Memorandum of Agreement
Utah Department of Health
Division of Health Care Financing
and
Division of Community and Family Health Services

I. **NAME OF AGREEMENT**: Interagency Coordination - Title V, Title XIX

II. **AGREEING PARTIES**: This agreement is between the Utah Department of Health, Division of Community and Family Health Services (DCFHS) as the designated Title V (Maternal and Child Health) agency and the Utah Department of Health, Division of Health Care Financing (DHCF) as the designated Title XIX (Medicaid) agency.

III. **PURPOSE OF AGREEMENT**: The purpose of this agreement is to formalize and strengthen the relationship between DCFHS and DHCF in areas of mutual interest and concern, avoid duplication of effort, improve access to Title XIX (Medicaid) and Title V [(Maternal and Child Health (MCH)] to eligible Medicaid clients; to enhance the quality of Medicaid and MCH services; to enhance program coordination and information exchange to the extent possible.

IV. **CONTRACT PERIOD**: This agreement is effective April 1, 2001, and will not terminate unless in accordance with the terms of this agreement.

V. **ATTACHMENTS**:
Attachment A: Coordination Forum Designees.
Attachment B: Utah Medicaid Provider Manual, Medical Supplies List, Nutrients
Attachment C: PKU "U" Codes
Attachment D: Medicaid Provider Agreement
Attachment E: Presumptive Eligibility
Attachment F: Enhanced Services for Pregnant Women
Attachment G: Definitions

VII. **SPECIAL PROVISIONS**:

A. DHCF agrees to:

1. Assign the Director of Health Care Financing, or designee, to be the Division liaison to DCFHS, and represent DHCF on the MCH Advisory Committee.

2. Coordinate and collaborate with DCFHS in planning and implementing Medicaid services related to maternal and child health populations, including but not limited to:

a. Early Periodic Screening, Diagnosis and Treatment (EPSDT, a.k.a. CHEC)
b. Reproductive health services
c. Early Intervention (diagnostic/rehabilitation services)
d. Immunizations
e. Children at risk programs
f. Dental services
g. Administrative case management
h. Children with special health care needs
i. Care coordination for children with special health care needs
j. Pregnant and postpartum women
k. Foster children
l. School health/school nurses
m. Migrant children's health
n. 1915(c) Home and Community Based Waiver for Technology Dependent children
o. Medical Home

3. Collaborate with DCFHS to improve access to and quality of services for Medicaid recipients who need MCH services:

a. Children with special health care needs in managed care settings;
b. Women and children in Medicaid managed care settings

4. Reimburse DCFHS, in accordance with the 42 Code of Federal Regulation (CFR) 431.615 paragraph c4, for the cost of services furnished Medicaid recipients by DCFHS and Title V grantees.

5. Provide the CHEC Program Plan which includes sections on needs assessment, outreach, and participation data, for use in the MCH Block Grant Application and Annual MCH Report.

6. Coordinate CHEC outreach activities with related programs. Collaborative efforts will include joint contract development and monitoring where applicable.

7. Coordinate outreach efforts related to the "Baby Your Baby" Program, including the "Hotline" and "Check Your Health" Program media efforts, and making referrals to DCFHS.

8. Collaborate with DCFHS in efforts to improve the immunization rates for all children.

9. Provide, upon request, at no cost to DCFHS, non-confidential and readily available enrollment, utilization and quality assurance data or similar information to assist DCFHS in accomplishing its mission. Provide such data that are not readily available to DCFHS for the cost associated with the request. Provide shared access for designated and trained staff to the Division Data Warehouse.

10. Disseminate information, annually, through Medicaid Information Bulletins or other such publication informing Medicaid recipients and providers of the procedures to bring policy issues to the attention of the Medical Care Advisory Committee or the Maternal and Child Health Advisory Committee.

11. Coordinate and collaborate with DCFHS in planning, implementing and evaluating QA/QI projects related to MCH and chronic disease population.

12. Coordinate and collaborate with DCFHS in monitoring services provided by managed care organizations to MCH and chronic disease populations.

13. Assure that all managed care contracts include provisions requiring managed care plans to contract with and/or pay DCFHS for minimum screening and follow-up services provided by DCFHS to eligible children with special health care needs. Payments will be at least at the current Medicaid rates.

14. Establish the Division of Community and Family Health Services as a Medicaid provider for selected enteral and metabolic products, and pay DCFHS for those products according to the Medicaid fee schedule.

15. Recognize the director of the Bureau of Children with Special Health Care Needs as a member of the EPSDT subcommittee for the Medicaid Utilization Review committee.

B. DCFHS agrees to:

1. Assign the Director, Bureau of Maternal and Child Health, with the responsibility to ensure the coordination of services, outreach and

education provided by the Title V (MCH) programs, including but not limited to: Reproductive Health; Women, Infants, and Children (WIC); Child, Adolescent and School Health; Oral Health and Immunizations with services and outreach provided by Medicaid.

2. Assign the Director, Bureau for Children with Special Health Care Needs with the responsibility to ensure coordination of services, outreach and education provided by the Title V (MCH) programs including but not limited to: Children's Special Health Care Needs programs.

3. Encourage Title V-funded and other DCFHS-sponsored programs to screen families for possible eligibility for Medicaid benefits; to inform those potentially eligible of services available through the Medicaid program; and to refer families to the appropriate eligibility offices.

4. Provide health care consultation and technical expertise for CHEC, Children with Special Health Care Needs, Reproductive Health, Oral Health and Preventive Child Health Services. These functions include, but are not limited to, recommending:

a. Components of physical examination and screening assessment;
b. Standards of service;
c. Scope of service;
d. Schedule for screening services;
e. Data to be collected from screening exams as to the health status of the woman and child services provided;
f. Standards for expanded services provided through the CHEC program; and
g. Criteria and definitions to be used in determining medical necessity and making recommendations to the Utilization Review Committee.

5. Provide dental consultation and serve as liaison with the dental provider community to:

a. Recommend criteria and definitions to be used in determining medical necessity and appropriateness;
b. Recommend criteria and definitions of quality dental care;
c. Recommend scope of Medicaid benefits, criteria, and determinations for the dental provider community; and
d. Explain the directions of the Medicaid dental program.

6. Designate DCFHS staff to coordinate the Child, Adolescent and School Health program; and other related programs with CHEC outreach, education, and case management activities with the DHCF CHEC Coordinator and the CHEC staff at the local community level.

7. Provide upon request at no cost to DHCF readily available MCH data related to Medicaid clients, or other similar information, to assist DHCF in accomplishing its mission. Provide such data that are not readily available to DHCF for the cost associated with the request.

8. DCFHS agrees to bill DHCF for selected enteral products subject to the following provisions:

a. When a WIC client of any age has part or all of the gastric system which is absent, damaged or malfunctioning (either temporarily or permanently), and

b. When the patient must be fed through a gastrostomy or jejunostomy tube that has been surgically attached, or must be fed through a nasogastric or nasojejunal system (an NG tube that is only used occasionally does not qualify a client for billing of this service), and

c. When the client and/or DCFHS meet all of the criteria as specified in the Medical Supplies manual, which includes but is not limited to:

i. Obtaining prior authorization,
ii. Having a physician order,
iii. Verifying client eligibility,
iv. Determining the client is fee-for-service,
v. Billing using the proper forms procedures, and according to manual specifications,
vi. Using the proper "B" codes, as specified in Attachment C for billing, and
vii. Billing any and all third party insurers before billing DHCF.

d. DDCFHS agrees to be responsible for any federal disallowance stemming from error or mistake by DDCFHS.

9. DDCFHS agrees to bill Medicaid for metabolic products subject to the following provisions:

a. When a WIC client's gastric system cannot metabolize nutrients due to an enzyme deficiency, and

b. When the product has been prescribed (ordered) by a physician (order includes quantity, dosage per day, duration), and

c. When all of the provisions of the Medicaid supplies manual have been met, this includes but is not limited to:

i. Obtaining prior authorization,
ii. Determining the client is in fee-for-service status,
iii. Using the proper forms, procedures, and in compliance with provider manual specifications,
iv. Billing the proper codes, as specified on Attachment C,
v. Billing any and all third party insurers before billing DHCF.

d. DCFHS agrees to be responsible for any federal disallowance stemming from error or mistake by DCFHS.

10. DCFHS agrees to bill Medicaid for selected enteral and metabolic products for specificWIC clients when these clients:

a. Have a severe biological or functional anatomical deficiency that gravely affects the assimilation of food, i.e., hepatic, lactate, lung, kidney, amino acid (phenylketonuria), lipid, and

b. Have a prescription order from a physician (which includes product, quantity, dosage and duration), and

c. Have exhausted their WIC benefit, and

d. Have obtained prior approval from DHCF.

e. DCFHS agrees to bill DHCF for these clients subject to the following provision:

i. Determining the clients are Medicaid eligible and are fee-for-service, and
ii. Using only the T codes as specified in Attachments B & C, and

iii. Following the procedures and using the appropriate forms as shown in the Medical Supplies manual, and

iv. Billing any and all third party insurers before DHCF,

f. DCFHS agrees to be responsible for any federal disallowance stemming from error or mistake by DCFHS.

11. DCFHS agrees to abide by the terms and conditions as stated in the modified Medicaid Provider Agreement in Attachment D.

12. DCFHS agrees to coordinate and interface with Medicaid managed care plans to follow the care of any person covered by provision B-8 or B-9, or B-10 of this agreement who is, may be, or was eligible for care through a managed care plan.

C. It is mutually agreed that:

1. Both DHCF and DCFHS will conduct mutual collaboration and coordination through the use of forums which will address matters relating to each of the component areas of the MCH Block Grant. Each Division will designate specific individuals for each forum to coordinate activities relating to that component area (Attachment A). MCH component areas are:

a. Component A: Preventive and Primary Services for Pregnant Women, Mothers and Infants up to age one.

b. Component B: Preventive and Primary Services for Children and Adolescents.

c. Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care Needs.

d. Component D: Health Promotion activities including but not limited to: Tobacco Prevention and Control; Chronic Diseases; other programs and grant projects related to health promotion and community health.

2. All information regarding recipients of services provided directly or indirectly through DHCF or DCFHS shall be treated as confidential. Publication of any information that would identify an individual recipient

is prohibited except upon written consent of the recipient or the responsible parent or guardian.

3. No modifications or changes will be made to this agreement unless in writing and signed by the Directors of both DHCF and DCFHS.

4. Both parties are governmental entities under the Governmental Immunity Act and public entities under the Indemnification of Public Officers and Employees Act, and consistent with the items of those acts, agree to hold each other harmless for their wrongful or negligent acts or those of their employees, officers, or agents.

5. This agreement may be terminated by either party upon 90 days advance written notice.

6. Both parties will review this document annually and update as needed.

VII. **Reference to agreements included in this Contract but not attached**

I. Agreements:

1. Dental Consultation
2. Early Intervention

3. Zyban for Tobacco Cessation

Memorandum of Agreement

UTAH DEPARTMENT OF HEALTH
Division of Health Care Financing
and
Division of Community and Family Health Services

SIGNATURES

DIVISION OF COMMUNITY AND FAMILY HEALTH SERVICES

_____ _____
George W. Delavan Date
Division Director

DIVISION OF HEALTH CARE FINANCING

_____ _____
Michael Deily Date
Division Director

UTAH DEPARTMENT OF HEALTH

_____ _____
Shari A. Watkins, C.P.A. Date
Director
Office of Fiscal Operations

ATTACHMENT A

Division of Health Care Financing
and
Division of Community and Family Health Services

COORDINATION FORUMS

Designees

Component A	Julie Olson Lois Bloebaum Linda Abel
Component B	Julie Olson Al Romeo Linda Abel Marilyn Haynes-Brokopp
Component C	Julie Olson Jeff Dean Holly Balken Fan Tait
Component D	Julie Olson LaDene Larsen (LaDene's folks)??
Dental issues not included under components A, B, or C	Steven Steed Don Hawley Andrea Hight
Director, Bureau of Coverage and Reimbursement Policy	Blake Anderson
Director, Bureau of Managed Health Care	Julie Olson
Director, Bureau of Maternal and Child Health	Nan Streeter

Director, Bureau for Children with Special Health Care Needs Fan Tait

Director, Bureau of Health Promotion LaDene Larsen

Attachment E

Presumptive Eligibility

1. Purpose: To provide delineation of responsibilities and administration for the presumptive eligibility program.

2. DCFHS will select Qualified Providers and monitor service offered under the Presumptive Eligibility Program.

3. Special Provisions

A. Disallowance:

1. DCFHS shall pay for any disallowance of federal financial participation for failing to meet the terms of this agreement and the MOA between DCFHS and the QP; failure of DCFHS agencies or QPs to comply with federal rules and regulations; or expenditures not qualifying for federal financial participation.

2. DHCF shall bill DCFHS quarterly for any disallowance as per 3. A once that disallowance is made known to DHCF by the CMS Regional office

B. Services

1. DHCF shall process for payment all claims submitted for PE clients in accordance with established state Medicaid policy.

2. DHCF shall receive all billings from providers of services to presumptively eligible individuals, check to determine if the individual has been determined to be Medicaid eligible, and approve the billing for payment from the appropriate fund.

3. DHCF shall establish provider types, unique provider numbers, and categories of service authorized for each qualified provider (QP) identified by DCFHS.

4. DHCF shall provide administrative support for the program.

5. DHCF shall suspend all claims submitted for presumptively eligible applicants, those from Qualified Providers, and those claims with published codes, based on the period of time beginning on the day PE is approved by a qualified provider and ending on the last day of the month following the month of the PE application has been approved, or the expiration date on the PE card.

a. Those individuals who are found to be Medicaid eligible will be processed through the normal MMIS process. Suspended claims will be resolved using Adjudication Decision Tables acceptable to all parties.

6. DHCF shall process all claims for PE clients against Medicaid funding based on B.5 (above). In the event the client is determined by authorized eligibility staff to be ineligible for Medicaid, all claims up to the date of expiration of the PE card will be processed against the Medicaid program.

7. DHCF shall adjudicate PE claims that are suspended for TPL reasons. These claims will be referred to the Office of Recovery Services (ORS) for possible collection activity.

8. DHCF shall send to ORS, copies of all forms containing TPL information on PE recipients who are determined not to be Medicaid eligible, but who have received services while qualified as PE. This information will be used for collection activity by ORS.

9. DHCF shall periodically review all claims paid through the PE program to determine if, following payment from the PE program funds, the individual subsequently became Medicaid eligible. In the event an individual becomes eligible for Medicaid, DHCF shall process an adjustment to pay for authorized expenditures using Medicaid funding.

10. DHCF shall conduct training sessions for QPs to acquaint them with the prior approval process, billing procedures, and services coverage limits of Medicaid when requested by DCFHS.

11. DHCF shall store PE forms for a period of time to meet access and availability requirements.

12. DCFHS shall ensure that all QPs have a current Memorandum of Agreement which clearly states the minimum expectations as defined in the State Plan, 88-13.

13 DCFHS shall monitor all QPs to ensure that all terms of their MOA are being met.

14. DCFHS shall identify to DHCF all QPs to be assigned unique provider numbers for the purpose of billing under the PE program.

15. DCFHS shall ensure that only those services which are defined in the 'Enhanced Services to Pregnant Women Service Codes and Definitions" (Attachment ??) or those previously approved for payment under Medicaid are provided under this program. Inappropriate referrals from QP s for services will be the responsibility of DCFHS.

16. All services offered under this program are subject to established Medicaid service limits and prior approval requirements.

C. Reports. DHCF shall provide DCFHS with mutually agreed upon reports summarizing all claims paid through the PE program and administrative expenditures charged to the program.

Attachment G

DEFINITIONS

Department of Health, Division of Health Care Financing (DHCF) - The agency assigned responsibility to administer the Medicaid program in the State of Utah.

Department of Health, Division of Community and Family Health Services (DCFHS) - The agency with responsibility to administer Title V programs in the State of Utah.

Centers for Medicare and Medicaid (CMS) Regional Office - Region VIII CMS office in Denver, Colorado. This regional office, under direction of the Central Office of the Centers for Medicare and Medicaid Services, is responsible for oversight of Utah Medicaid.

Third Party Liability (TPL) - Possible sources of funds to cover the services offered under the Medicaid and Title V programs. Sources could be other insurance programs, verteans benefits, other governmental programs, etc.

Office of Recovery Services (ORS) - The office within the Department of Human Services with contractual responsibility to investigate and collect TPL on Medicaid claims.

Managed Care Organization (MCO) - An organization contracted with the Medicaid program to provided necessary health services to recipients.

Presumptive Eligibility (PE) - A period of time beginning on the day PE is approved by a qualified provider and ending the last day of the month following the month the woman is approved for PE.

Presumptive Eligibility Determination - the process of completing the presumptive eligibility application form and submitting the form to DHCF. Presumptive eligibility determination is made on the basis of preliminary information that the woman's household income does not exceed the applicable income standard for a household of the same size. Presumptive eligibility is based on household income and a verifiable pregnancy. Presumptive eligibility determination is made by appropriate staff of a qualified provider.

Qualified Provider (QP) - A facility or organization identified by DCFHS and bound by a Memorandum of Agreement as qualified to determine presumptive eligibility and provide services in accordance with the established DCFHS Reproductive Health Program and by the Code of Federal Regulations.

The Qualified Provider must meet criteria established by the Social Security Act, Section 1920, and amendments, as noted below:

A. Is eligible for payment under an approved State Plan; and

B. Provides one of the following services:

I Outpatient hospital services (section 1905(a)(2)(A) of the Act),
ural health clinic service (if contained in the State Plan) (Section 1905(a)(2)(B)),
nic service furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician (Section

C. Is designated by the State (DCFHS) in writing as being capable of making presumptive eligibility determinations based on family income.

D. A qualified provider meets one of the following:

1. Receives funds under:

igrant Health Centers or Community Health Centers (Section 329, 330, or 340 of the Public Health Service Act);
ernal and Child Health Services Block Grant Program (Title V of the Social Security Act);
IIf the Indian Health Care Improvement Act;

2. Participates in the program established

III The Special **Error! Bookmark not defined.**Supplemental Food Program for Women, Infants and Children (Section 17 of the Child Nutrition Act of 1966)
IV The Commodity **Error! Bookmark not defined.**Supplemental Food Program (Section 4(a) of the Agriculture and Consumer Protection Act of

3. Participates in a State perinatal program; or

4. Is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act (P.L. 93-638)

Risk Assessment - the systematic review of relevant client data to identify potential problems and to plan for care directed at preventing or ameliorating those problems. A formalized risk assessment tool is to be used by all providers authorized to complete the risk assessment. The care plan for low risk client incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation

with an appropriate specialist, individualized counseling, and services designed to address the particular risk factors involved.

Expanded or Enhanced Services - Approved ambulatory services provided to Medicaid eligible pregnant women to meet individual needs without having to offer comparable services to all other categorically eligible individuals. This provision was established by SOBRA 1985. The expanded or enhanced service include care coordination, mental health counseling, nutritional assessment and counseling, health education, and home visits.

Title V MCH and CSHCN – Federally funded program to states which includes funding for programs for mothers, infants and children and children and youth with special health care needs.

EPSDT/ CHEC -

WIC – Supplemental Food and Nutrition Education Program for Women, Infants and Children which provides nutrition assessment and education as well as food vouchers for income eligible pregnant and postpartum women and infants and children at nutritional risk up to age five years.