DMHF SPA Matrix 4-21-22

SPA Summary	Public Notice Date	Proposed Effective Date	Target Date or Date Submitted to CMS	CMS Approval Date	CMS Approved Effective Date	MCAC Present Date
22-0001-UT FQHC and RHC Updates; This amendment includes provisions of reimbursement for single-day patient encounters in federally qualified health centers and rural health clinics. It also updates and clarifies prospective payment and alternative payment methodologies.	**12-19-21**	**1-1-22**	**3-31-22**	**Pending**	**Pending**	**4-21-22**
22-0002-UT Qualifying Clinical Trials; In accordance with federal law, this amendment assures and implements mandatory coverage of routine patient costs for services in connection with participation in qualifying clinical trials.	**N/A**	**1-1-22**	**3-31-22**	**Pending**	**Pending**	**4-21-22**

OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

a. ~~Beginning February 3, 2004,~~ FQHCs located in Utah that serve Utah Medicaid clients

FQHCs may elect to be paid under one of two payment methods~~ -~~ the Prospective Payment Method (PPS) or the Alternative Payment Method (APM). Each FQHC must elect its payment methodology preference and give notice to the ~~Division of Health Care Financing (DHCF) on or before January 1, 2004, to be effective February 3, 2004.~~Medicaid agency. If an FQHC elects to change payment methods ~~in subsequent years~~, an election to do so must be made no later than thirty (30) calendar days prior to the beginning of the FQHC's fiscal year by written notice to ~~(DHCF).~~the Department.

~~a~~ FQHCs are reimbursed for one encounter per day per patient. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the same day constitute a single encounter.

i. Prospective Payment System (PPS).

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

~~PPS~~

The FQHC rates set for each ~~FQHC are determined on the basis of their 1999 and 2000 fiscal years' reasonable costs, adjusted for any subsequent change in scope of services (See Section A.9.c). The average of the two-year costs are divided by the average number of visits (physician services as defined by the State Plan, Attachment 3.1-A, Attachment #5) for the same two-year period. The resulting~~ provider are effective January 1, 2021. The prospective ~~rate is~~rates are increased ~~on January 1 of~~ each ~~subsequent year~~April 1 by the applicable Medicare Economic Index for primary care services and are effective for services on or after that date. Payment will be based on the established PPS rates.

1. ~~2. Regarding~~For FQHCs which contract with ~~Managed~~Managed Care ~~Organizations (MCOs), supplemental payments~~ Entities (MCEs):
   a. Supplemental payment amounts will be estimated and paid quarterly ~~to the FQHCs for the~~ to the FQHCs for the difference between amounts paid by the ~~MCOs~~MCEs and amounts the FQHCs are entitled to under the PPS.
      i. ~~to under the PPS.~~ Quarterly interim payments will be made ~~no later than~~ approximately thirty (30) days after the end of the quarter.
      ii. The quarterly amount may be less than the calculated amount if requested by the FQHC.

b. Annual reconciliations to ensure FQHCs are paid up to the PPS rate will be made and settled.

~~3. Mental Health (MH) services require FQHCs to contract with local MH providers that~~ b. ~~are paid a capitation rate by DHCF.~~ If Medicaid over-paid, pay-back to ~~avoid duplicate payments. FQHC MH charges are billed to MH providers which reimburse FQHCs on the basis of the MH provider fee schedule. The difference between FQHC MH cost and MH provider payments are reimbursed by DHCF as noted in section A.9.d~~the State of the settlement amount is required from the FQHC. If under-paid, a payment for the settlement amount will be made to the FQHC.

c. ~~4. The PPS rate for newly qualified FQHCs in 2001 and later~~Only claims where Medicaid is the primary payer will be ~~established by reference to PPS rates of other FQHCs in the same or adjacent areas with similar caseload, or by~~ considered in cost ~~reporting methods~~settlements.

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2. The PPS cost settlement reports MCE patient claim records in summary and in detail.
   a. Summary Cost Settlement Payment Report – This report presents the total amount due to or from the FQHC. There are two parts to this calculation. First, a calculation of the difference between the total amount that would have been paid under PPS principles and the total actual payment amount. Second, the sum of the quarterly interim payments made to the provider is then subtracted from the amount from step one. The difference is the settlement amount.
   b. Claim Detail Cost Settlement Report – This report contains medical and dental managed care claim detail and is the source for the summary report described in section (a) above.
   c. Only claims where Medicaid is the primary payer will be considered in cost settlements.

3. PPS Rate Establishment for new FQHCs

The PPS rate for newly qualified FQHCs will be established by referencing PPS rates of other FQHCs in the same or adjacent areas with similar caseload, or by cost reporting methods and as otherwise negotiated with the new FQHC.

4. Scope of Service Changes

Scope of service changes must be substantiated by adequate documentation. FQHCs electing the PPS method must submit documentation with an estimate of the cost of the change in scope of service to receive consideration for an adjustment to the FQHC's PPS rate. Once approved, the modified PPS rate will be effective for the subsequent fiscal period.

5. Rebasing

Periodic rebasing of the PPS rates may be appropriate to maintain consistency with the rates covering the FQHC costs. The state may, therefore, elect to rebase FQHCs rates when appropriate. FQHCs must, as requested by the Department, submit cost and patient visit documentation covering the specified period. Once approved, the modified PPS rate will be effective for the subsequent fiscal period.

6. Mental Health Services

Mental Health Services provided by FQHCs should be billed directly to Medicaid on a fee for service basis and will be paid the PPS rate. Therefore, mental health service claims will not be included in any settlements.

Commented [JC1]: What about UMIC? Is this carved out and billed FFS.

Commented [JC2R1]: It is carved out of UMIC too.

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

1. The Alternative Payment Methodology Cost Settlement (APM) – This cost settlement uses two different methodologies.

   a. The first method is the Alternative Payment Methodology (APM). FQHCs participating in the APM shall provide the Department with annual cost reports and audited financial statements required by the Department within twelve months of the close of their fiscal year period. The Department will conduct a review of submitted cost reports and perform a cost settlement.

A provider's costs and charges are compared to the provider's Medicaid charges to come up with a Medicaid charge percentage. The Medicaid charge percentage is then multiplied by the provider's total allowable costs to come up with the provider's Medicaid allowable costs. The difference between the provider's Medicaid allowable cost and total Medicaid payments, including all quarterly interim payments, is the APM cost settlement amount.

The amounts billed for services cannot exceed the usual and customary charge to private pay patients.

b. The second method is the Prospective Payment System (PPS). This reports the Inpatient Medicaid amount (Inpatient Medicaid claims multiplied by the Medicaid rate for each CPT code) and the Outpatient PPS payment. The Outpatient PPS payment is calculated by multiplying the provider's established PPS rate by the number of outpatient encounters that qualify for the PPS rate.

Total Medicaid payments is subtracted from the sum of the Inpatient Medicaid amount and the outpatient PPS payment to arrive at the settlement amount under the PPS payment methodology.

c. The settlement amount under the APM settlement methodology is compared to the settlement amount under the PPS settlement methodology. The most advantageous settlement amount for the provider is used as the final settlement. If Medicaid over-paid, pay-back to the State of the settlement amount is required from the FQHC. If under-paid, a payment for the settlement amount will be made to the FQHC.

d. Only claims where Medicaid is the primary payer will be considered in cost settlements.

2. A tribal health program selecting to enroll as a FQHC and agreeing to an alternate payment methodology (APM) will be paid using the APM, which is the all-inclusive rate (AIR).

Utah Medicaid will establish a Prospective Payment System (PPS) methodology for Tribal FQHCs. The PPS rate shall be the average rate of other FQHCs in the state. Annually, Utah Medicaid will compare the APM rate to the PPS rates to ensure the APM is equal to or greater than the PPS rate. A Tribal FQHC is not required to report its costs for the purposes of establishing a PPS rate.

b. FQHCs located outside of Utah that serve Utah Medicaid clients

i. FQHCs located out-of-state that serve Utah Medicaid clients will be paid the reimbursement rate applicable to the state in which services are provided.

b. Alternative Payment Method (APM)–Ratio of Covered Beneficiary Charges to Total Charges Applied to Allowable Cost (RCCAC)

(1) Beginning February 3, 2004, an alternative payment method (APM) is adopted and available for election. Under RCCAC, allowable costs are determined using applicable Medicare cost principles, as addressed in 42 CFR and CMS Publication 15-1, and allowable costs are allocated to Medicaid using the percentage of Medicaid covered billed charges to total charges for all patients. Total allowable costs are multiplied by the Medicaid charge percentage to determine the amount of allowable cost to be paid by Medicaid. Interim payments will be made on the basis of billed charges and valid claims processed and paid by Medicaid will reduce the final settlements. Third party liability (TPL) collections for Medicaid patients will also be considered as claim reimbursements in completing cost settlements.

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

(3) The alternative payment method described herein will be compared with the reimbursements calculated using the PPS methodology described in A.9.a. The greater amount will be paid to the FQHCs.

T.N. # 12-006

ii. These FQHCs shall annually provide the PPS rate applicable to the FQHC to the Utah Medicaid agency's FQHC lead.

Approval Date 8-30-12

Supersedes T.N. # 05-005 Effective Date 7-1-12

A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

9. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) (Continued)

1. c. Scope of Service Changes

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

d. Managed Care Organization and Mental Health Settlements

For FQHCs servicing Medicaid clients of Managed Care Organizations (MCOs) and capitated MH organizations, the difference between FQHC costs minus MCO, MH and TPL reimbursement will be determined annually and settled. The determination of cost will be on the basis of the RCCAC as noted in Section A.9.b. Quarterly estimated payments will be made to FQHCs on the basis of the most recent prior year annual reconciliation.

10. RURAL HEALTH CLINICS (RHCs)

a. a. ProspectiveRHCs subject to same provisions as FQHCs

Except for the Alternative Payment System (PPS)

(1) Payment for Rural Health Clinic services conforms to Methodology section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. All Rural Health Clinics are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect, which is not applicable to services furnished on or after January 1, 2001, and each succeeding year.

(2) Payment rates will be set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000, adjustedRHCs, all FQHC state plan requirements (section 9) apply also to take into account any increase or decrease in the scope of services furnished during the clinic's fiscal year 2001. These costs are divided by the average number of visits for the two year period to arrive at a cost per visit. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and

adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that fiscal year. The clinic must supply documentation to justify scope of service adjustmentsRHCs.

T.N. # 22-0001 Approval Date

Supersedes T.N. # 05-005 Approval Date 1-18-06

Supersedes T.N. # 04-003 Effective Date 1-1-05

42 CFR
Attachment 4.19-B
440.90
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A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

10. RURAL HEALTH CLINICS (RHCs) (Continued)

a. Prospective Payment System (PPS) (Continued)

(3) For newly qualified RHCs after State fiscal year 2000, initial payments are

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

(4) Until a prospective payment methodology is established, the state will reimburse RHCs based on the State Plan in effect on December 31, 2000. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

b. Managed Care Organization Settlements

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

c. Out-of-State Providers

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

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Provided: X

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State/Territory: _____

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Provided: X

II. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

INPATIENT HOSPITAL SERVICES

DEFINITION

Inpatient Hospital Services means services provided in a hospital licensed by the Utah Department of Health. General services are defined under Subsection 26-21-2(11) of the Utah Code and in the Utah Administrative Code under *Rule R432-100 General Hospital Standards*. Specialty services are defined under Subsection 26-21-2(21) of the Utah Code and in the Utah Administrative Code under *Rules R432-103 Specialty Hospital - Rehabilitation* and *R414-515 Long Term Acute Care*.

LIMITATIONS

1. *The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.*

2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.

3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.

4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.

5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services. This policy does not apply to members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the Consolidated Appropriations Act of 2021.

6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval. A list will be maintained in the Medicaid Inpatient Hospital Provider Manual.

9. Except for item 7 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. that the proposed services are medically appropriate; and
   b. that the proposed services are more cost effective than alternative services.

OUTPATIENT HOSPITAL SERVICES

DEFINITION

Outpatient Hospital means a facility that is in, or physically connected to, a hospital licensed by the Utah Department of Health as a hospital - general, as defined by Utah Code Annotated, Section 26-21-2(8), 1990, as amended; and by Utah Administrative Code, R432-100-1 and 432-100.101, 1992, as amended.

LIMITATIONS

1. Procedures determined to be cosmetic, experimental, or of unproven medical value, are not a benefit of the program. This policy does not apply to members participating in qualifyiing clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the Consolidated Appropriations Act of 2021.

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FAMILY PLANNING SERVICES AND SUPPLIES

DEFINITION

Family planning services means diagnostic, treatment, drugs, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. Family planning services are provided by or under the supervision of a physician for individuals of childbearing age, including minors who are sexually active.

LIMITATIONS

The following services are excluded from coverage as family planning services:

1. Experimental or unproven medical procedures, practices, or medication. This policy does not apply to members participating in qualifying clinical trials for the prevention, detection, or treatment of any life-threatening disease or condition as outlined in Section 210 of the Consolidated Appropriations Act of 2021.

2. Surgical procedures for the reversal of previous elective sterilization, both male and female.

3. In-vitro fertilization.

4. Artificial insemination.

5. Surrogate motherhood, including all services, tests, and related charges.

6. Abortion services, except as covered under ATTACHMENT 3.1-a, (Attachment #5a).

7. Except for item 6 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and
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PHYSICIAN SERVICES

LIMITATIONS

1. Supervision by a Physician - Physician services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by a non-physician practitioner licensed to serve the health care needs of a practice population within their scope of practice.

2. Abortion services may only be covered in accordance with ATTACHMENT 3.1-A, (Attachment #5a).

3. Admission to a general hospital for psychiatric care by a physician is limited to those cases determined by established criteria and utilization review standards to be of a severity and intensity that appropriate service cannot be provided in any alternative setting.

4. Inpatient hospital care for the treatment of alcoholism, drug dependency or both will be limited to acute care for detoxification only.

5. Services not actually furnished to a client because the client failed to keep a scheduled appointment will not be covered by Medicaid.

6. Procedures determined to be cosmetic, experimental, or of unproven medical value are non-covered services. This policy does not apply to members participating in qualifying clinical trials for the prevention, detection, or treatment of any serious or life-threatening disease or condition as outlined in Section 210 of the Consolidated Appropriations Act of 2021.

7. Organ transplant services will be limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

8. Physicians may bill for pain management services using the appropriate evaluation and management codes.

   a. A physician may complete a consultation and provide a treatment plan to the primary care provider or continue as the patient's pain management physician.

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1. *The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.*

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