STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

PROFESSIONAL MEDICAL PERSONNEL AND SUPPORTING STAFF USED IN THE ADMINISTRATION OF THE PROGRAM AND THEIR RESPONSIBILITIES

Attached is a description of the kinds and number of the medical assistance program staff and of their responsibilities.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _______________ UTAH _______________

DIRECTOR'S OFFICE

The Division Director is responsible to the Executive Director of the Utah Department of Health.

FUNCTIONS

The Director's Office administers, coordinates and delegates program responsibilities to develop Utah's Medicaid and SCHIP programs in compliance with Title XIX and Title XXI of the Social Security Act, the laws of the state of Utah, and the appropriated budget. This is accomplished by planning, managing and evaluating activities that authorize payments for approved services to qualified providers, who submit claims for appropriate and necessary medical assistance rendered to Medicaid eligible beneficiaries.

MAJOR RESPONSIBILITIES

1. Develop, promulgate and ensure the implementation of plans, policies and procedures consistent with Title XIX of the Social Security Act, the laws of the state of Utah, and appropriated budgets.

2. Direct the development of long range plans for policy development and cost containment strategies.

3. Delegate, supervise, coordinate, and evaluate bureau director activities and Director's Office staff.

4. Coordinate and oversee the negotiation of all contracts for services.

5. Maintain a liaison with provider and consumer organizations external to the Medicaid and SCHIP programs.

6. Staff and utilize the Medical Care Advisory Committee for input and advice regarding current and proposed Medicaid policies.

7. Maintain liaison and coordinate activities with other government agencies that impact the Medicaid and SCHIP programs.

8. Maintain liaison and communications with the Legislature, government officials and community leaders.

T.N. # __________ 07-008 Approval Date 9-6-07

Supersedes T.N. # 14-88 Effective Date 4-1-07
FORMAL HEARING UNIT

The Formal Hearing Unit is authorized and mandated by Section 1902(a)(3) of the Social Security Act and 42 CFR 431.200, which require that a State Plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon with reasonable promptness. The Formal Hearing Unit is also authorized under the Medical Assistance Act found in Utah Code Title 26, Chapter 18. The Medical Assistance Act mandates hearings that include the following issues: (1) financial eligibility that includes income, assets, and disability; (2) safeguarding against unnecessary or inappropriate hospital admissions or lengths of stay; (3) denying provider service claims that fail to meet medically necessary criteria; (4) prepayment and postpayment review systems to determine if utilization is reasonable or necessary; (5) preadmission certification of nonemergency admissions; (6) long term care physical and mental health certifications; and (7) alleged patient abuse in Medicare and Medicaid certified nursing facilities.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _______________ UTAH _______________

DIRECTOR'S OFFICE (Continued)

MEDICAL CARE ADVISORY COMMITTEE

The Medical Care Advisory Committee (MCAC) advises the Medicaid agency director on health and medical care services. The committee includes board-certified physicians, health care representatives and other advocacy groups. The agency director appoints members to this committee on a rotating and continuous basis. The committee participates in policy development and program administration to further recipient participation in the Medicaid program. This committee meets monthly to discuss important Medicaid issues and conducts an annual public hearing to discuss the Medicaid fiscal year budget.

DRUG UTILIZATION REVIEW BOARD

The Drug Utilization Review Board (DUR) assesses the proper use of outpatient drugs in the Medicaid program, promotes cost effective drug use, and safeguards against fraud and improper drug utilization. The board is comprised of licensed and actively practicing members in accordance with 42 U.S.C. 1396r-8(g).

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Supersedes T.N. # __ 07-008 Effective Date __ 4-1-17
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ____________________ UTAH ____________________

DIRECTOR'S OFFICE (Continued)

CONSTITUENT SERVICES

Constituent Services are under the direction of the Director's Office within the Division of Health Care Financing (DHCF).

PURPOSE

The purpose of Constituent Services is to have administrative staff investigate and respond to customer concerns and track issues raised by the public, providers and clients.

FUNCTION

Constituent Services respond to written and oral questions related to policy, service coverage, procedures, customer service, provider and client issues, and other Medicaid, PCN and CHIP topics. It also serves as a public information liaison to respond to media calls and to contact appropriate staff when data requests are made.

STAFF OF THE DIRECTOR'S OFFICE INCLUDE:

   Director, Division of Health Care Financing
   Secretary
   Administrative Law Judge and Staff
   (2) Assistant Directors
   Indian Health Liaison
   Constituent Services

42 CFR REFERENCES

430.0, 430.1, 431.11, 431.12

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Supersedes T.N. # __14-88__ Effective Date __4-1-07__
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY

Authority for this program is part of the Medicaid administrative functions specified in Utah Code Title 26, Chapter 18. The Bureau of Coverage and Reimbursement Policy makes recommendations to the Division Director and the Department Director on new Medicaid policy and policy changes.

The bureau maintains the Medicaid State Plan with its additions and changes and is responsible for all rulemaking for the division. The bureau is responsible for federal and state policy interpretation on coverage and reimbursement issues for institutional and non-institutional services, including organ transplantation, pharmacy, medical supplies, medical transportation, dental services, etc.

The bureau participates in administrative hearings to resolve policy disputes with Medicaid clients and providers. The bureau also monitors and manages the utilization of Medicaid’s fee-for-service programs, and performs federally mandated reviews to identify and pursue action in cases of fraud and abuse. This unit handles prior authorizations of services and post-payment analysis of claims.

Through its reimbursement unit, the bureau establishes reimbursement rates for medical services and supplies, including hospitals, nursing homes, physicians, and dentists. It also establishes prospective premium rates for HMOs and mental health centers that contract with the Medicaid and SCHIP programs.

Through the pharmacy program, the bureau sets Medicaid pharmacy policy and provides staff support to the Drug Utilization Review Board.

The bureau also manages the State response to and compliance with the PERM regulations.

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BUREAU OF COVERAGE AND REIMBURSEMENT POLICY (Continued)

REIMBURSEMENT POLICY UNIT

The Reimbursement Policy Unit has two primary responsibilities:

1. Reimbursement Policy.
2. Rate Setting.

The following are reimbursement responsibilities:

1. Analyze, research, develop, make recommendations and plan for the implementation of policy impacting the medical assistance budget.
2. Perform highly technical actuarial type cost analysis and cost projections.
3. Analyze program medical benefits (optional and required); participant utilization factors; participant eligibility groups; medical cost including fees; inflationary factors, federal regulation requirements and other risk factors affecting costs in the health care industry.
4. Prepare and make recommendations regarding rate setting and audit procedures, program reviews, quality control, reimbursement policy with related program policies.
5. Prepare and make professional verbal and visual presentations to division, department and provider groups.
6. Research Medicaid payment issues and prepare responses to providers.

The following are responsibilities of rate setting:

1. Establish a pricing strategy.
2. Develop pricing policies and methodologies.
3. Create a process to systematically review and update prices.
4. Perform other responsibilities directly related to the price setting functions.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY (Continued)

TECHNICAL WRITING UNIT

Responsibilities include:

1. Coordinating, compiling and editing administrative rules and State Plan Amendments for final approval at the division and department levels.

2. Giving timely e-mail notice to bureaus and program personnel requesting drafts of State Plan Amendments that require completion before the end of the quarter.

3. Providing the official State Plan pages to be amended so that program staff work from the existing State Plan Amendment.

4. Editing State Plan Amendments and administrative rules for proper grammar, meaning, punctuation, flow, formatting, and correct transmittal information.

5. Weekly mailing of matrix that includes target dates of completion for administrative rules and State Plan Amendments.

6. Coordinating and sending State Plan Amendments and other corrected changes to the CMS Region VIII office in Denver.

7. Upon department approval, electronically filing administrative rules.

8. Sending a notification letter to the Legislative Executive Appropriations Committee before a State Plan Amendment is approved.

9. Sending a notification letter before the adoption of an administrative rule, if the rule includes a change in services or reimbursement, increases or decreases services or benefits for individuals or families, includes cost-shifting to more expensive services, and affects current or future appropriations from the Legislature.

10. When necessary, conducting public hearings regarding policy and administrative rule changes.

T.N. # 07-008 Approval Date 9-6-07

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11. Providing public notice for any significant proposed change in methods and standards for setting payment rates for services.

12. Maintaining a filing system where State Plan Amendment materials and administrative rule filings are accessible to all Division of Health Care Financing (DHCF) staff.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: SPECIALTY UTAH

BUREAU OF COVERAGE AND REIMBURSEMENT POLICY (Continued)

PROGRAM INTEGRITY UNIT AND UTILIZATION MANAGEMENT UNIT

The Program Integrity and Utilization Management Units within the Bureau of Coverage and Reimbursement Policy provide both a pre-payment and post-payment professional evaluation of services provided to Medicaid applicants and recipients in order to reduce and recover inappropriate payment, to safeguard against unnecessary or inappropriate use of Medicaid services, to comply with MMIS/SURS requirements, to safeguard against excess payments, to assure that services are in compliance with current Medicaid policy and regulations, to assure that services are sufficient in amount, duration and scope to reasonably achieve their purpose, ensure that services requested are medically necessary, and to assess the quality of services.

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Effective Date 4-1-07
BUREAU OF COVERAGE AND REIMBURSEMENT POLICY (Continued)

HEALTH PROGRAM MANAGERS

There are seven program managers; each has different programs. Two have responsibility for the following programs:

- Inpatient Hospital
- Outpatient Hospital
- Physician
- Lab and x-rays

Certified Nurse Anesthetist
Certified Nurse Midwife
Rural Health and Home Health
Local Health Departments

Another program manager has responsibility for the following programs:

- Acquired Immune Deficiency Syndrome
- Speech
- Audiology
- Medical Supplies

Podiatry
Dental
Transportation
Vision

A fourth program manager has responsibility for Program Integrity activities.

The fifth program manager has responsibility for Utilization Control/Medical Necessity determinations.

The sixth program manager is responsible for the PERM program.

A seventh program manager is responsible for the pharmacy program.

The duties for these managers are similar but apply to different programs. The primary focus is to analyze, interpret, research, and formulate policy recommendations for assigned programs using medical training and MMIS system knowledge.

There are several professional activities associated with these primary responsibilities. For example, extensive research and a comprehensive knowledge of federal regulations, state regulations and program operations is essential. During policy development, interaction and coordination with other bureaus and divisions within the Department of Health is also important. In addition to interagency coordination, coordination with regulatory personnel outside the Department of Health, provider representatives and client groups is necessary. Further, knowledge of the budgetary process and the impact of policy on expenditures is essential during the policy formulation phase. Additionally, the ability to monitor reports for problem identification and policy evaluation is a valuable skill. Above all, the most important responsibility is the professional judgement required to make the best possible decisions. Medical professional judgement is essential in five of the program manager positions.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF ELIGIBILITY SERVICES

FUNCTION

To determine eligibility policy for the Medicaid program and oversee the contracts with the Utah Department of Workforce Services and the Utah Department of Human Services for the determination of medical assistance program eligibility.

PROGRAM ELEMENTS

- Ensure State Plan is accurate and up to date on eligibility policy.
- Comply with state rulemaking guidelines.
- Write Medicaid policy used for eligibility determinations.
- Manage contracts with Department of Workforce Services (DWS) and Department of Human Services (DHS) for Medicaid eligibility determinations.
- Monitor DWS contracts and DHS contracts.
- Provide disability determinations.
- Monitor quality of eligibility determinations.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF ELIGIBILITY SERVICES (Continued)

PROGRAM ELEMENTS (Continued)

- Make referrals to other community resources.

RESPONSIBILITIES

- Interpret, analyze and make policy for Medicaid.
- Evaluate and analyze current eligibility policy.
- Prepare waivers regarding eligibility.
- Act as liaison with DWS and DHS concerning Medicaid and PCN eligibility policy.
- Write Medicaid eligibility policy.
- Represent the bureau at Medicaid eligibility-related fair hearings.
- Prepare the state’s annual Medicaid corrective action plan.
- Assist in the preparation of health sponsored Medicaid eligibility state legislation.
- Resolve eligibility complaints.
- Represent the Utah Department of Health with client and professional organizations on matters involving Medicaid eligibility policy.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF FINANCIAL SERVICES

The Bureau of Financial Services represents a consolidation of financial support activities within the Division of Health Care Financing. These activities are accomplished through four units that are responsible for the following functions:

Audit

This unit conducts and coordinates all internal and external audits of Medicaid, Primary Care Network (PCN) and Children's Health Insurance Program (CHIP) service programs and providers. It is responsible for coordination and monitoring of all Third Party Liability (TPL) activities and selective System Performance Reviews (SPR). It also conducts internal and operational audits of the Division of Health Care Financing.

Finance

This unit is responsible for all financial aspects to include appropriation requests, budget and expenditure tracking for medical services and administration. It is also responsible for the monitoring of the Management and Administrative Reporting Subsystem (MARS), purchasing and monitoring of contracts, acquisition of system hardware and software, and collection of pharmacy rebates and nursing home assessments.

Medicaid Quality Control (MEQC)

This unit is federally mandated and responsible for providing data to the Centers for Medicare and Medicaid Services (CMS) regarding the accuracy of Medicaid eligibility determinations for the state of Utah. The federal government currently allows states to do targeted pilot projects to see if eligibility is determined correctly for the various Medicaid programs statewide.

Eligibility Support

This unit has the responsibility to provide the primary support for the Bureau of Eligibility Services in the areas of purchasing, financial network (FINET) and accounting, budget revenue, expenditure tracking and financial reporting, monitoring and facilitating personnel movement, data processing coordination, furniture and equipment inventory control, and managing bureau contracts. This unit also provides support to the Division of Health Care Financing in the areas of statistical (caseloads) reporting, processing Medicaid refund requests and processing manual certificates of coverage.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF FINANCIAL SERVICES (Continued)

AUDIT UNIT

FUNCTION

Coordinate and monitor audit function.

RESPONSIBILITIES

1. Internal reviews (division).
2. Provider audits.
3. Hospital settlements.
4. Internal financial support (division).
5. Third party liability (TPL) monitoring.
7. External audits.
8. Manage contract audit resources.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: UTAH

BUREAU OF FINANCIAL SERVICES (Continued)

FINANCE UNIT

FUNCTION

Manage all financial aspects of the program.

RESPONSIBILITIES

1. Maintain an information base.
2. Federal reporting.
3. MARS - maintenance, development and training.
4. Appropriation request, budget preparation and expenditure tracking for medical services and administration.
5. Annual medical assistance publication.
6. Maintain an accounts receivable accounting system.
7. Coordinate and monitor in-state and out-of-state travel requests.
8. Maintain a collection system.
10. Financial tracking of contracts.
11. MARS balancing and output report distribution.
12. Coordinate and monitor computer hardware and software acquisitions.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF FINANCIAL SERVICES (Continued)

MEDICAID QUALITY CONTROL UNIT (MEQC)

FUNCTIONS

Coordinate and monitor the Claims Processing and Assessment System (CPAS).

Interface quality control with the Department of Human Services (DHS).

RESPONSIBILITIES

1. Coordinate and monitor CPAS, which is the state operated program for assessing the administration of the Medicaid program for accuracy in claims processing and third party liability.

2. To submit summary reports to CMS at the end of each project with a list of findings and recommendations for program improvement. The reports are also submitted to the Department of Health and the Department of Workforce Services.

3. To provide a review of negative actions to assure accuracy in their determination. These are cases that have closed or been denied Medicaid funds. The report is generated annually providing their findings.

42 CFR REFERENCES

431.16, 432.55, 433, Subparts A, B and C.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF FINANCIAL SERVICES (Continued)

ELIGIBILITY SUPPORT UNIT

FUNCTIONS

Provide eligibility support to Medicaid recipients.

RESPONSIBILITIES

1. Purchasing - Order equipment, furniture and supplies for 300+ Bureau of Eligibility Services full-time employees and 70 office and clinic locations statewide.

2. FINET and accounting - Monitor support documentation and approve bureau FINET interagency transfers. Review deposit transmittals and record cash receipts.

3. Financial tracking and reporting - Monitor bureau administrative expenditures and revenues through the FINET data warehouse. Prepare and distribute monthly medical and dental clinic expenditure and revenue reports to management.

4. Personnel actions - Facilitate approval of personnel actions.

5. Data processing coordination - Coordinate bureau data processing needs.

6. Contracts - Manage, write and facilitate bureau contracts.

7. Statistical reporting - Prepare and distribute Medicaid caseload trend reports from Public Assistance Case Management Information System (PACMIS).

8. Medicaid Refund Requests - Process Form 79R Medicaid Refund Requests for payment or denial.

9. Certificates of Coverage - Prepare Medicaid Managed Care System (MMCS) manual certificates of coverage at the request of Medicaid clients.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _______________ UTAH _______________

____________________________________________________________________________________

BUREAU OF MANAGED HEALTH CARE

FUNCTION

The Bureau of Managed Health Care promotes wellness and access to services through effective managed health care and other health care delivery systems. The bureau has a special focus on access to services for Early Periodic Screening Diagnosis and Treatment (EPSDT) eligibles.

MAJOR RESPONSIBILITIES

1. Obtaining federal approval of cost effective managed care systems and negotiating agreement with managed care entities.

2. Educating Medicaid recipients so they make informed choices about the appropriate use of their health care benefit.

3. Linking Medicaid and Primary Care Network (PCN) recipients with primary care providers and other health systems to ensure access to necessary health and health related care services.

4. Providing advocacy for Medicaid, PCN and Children’s Health Insurance Program (CHIP) recipients enrolled in managed care programs and with primary care physicians.

5. Promoting and facilitating access for children to necessary services through the federal EPSDT mandate.

6. Monitoring services delivered through a variety of contracts with managed care entities, public health entities and other public and private entities.

7. Collaborating with public health, human services, education, and private entities to promote wellness among the Medicaid population.

42 CFR REFERENCES

434 Subpart D, Part 438 and 447.362

____________________________________________________________________________________

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ___________________ UTAH ___________________

BUREAU OF HEALTH FACILITY LICENSING, CERTIFICATION AND RESIDENT ASSESSMENT

FUNCTION

The bureau is assigned by the Utah Department of Health to regulate health care facilities and providers in the State of Utah. The bureau is part of the Division of Health Systems Improvement.

MAJOR RESPONSIBILITIES

1. License health care facilities required by state law to hold a license and regularly inspect these facilities for compliance with state laws and regulations.

2. Work with the Health Facilities Committee, whose members are appointed by the governor, to develop and revise state regulations to govern the building, operation, and quality of care in licensed facilities.

3. Review the architectural plans of new building and remodeling projects of licensed providers to assure compliance with building and safety standards.

4. Perform regular on-site inspections of Utah health care providers participating in the Medicare and Medicaid programs to ensure compliance with federal health, treatment and safety standards.

5. See that every Medicaid-funded nursing home and institutional patient in the state meets standards of medical need before admission and throughout their stay.

6. Conduct background screenings on all direct care staff in certain health care industries, as required by law.

7. Investigate complaints from the public about poor care or unsafe conditions in all licensed and certified facilities or providers.

8. Assure facility correction through requiring plans of correction, follow up inspections, use of sanctions, (fines, bans on admissions, closure) and on-site monitoring.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

BUREAU OF MEDICAID OPERATIONS

FUNCTION

This bureau is responsible for processing Medicaid and Crossover claims in accordance with federal regulations and state law and rules. The bureau receives and accounts for claims and related documents; maintains an accurate computer database; adjudicates claims excepted by the computer manually; responds to client and provider inquiries; and trains participating providers in Medicaid policies and procedures. The bureau is responsible for preparing and disseminating provider manuals and Medicaid information bulletins that supply specific Medicaid scope of service benefits and billing instructions for paper and electronic submission of claims.

MAJOR RESPONSIBILITIES

1. Coordination of all operational activities related to the Medicaid program. These activities are carried out through the various units of the bureau. These include the Client and Provider Physician/Dental/Other Provider Types Teams known as the Customer Service Unit, Document Control Unit, Buy Out Program Unit, Data Management Unit, Operations Support and Development Unit, and the functions of the Medicaid Management Information System (MMIS) managers, Information Analyst, and training staff.

2. Provide to the client and provider education of covered services, rate of reimbursement, adjustment process, and prior authorization process.

3. Manage all medical claims, claims research and adjustment, including all functions that relate directly to the recipient, insure that providers are paid accurately and that checks are mailed out properly.

4. Coordinate inter-program operations as they impact Title XIX through the Home and Community Based program, Presumptive Eligibility program, Targeted Case Management, Primary Care Network, Indian Health Services, and Custody Medical Care program.

5. Maintain an accurate and effective data processing system to support the administration and operation of the Medicaid program.

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BUREAU OF MEDICAID OPERATIONS (Continued)

6. Develop and maintain provider manuals and Medicaid information bulletins.

7. Establish a positive working relationship with all Medicaid and Crossover providers.

8. Maintain provider and recipient files.

9. Educate Medicaid providers concerning administrative policy, program policy, benefit policy, and reimbursement policy.

10. Educate Medicaid providers on billing on Medicaid claim forms, prior authorization requests, use of remittance advice, claim correction forms, and adjustment requests.

11. Maintain client and provider relations and respond to their concerns.

12. Respond to mail inquiries on a timely basis in accordance with the program goals and objectives.

13. Implement procedure changes based on policy developed by the Bureau of Coverage and Reimbursement Policy, which are pertinent to the payment of medical claims.

14. Process claims submitted for covered services within approved time frames.

42 CFR REFERENCES

431.17, 431.18, 431.107, 431.300-307, 447.45, 42 CFR 457

T.N. # 07-008 Approval Date 9-6-07

Supersedes T.N. # 14-88 Effective Date 4-1-07
BUREAU OF ACCESS

PURPOSE

The bureau oversees the Children's Health Insurance Program (CHIP), the Primary Care Network (PCN), and Utah's Premium Partnership for Health Insurance (UPP) program.

FUNCTIONS

CHIP can provide health insurance for 40,000 children with current funding. Each dollar of state funding is matched with approximately $4 in federal funds. CHIP contracts with two of Utah's health insurers to provide coverage to enrollees. Eligibility determination is handled through the Bureau of Eligibility Services.

PCN can provide limited health insurance for 19,000 adults. The program operates under a Medicaid waiver that allows the state to limit recipient benefits. PCN does not cover inpatient hospital or specialty care services. However, case managers seek to arrange donated services in these areas.

The UPP program is a Section 1115 Demonstration Waiver that allows the Department of Health to pool personal and employer funds from the Children's Health Insurance Program (CHIP) and Primary Care Network (PCN), and enables individuals and families to purchase health insurance through their employer.

MAJOR RESPONSIBILITIES

Manage State Plan for CHIP and Medicaid waiver for PCN and UPP.

Review and update administrative rules, policy manuals and provider guides for these programs.

Manage CHIP budget including determining periods of open enrollment.

Collect premiums from CHIP families.

Promote programs through community outreach, media buys, etc.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

BUREAU OF ACCESS (Continued)

MAJOR RESPONSIBILITIES (Continued)

Determine periods of open enrollment for PCN.

Arrange donated specialty care services for PCN clients.

42 CFR REFERENCES

42 CFR, Part 441, Subpart G

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

LONG TERM CARE BUREAU

ORGANIZATION AND FUNCTIONS:

A. Bureau Purpose

To promote quality, cost effective, long term care services programs to meet the needs and preferences of Utah’s low income citizens.

B. Bureau Role

The Long Term Care Bureau functions as the administrative authority over specific home and community-based services programs, chronic care services programs and institutional long term care services. The Long Term Care Bureau performs these functions through collaboration with multiple stakeholders and recognition of the full continuum of long term care services.

C. Bureau Functions

1. Administers and enforces Medicaid regulations related to home and community-based services programs, chronic care State Plan services and institutional long term care services.

2. Develops policy for and oversees implementation of specific home and community-based waiver programs, chronic care State Plan services and institutional long term care services.


4. Quality assurance and oversight activities of the home and community-based waiver programs and chronic care State Plan services.

5. Designs and submits applications to the Centers for Medicare and Medicaid Services for new and renewing home and community-based waiver programs.

6. Initiates and oversees contractual relationships with home and community-based waiver program operating agencies.

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LONG TERM CARE BUREAU (Continued)

Bureau Functions (Continued)

7. Collects and reports data to support policy and reporting requirements of the bureau’s programs.

8. Coordinates long term care with the Bureau of Health Facility Licensing, Certification and Resident Assessment (See Attachment 1.2-C, Page 20).

42 CFR REFERENCES

42 CFR, Part 441, Subpart G