMS/CMCHO); Kress, Marielle J. (CMS/CMCS)
Cc: Turner, Trudy J. (CMS/WC)
Subject: RE: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Thanks, I'm not reviewing it. Marielle is.
Mary

From: Strom, Mandy L. (CMS/CMCHO)
Sent: Monday, January 06, 2014 4:35 PM
To: Corddry, Mary C. (CMS/CMCS); Clemens, Ann C. (CMS/CMCHO)
Cc: Turner, Trudy J. (CMS/WC)
Subject: Utah submitted PE Hospital SPA 14-0007-MM in MMDL

Hi Ladies,
I am not sure if you both will be reviewing the S21 template, but wanted to let you know that Utah submitted it last Friday in MMDL.

Mandy Strom| Division of Medicaid and Children's Health Operations | Denver Regional Office | Centers for Medicare & Medicaid Services | 1600 Broadway, Suite 700, Denver, CO 80202 | ☎: (303) 844-7068 | : (443) 380-6091| : Mandy.Strom@cms.hhs.gov



Strom, Mandy L. (CMS/CMCHO)

From: mmdl.support@truvenhealth.com
Sent: Friday, January 03, 2014 8:58 AM
To: Cash, Judith (CMS/CMCS); Bodon, Maritza (CMS/CMCS); Strom, Mandy L. (CMS/CMCHO); Riddle, Cynthia A. (CMS/CMCHO); Turner, Trudy J. (CMS/WC); formssupport@truvenhealth.com; Washington, Barbara A. (CMS/CMCS); maraizu.onyenaka@truvenhealth.com; Billy, Indy A. (CMS/CMCS); Volesky, Curtis (CMS/CMCHO); Adams, Janice M. (CMS/WC); Gaskins, Sheri P. (CMS/CMCS); CMS SPA_Waivers_Denver_R08; Jensen, Laurie (CMS/CMCHO); Kayani, Siani S. (CMS/CMCS); marjorie.hatzmann@truvenhealth.com
Subject: {MAC} Submission {UT.0725.00.00}: Submitted

{MAC} Submission {UT.0725.00.00}: Submitted on {01/03/2014 10:53:00}.

Medicaid State Plan Eligibility

Medicaid State Plan Eligibility: General Information

State/Territory name: **Utah**

Transmittal Number: **UT-14-0007**

General Information:

Submission Title:

short (under 100 characters) label used to identify this submission in the web application

14-0007-MM

Description:

Presumptive Eligibility by Hospitals - S21

Populations Covered:

Mandatory Coverage:

- **Parents and Other Caretaker Relatives**
- **Pregnant Women**
- **Infants and Children under Age 19**
- **Adult Group**
- **Former Foster Care Children**

Options for Coverage:

- **Individuals above 133% FPL**
- **Optional Coverage of Parents and Other Caretaker Relatives**
- **Reasonable Classification of Individuals under Age 21**
- **Children with Non IV-E Adoption Assistance**
- **Optional Targeted Low Income Children**
- **Individuals with Tuberculosis**
- **Independent Foster Care Adolescents**
- **Individuals Eligible for Family Planning Services**

Medicaid State Plan Eligibility: File Management Summary

State/Territory name: **Utah**

Transmittal Number: **UT-14-0007**

Type of SPA	Form Code	Form Name/Description	Uploaded?
MAGI-Based Eligibility Groups	S14	AFDC Income Standard	no
MAGI-Based Eligibility Groups	S25	Mandatory: Parents and Other Caretakers	no
MAGI-Based Eligibility Groups	S28	Mandatory: Pregnant Women	no
MAGI-Based Eligibility Groups	S30	Mandatory: Infants and Children Under Age 19	no

Type of SPA	Form Code	Form Name/Description	Uploaded?
MAGI-Based Eligibility Groups	S32	Mandatory: Individuals Below 133% of the FPL	no
MAGI-Based Eligibility Groups	S33	Mandatory: Former Foster Care Children up to age 26	no
MAGI-Based Eligibility Groups	S50	Optional: Individuals Above 133% of the FPL	no
MAGI-Based Eligibility Groups	S51	Optional: Optional Parents and Caretakers	no
MAGI-Based Eligibility Groups	S52	Optional: Reasonable Classifications of Individuals	no
MAGI-Based Eligibility Groups	S53	Optional: Non IV-E Adoption Assistance	no
MAGI-Based Eligibility Groups	S54	Optional: Optional Targeted Low Income Children	no
MAGI-Based Eligibility Groups	S55	Optional: Tuberculosis	no
MAGI-Based Eligibility Groups	S57	Optional: Foster Care Adolescents - Chafee	no
MAGI-Based Eligibility Groups	S59	Optional: Family Planning	no
Eligibility Process	S94	Single streamlined application or alternative, Renewals, Coordination for enrollment and eligibility (agreements with Exchanges)	no
MAGI Income Methodology	S10	Designates the income options the state is electing in 2014 (e.g. how pregnant women are counted, reasonably predictable changes in income, cash support, how full-time students are counted)	no
Single State Agency	A1-3	Addresses single state agencies delegation of appeals and determinations	no
Residency	S88	State affirms residency regulations and addresses interstate agreements and temporary absence	no
Citizenship & Immigration Status	S89	State affirms citizenship regulations, specifies reasonable opportunity options, and specifies policy options related to immigrant eligibility	no
Hospital Presumptive Eligibility	S21	State specifies options for presumptive eligibility conducted by hospitals	yes

Medicaid State Plan Eligibility: File Management Detail

Form S14: AFDC Income Standards

Form Description:

Uploaded Form:

Support Documents

Document

Form S25: Eligibility Groups - Mandatory Coverage: Parents and Other Caretaker Relatives

Form Description:

Uploaded Form:

Support Documents

Document

Form S28: Eligibility Groups - Mandatory Coverage: Pregnant Women

Form Description:

Uploaded Form:

Support Documents

Document

Form S30: Eligibility Groups - Mandatory Coverage: Infants and Children under Age 19

Form Description:

Uploaded Form:

Support Documents

Document

Form S32: Eligibility Groups - Mandatory Coverage: Adult Group

Form Description:

Uploaded Form:

Support Documents

Document

Form S33: Eligibility Groups - Mandatory Coverage: Former Foster Care Children

Form Description:

Uploaded Form:

Support Documents

Document

Form S50: Eligibility Groups - Options for Coverage: Individuals above 133% FPL

Form Description:

Uploaded Form:

Support Documents

Document

Form S51: Eligibility Groups - Options for Coverage: Optional Coverage of Parents and Other Caretaker Relatives

Form Description:

Uploaded Form:

Support Documents

Document

Form S52: Eligibility Groups - Options for Coverage: Reasonable Classification of Individuals under Age 21

Form Description:

Uploaded Form:

Support Documents

Document

Form S53: Eligibility Groups - Options for Coverage: Children with Non IV-E Adoption Assistance

Form Description:

Uploaded Form:

Support Documents

Document

Form S54: Eligibility Groups - Options for Coverage: Optional Targeted Low Income Children

Form Description:

Uploaded Form:

Support Documents

Document

Form S55: Eligibility Groups - Options for Coverage: Individuals with Tuberculosis

Form Description:

Uploaded Form:

Support Documents

Document

Form S57: Eligibility Groups - Options for Coverage: Independent Foster Care Adolescents

Form Description:

Uploaded Form:

Support Documents

Document

Form S59: Eligibility Groups - Options for Coverage: Individuals Eligible for Family Planning Services

Form Description:

Uploaded Form:

Support Documents

Document

Form S94: General Eligibility Requirements: Eligibility Process

Form Description:

Uploaded Form:

Support Documents

Document

Form S10: MAGI-Based Income Methodologies

Form Description:

Uploaded Form:

Support Documents

Document

Form A1-3: Medicaid Administration: Single State Agency

Form Description:

Uploaded Form:

Support Documents

Document

Form S88: Non-Financial Eligibility: State Residency

Form Description:

Uploaded Form:

Support Documents

Document

Form S89: Non-Financial Eligibility: Citizenship and Non-Citizen Eligibility

Form Description:

Uploaded Form:

Support Documents

Document

Form S21: Presumptive Eligibility by Hospitals

Form Description: Presumptive Eligibility by Hospitals

Uploaded Form: S21-hospital presumptive.pdf

Support Documents

Document
Please provide a short description of this support document: Hospital Presumptive Eligibility Application **Uploaded Document Name:** HPE App with CMS' Feedback.pdf
Please provide a short description of this support document: Hospital Presumptive Eligibility Training Powerpoint **Uploaded Document Name:** HPE Powerpoint updated based on CMS' feedback.pdf
Please provide a short description of this support document: Hospital Presumptive Eligibility Training Manual **Uploaded Document Name:** HPE TRAINING MANUAL updated per CMS feedback.pdf

Medicaid State Plan Eligibility: Tribal Input

State/Territory name: Utah

Transmittal Number: UT-14-0007

One or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State.

This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.

The State has solicited advice from Indian Health Programs, Urban Indian Organizations, and/or Tribal governments prior to submission of this State Plan Amendment.

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner. *States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:*

Indian Tribes

Indian Tribes
Name of Indian Tribe: Goshute Indian Tribe Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Tribe: Navajo Indian Tribe

Indian Tribes
Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Tribe: Paiute Indian Tribe Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Tribe: Shoshone Indian Tribe Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Tribe: Ute Indian Tribe Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.

Indian Health Programs

Indian Health Programs
Name of Indian Health Programs: Fort Duchesne Health Center Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Health Programs: Navajo Area Indian Health Service Date of consultation: 07/16/2013 (mm/dd/yyyy) Method/Location of consultation: Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.
Name of Indian Health Programs: Utah Navajo Indian Health Systems, Inc.

Indian Health Programs
Date of consultation:
07/16/2013 (mm/dd/yyyy)
Method/Location of consultation:
Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.

☑ **Urban Indian Organization**

Urban Indian Organizations
Name of Urban Indian Organization:
Urban Indian Center of Salt Lake
Date of consultation:
07/16/2013 (mm/dd/yyyy)
Method/Location of consultation:
Meeting at the Utah Department of Health (Highland Drive Bldg., SLC, UT). Bridge line was available to access meeting by phone.

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Document
Please provide a short description of this support document: Agenda for ACA Implementation Meeting
Uploaded Document Name:
Agenda for ACA Implementation Meeting.pdf

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: **Utah**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

UT-14-0007

Proposed Effective Date

01/01/2014 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Pub. L. No. 111-148

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Presumptive Eligibility by Hospitals - The fiscal impact for this SPA is included in the fiscal impact entered for the MAGI eligibility group SPA 14-0001-MM.

Governor's Office Review

- **Governor's office reported no comment**
- **Comments of Governor's office received**
  Describe:

- **No reply received within 45 days of submittal**
- **Other, as specified**
  Describe:

Signature of State Agency Official

Submitted By:	**Craig Devashrayee**
Last Revision Date:	**Apr 1, 2014**
Submit Date:	**Jan 3, 2014**