

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

1. The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:
 - a. SPA submission requirements – the agency requests modification of the requirement to submit this SPA and any other COVID-19 related SPAs by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
 - b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA and any other COVID-19 related SPAs submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
 - c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

T.N. # 20-0006

Approval Date 5-18-20

Supersedes T.N. # New

Effective Date 3-18-20

The Department presented this SPA to the Utah Indian Health Advisory Board on May 8, 2020.

Section A – Eligibility

- 1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

The state elects to cover all uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act.

- 2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

- 3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

Adding uninsured individuals for COVID-19 testing and related services as a Hospital Presumptive Eligibility (HPE) group. The State is selecting unlimited PE periods for the COVID testing group only. The State will continue the reasonable limits the State elected in its approved HPE SPA for all other groups. The State is not changing the existing performance standards for HPE providers.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

State/Territory: UTAH

Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

The State waives cost sharing for testing services (including in-vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed.

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

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State/Territory: UTAH

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

Please describe.

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State/Territory: UTAH

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.
8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

- b. ____ Other:

Describe methodology here.

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Effective Date _____ 3-18-20

State/Territory: UTAH

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

Please describe criteria.

- b. Payments are increased through:

- i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. ____ An increase to rates as described below.

Rates are increased:

____ Uniformly by the following percentage: _____

____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

____ Up to the Medicare payments for equivalent services.

____ By the following factors:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

T.N. # 20-0006 Approval Date 5-18-20

Supersedes T.N. # New Effective Date 3-18-20

State/Territory: UTAH

- a. ____ The individual's total income
 - b. ____ 300 percent of the SSI federal benefit rate
 - c. ____ Other reasonable amount: _____
2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

T.N. # _____ 20-0006

Approval Date _____ 5-18-20

Supersedes T.N. # New

Effective Date _____ 3-18-20

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

1. The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:
 - a. SPA submission requirements – the agency requests modification of the requirement to submit this SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
 - b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
 - c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

T.N. # 20-0009 Approval Date 6-5-20

Supersedes T.N. # 20-0006 Effective Date 3-1-20

The Department presented this SPA to the Utah Indian Health Advisory Board on May 8, 2020.

Section A – Eligibility

- 1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

- 2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

- 3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

- 4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from

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State/Territory: UTAH

the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

T.N. # _____ 20-0009 Approval Date _____ 6-5-20 _____

Supersedes T.N. # New Effective Date _____ 3-1-20 _____

State/Territory: UTAH

5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

T.N. # 20-0009 Approval Date 6-5-20

Supersedes T.N. # New Effective Date 3-1-20

2. The agency makes the following adjustments to benefits currently covered in the state plan:

Effective retroactive to March 1, 2020, for the purposes of testing to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, tests conducted in non-office settings such as parking lots are covered, exempting requirements in 42 CFR 440.30(b).

Coverage also includes laboratory processing of self-collected test systems that the FDA has authorized for home use, if available to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19, even if those self-collected tests would not otherwise meet the requirements in § 440.30(a) or (b), as long as the self-collection of the test is intended to avoid transmission of COVID-19.

The State will increase bed hold/therapeutic absence days for nursing facilities and ICF/IIDs to 60 days per calendar quarter. This allowance would be through the public health emergency period.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

T.N. # 20-0009 Approval Date 6-5-20

Supersedes T.N. # New Effective Date 3-1-20

State/Territory: UTAH

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

- b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

Please describe criteria.

- b. Payments are increased through:

- i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. ____ An increase to rates as described below.

Rates are increased:

T.N. # 20-0009

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Supersedes T.N. # New

Effective Date 3-1-20

State/Territory: UTAH

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. _____ The individual's total income
 - b. _____ 300 percent of the SSI federal benefit rate
 - c. _____ Other reasonable amount: _____
2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

T.N. # _____ 20-0009 _____ Approval Date _____ 6-5-20 _____

Supersedes T.N. # New _____ Effective Date _____ 3-1-20 _____

Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

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The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

1. The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:
 - a. SPA submission requirements – the agency requests modification of the requirement to submit this SPA and any other COVID-19 related SPAs by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
 - b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA and any other COVID-19 related SPAs submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
 - c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

T.N. # 20-0013

Approval Date 06-23-21

Supersedes T.N. # New

Effective Date 12-11-20

State/Territory: UTAH

Pursuant to Section 1135, the agency will submit this SPA before initiating tribal consultation. Nevertheless, the agency will email this information to the tribes and present this SPA at the next available Utah Indian Health Advisory Board (UIHAB) meeting.

Section A – Eligibility

1. The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.'

Include name of the optional eligibility group and applicable income and resource standard.

The state elects to cover all uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

T.N. # 20-0013

Approval Date 06-23-21

Supersedes T.N. # New

Effective Date 12-11-20

This SPA is in addition to the Disaster Relief SPAs approved on May 18, 2020, and June 5, 2020, and does not supersede anything approved in those SPAs.

State/Territory: UTAH

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

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This SPA is in addition to the Disaster Relief SPAs approved on May 18, 2020, and June 5, 2020, and does not supersede anything approved in those SPAs.

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5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

The State waives cost sharing for testing services (including in-vitro diagnostic products), testing-related services, and treatments for COVID-19, including vaccines, specialized equipment and therapies (including drugs), for any quarter in which the temporary increased FMAP is claimed.

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

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This SPA is in addition to the Disaster Relief SPAs approved on May 18, 2020, and June 5, 2020, and does not supersede anything approved in those SPAs.

State/Territory: UTAH

Section D – Benefits

Benefits:

1. ___ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. The agency makes the following adjustments to benefits currently covered in the state plan:

The State will cover the administration of COVID-19 vaccines, tests, and treatment upon Emergency Use Authorization or approval from the Food and Drug administration and disregards all language in Attachment 3.1-A and 3.1-B that precludes coverage of administration of COVID-19 vaccines, tests, and treatment approved for Emergency Use Authorization. This applies to vaccine administration, tests, and treatment covered under the inpatient hospital, outpatient hospital, and physician services benefits.

Other Licensed Practitioners Benefit: Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations. In addition, the State covers pharmacist-ordered and administered COVID-19 tests. Pharmacy interns and pharmacy technicians may also administer COVID-19 vaccines and COVID-19 tests under the supervision of a licensed pharmacist.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).
4. ___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a. ___ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. ___ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. ___ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

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State/Territory: UTAH

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules –

Effective date (enter date of change):

Location (list published location):

- b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

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COVID-19 vaccine administration.

- a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

- b. Payments are increased through:

- i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

- By the following factors:

In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at \$22.67 per dose for vaccines administered from December 11, 2020, through March 14, 2021. On or after March 15, 2021, to the end of the PHE, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided: <https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies>

Second and additional doses - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at \$22.67 per dose for vaccines administered from December 11, 2020, through March 14, 2021. On or after March 15, 2021, to the end of the PHE, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided.

Inpatient and Outpatient Hospital Services - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at \$22.67 per dose for vaccines administered from December 11, 2020, through March 14, 2021. On or after March 15, 2021, to

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the end of the PHE, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. Vaccine administration rates are paid in addition to the Diagnosis Related Group (DRG) reimbursement when the vaccine is administered in conjunction with an inpatient or outpatient hospital visit.

Physician Services - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at \$22.67 per dose for vaccines administered from December 11, 2020, through March 14, 2021. On or after March 15, 2021, to the end of the PHE, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. These vaccine administration rates are reimbursed separately from and in addition to reimbursement for a comprehensive office visit.

Nursing Facilities – In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at \$22.67 per dose for vaccines administered from December 11, 2020, through March 14, 2021. On or after March 15, 2021, to the end of the PHE, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. Payment for vaccine dose administration in nursing facilities is billed through the contracted pharmacy as provider type 60.

Indian Health Service – Payment for vaccine dose administration through Indian Health Service facilities is the All-Inclusive Rate (AIR).

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. ____ The individual's total income
 - b. ____ 300 percent of the SSI federal benefit rate
 - c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

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Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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This SPA is in addition to the Disaster Relief SPAs approved on May 18, 2020, and June 5, 2020, and does not supersede anything approved in those SPAs.

ARPA Spending Plan Supplemental Payments

1. Based on paid data from April 1, 2021 through March 31, 2023, the agency increases payment for the providers referenced in Utah's American Rescue Plan Act Home and Community Based Services Enhanced Funding Spending Plan and that are listed in Appendix B., or could be listed in Appendix B., of the American Rescue Plan Act, State Medicaid Director Letter, *SMD# 21-003 Implementation of American Rescue Plan Act of 2021 Section 9817*: including:
 - a. Home Health Services
 - b. Private Duty Nursing – in home services only
 - c. Hospice Services – in home services only
 - d. Personal Care Services
 - e. School Based Services
 - f. Rehabilitative Services - Behavioral Health Services
 - g. Early Periodic Screening Diagnosis and Treatment, Autism Spectrum Disorder Related Services

2. Temporary supplemental payments will be made based on the following criteria:
 - a. Eligibility for quarterly supplemental payments require providers to attest to the following:
 - i. An understanding these are time-limited payments which are anticipated to not extend beyond March 2024
 - ii. An agreement that a portion of the funds will be used to address direct-care worker issues (i.e., salary/benefit increases, staff retention bonuses, employer paid training, provision of PPE, paid time to receive vaccinations, etc.)
 - iii. An agreement that funds will be used to expand, enhance or strengthen their program

 - b. Payments are increased through a supplemental payment:
 - i. The State will make supplemental payments to qualified providers who have made an attestation per (2)(a).
 - ii. The quarterly payments will equal 5 percent of the claims (fee for service based on paid date and managed care encounters based on state received date) from the previous quarter. For example, April, May and June paid claims will be used to inform the payment for that period. If \$100 were paid in that period, the quarterly payment will be \$5. The exact timing of payments may vary; however, the payments will be based on the example noted.
 - iii. The payments are made to billing providers.

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Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

The amended changes to the school-based services payment methodology in this SPA are effective July 1, 2021, through September 30, 2021.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

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- c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

The Department presented this SPA to the Utah Indian Health Advisory Board on September 10, 2021, as an initial step in the consultation process. The Board had questions regarding FFS reimbursement for certain rehabilitative services such as physical therapy, occupational therapy, and speech therapy. The Department responded that by federal mandate, institutions of public education provide these services to students free of charge. The Board also asked whether Native American children would be covered under the program. The Department affirmed they can be covered as long as they are enrolled in Medicaid with a school district that participates.

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.
2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

Income standard: _____

3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

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4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

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This SPA is in addition to Utah's other Disaster Relief SPAs approved by CMS. This SPA does not supersede any disaster relief SPAs previously approved by CMS.

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4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

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This SPA is in addition to Utah's other Disaster Relief SPAs approved by CMS. This SPA does not supersede any disaster relief SPAs previously approved by CMS.

State/Territory: UTAH

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. The agency makes the following adjustments to benefits currently covered in the state plan:

Skills Development Services

EPSDT Services Provided by Local Education Agencies

A. Medicaid provides direct coverage to eligible recipients pursuant to EPSDT for services furnished in the school-setting, in accordance with section 1905(a) of the Social Security Act. Under EPSDT, the state must provide all 1905(a) coverable benefits/services to individuals under the age of twenty-one in accordance with regulations at 42 CFR 440. Services must be determined medically necessary by the state. Medicaid eligible individuals up to the age of 21, receiving covered services in a school setting, must have a valid IEP.

LEA Responsibilities

1. LEAs shall ensure that all service providers act within the requirements of proper licensure or certification.
2. LEAs shall ensure that all unlicensed/uncertified providers requiring supervision are properly supervised.
3. LEAs shall ensure that licensed/certified supervising providers assume professional liability for unlicensed/uncertified providers rendering covered Medicaid services.
4. LEAs shall ensure that proper documentation of rendered services is created and maintained to ensure that all compliance requirements are met.

Service Exclusions

1. Services are not covered when the service is educational or academic in nature.
2. Services are not covered when the service is considered to be social, vocational, or extracurricular in nature.

Service Provision

- A. Orientation and Mobility Services (O&M):

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1. Orientation and Mobility services are rehabilitative services recommended by a physician or other licensed practitioner related to the evaluation, diagnosis, and treatment of a student who is blind or visually impaired to attain systematic and safe orientation and movement within their environment through sensory integrative techniques. Orientation and Mobility services also include direct assistance with the selection, acquisition, training, and use of an Assistive Technology Device. The following providers may render these services:

a. Orientation and Mobility Services performed by an Orientation and Mobility Specialist with Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals.

b. Paraprofessional under the supervision of a qualified Orientation and Mobility Specialist.

B. Aural Therapy Services

1. In addition to audiologists and speech language pathologists, this rehabilitative service may also be performed by Teachers for the Deaf and Hard of Hearing who meet the qualifications of having a master's degree from an accredited college or university with a major in the Teaching of the Deaf and Hard of Hearing and are under the direction of a speech pathologist or audiologist.

3. The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. _____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. _____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

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Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules

Effective date (enter date of change): _____

Location (list published location): _____

- b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

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Please describe criteria.

b. Payments are increased through:

- i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. _____ Are not otherwise paid under the Medicaid state plan;
- b. _____ Differ from payments for the same services when provided face to face;
- c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

- i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

- ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

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Other:

4. Other payment changes:

Effective 7/1/2021, Utah's School-Based Skills Development payment model is as follows:

A. Reimbursement Methodology for School-Based Skills Development Services

School-based services, known as School-Based Skills Development Services (SDS) in Utah, are delivered by the school districts, charter schools and public K-12 educational institutions (herein after referred to as "Local Education Agencies" or "LEAs"), and include the following Medicaid 1905(a) services:

- Nursing Services;
- Personal Care Services;
- Psychology Services;
- Counseling Services;
- Social Work Services;
- Orientation, Mobility, and Vision Services;
- Speech-Language Services;
- Audiology Services;
- Occupational Therapy (OT);
- Physical Therapy (PT);

All costs described within this methodology are for Medicaid services provided by qualified personnel or qualified health care professionals who have been approved under Attachments 3.1-A and 3.1-B of the Medicaid state plan.

B. Direct Medical Payment Methodology

LEAs will be paid on a cost basis. LEAs will be reimbursed interim rates for SDS direct medical services. On an annual basis, an LEA-specific cost reconciliation and cost settlement for all over and under payments will be processed.

1. Participating SDS LEAs are reimbursed interim payments based on a monthly calculated rate. Interim payments under the SDS Program are calculated prior to the school year beginning and are divided into twelve equal monthly installments, to be paid July 1 through June 30. Interim payments shall be tied to claim submissions by the LEA.

a. For the 2021-22 school year, the interim rates were calculated based on the LEA's reported costs from the 2019-20 school year.

b. For the 2022-23 school year, the interim rates were calculated using the cost data for the direct service cost pools from the October-December 2021 quarterly financial submissions for the administrative claims.

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c. For the 2023-24 and subsequent years, the interim rates shall be based on the LEA's actual, certified costs identified in their most recently filed annual cost report from the prior fiscal year.

d. For a new participating LEA, the interim rate shall be calculated based on statewide historical data.

e. When an LEA's Total Medicaid Allowable Cost amount has been calculated following the processes defined in the following sections, the amount is then divided by 12 to arrive at a monthly rate figure. These monthly rates will be implemented to support the interim payments for the following fiscal year. Each LEA will have their own monthly rate inclusive of their Medicaid Allowable Costs for both of the direct service cost pools.

f. The LEA is then given the option to request that the monthly amount be paid at either 80% or 90% of the total calculated amount. The percentage is applied in an effort to minimize LEA overpayments.

g. A cost reconciliation and cost settlement is completed annually as described in Sections G and H. If an LEA's total monthly interim payments for the year exceed their costs to render services, the LEA will be invoiced the difference and the state will recoup the amount. If the total amount of monthly interim payments for the year is less than what the LEA's costs were to render services, the LEA will be reimbursed the difference.

2. LEAs will continue to submit claims for Medicaid covered services rendered, but will not be paid for claim charges. All claims will be submitted to Medicaid with a \$.00 charge. LEAs will only be paid through the monthly interim payment.

C. Data Capture for the Cost of Providing School-Based Skills Development Services

Data capture for the cost of providing SDS will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:

a. SDS cost reports received from LEAs;

b. Utah State Board of Education (USBE) Unrestricted Indirect Cost Rate (UICR);

i. The unrestricted indirect cost rate is derived from costs having to do with administrative, overhead maintenance and other support services. Staff included on the LEA's staff pool list are not paid from these areas.

ii. LEAs are specifically instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures. This ensures that there is no duplication of costs for indirect rates.

iii. Some LEAs do not have a calculated USBE Unrestricted Indirect Cost Rate (UICR). For those that do not have one calculated, a de minimis rate of 10% will

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be charges to Medicaid. All LEAs with a calculated UICR will use their calculated rate.

c. Random Moment Time Study (RMTS) Activity Code 4B (Direct Medical Services) and Activity Code 10 (General Administration):

i. Direct Medical IEP activity code is accounted for in the annual cost settlement report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

ii. General Administration code 10 is accounted for in both the quarterly Medicaid Administrative Claim as well as the annual Cost Reconciliation and Cost Settlement.

a. General Administrative code 10 is a General Administrative Overhead Factor and is calculated to determine the amount of time that is eligible for reimbursement in the MAC Claim. General Administration is distributed to the reimbursable code based on the percentage of total time as dictated by the Random Moment Time Study.

b. General administrative code 10 is also accounted for in the annual cost report. It is distributed to the reimbursable codes based on the percentage of total time as dictated by the Random Moment Time Study.

iii. The resulting direct medical service percentages will be specific to each cost pool and reflected as a statewide average.

d. LEA specific Medicaid Enrollment Ratio (MER):

i. For the purposes of the annual cost reconciliation and cost settlement process, the Medicaid Enrollment Ratio (MER) is referred to as the Medicaid IEP Ratio. This IEP Ratio is unique to each participating LEA and is used to apportion the Total Direct Medicaid Service costs between Medicaid and non-Medicaid. The ratio will be calculated based on a December 1 student count with the numerator reflecting the total number of students with a covered medical service in their IEP that are Medicaid enrolled and the denominator reflects the total number of all students with a covered medical service in their IEP.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

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1. Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs in the Utah Administrative Code. These direct costs will be calculated on an LEA-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically related purchased services, supplies and materials. These direct costs are accumulated on the annual School-Based Skills Development Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the LEA level. The Chart of Accounts is uniform throughout the State of Utah. Costs will be reported on an accrual basis.

- a. Medically related purchased services include contracted services. LEAs report the amounts they pay to contracted providers as salaries. Benefits are not reported by the LEA for contracted staff.

- i. The USBE's Unrestricted Indirect Cost Rate is multiplied by the sum of the LEA's total regular staff salaries and the total contracted salaries.

- b. Medicaid Direct Medical Service costs are funded by the state and local dollars. Any expenditures that are fully paid for using federal funds will be removed from the cost report. Expenditures that are partially funded by federal funds will be reduced by the amount of federal funds. Only the portion of expenditures paid for with state or local funds is included in the calculation of the Medicaid Direct Medical Service costs. Providers of Medicaid Direct Medical Service costs make up this non-federally funded cost pool.

Allowable costs for this provider pool consist of:

- i. salaries;
- ii. benefits;
- iii. medically-related purchased services; and
- iv. medically-related supplies and materials

2. Indirect Costs: Indirect costs are determined by applying the LEA's specific Unrestricted Indirect Cost Rate (UICR) to its adjusted direct costs. Utah LEAs use predetermined fixed rates for indirect costs. Utah State Board of Education (USBE) has, in cooperation with the United States Department of Education (DOE), developed an indirect cost plan to be used by LEAs in Utah. Pursuant to the authorization in 34 CFR §75.561(b), USBE approves unrestricted indirect cost rates for LEAs for the DOE, which is the cognizant agency for LEAs. If an LEA does not have a calculated UICR a de minimis rate of 10% will be utilized. Providers

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are permitted only to certify Medicaid-allowable costs and are not permitted to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

Indirect Cost Rate

- a. Apply the Utah State Board of Education Cognizant Agency UICR applicable for the dates of service in the rate year.
- b. The UICR is the unrestricted indirect cost rate calculated by the Utah State Board of Education.

To ensure non-duplication of costs, LEAs are instructed that costs from accounting codes that are used in the calculation of the unrestricted indirect cost rate are not to be included in the reported expenditures on the annual cost report.

3. Time Study Percentages: A time study separately approved by HHS (outside the state plan process) must be approved before claiming and drawing down FFP for eligible services. This is captured by using a Random Moment Time Study (RMTS) methodology, and is used to determine the percentage of time that medical service personnel spend on IEP, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The RMTS methodology will utilize three cost pools in total. Two cost pools are for direct medical services and one cost pool for administrative activities.

a. The first cost pool is the Direct Service cost pool and includes all eligible staff and other medical services providers except staff that primarily provide personal care and behavior modification services. These individuals are eligible to bill direct medical services. Eligible positions included in this cost pool are:

- Audiologist;
- Audiologist Aide;
- Certified Occupational Therapy Assistant (COTA);
- Licensed Practical Nurse;
- Occupational Therapist;
- Occupational Therapy Aide;
- Orientation and Mobility Specialist;
- Physical Therapist;
- Physical Therapy Assistant (PTA);
- Psychologist;
- Registered Nurse;
- School Counselor;
- School Social Worker;
- School Psychologist;
- School Hearing Specialist;
- Speech Language Pathologist;
- Speech Language Pathology Aide;
- Vision and Hearing Aide.

b. The second cost pool is the Other Direct Service cost pool and includes staff that primarily provide personal care and behavior services. These individuals are also eligible to bill direct medical services. Eligible positions included in this cost pool are:

- Health Special Education Teachers (who supply Personal Care and Behavior Services);
- Para Educator.

c. The third cost pool is the Administrative Outreach Personnel cost pool and includes individuals whose primary duties are administrative in nature. These individuals are not eligible to bill direct medical services. Staff included in the cost pool are not included on the annual cost report and the time study results for this cost pool are not included as part of any calculations for the annual cost reconciliation and cost settlement process. Examples of staff that are eligible to be included in this cost pool are:

- Administrators;
- Diagnosticians;
- Interpreters and Interpreter Assistants;
- Program Specialists;
- Pupil Support Services Administrators;
- Pupil Support Services Technicians;
- Special Education Administrators;
- Special Education Teachers;
- Special Education Coordinators;
- School Bilingual Assistants.

d. Staff cannot be included in more than one cost pool. If an individual performs job duties that correspond to more than one cost pool, the individual must be added to the cost pool that corresponds with their primary job responsibilities.

e. Participants from all cost pools complete RMTS for all regular school days, with a precision level of +/- 2% and a 95% confidence level

f. Summer Vacation periods (when most students are not attending according to the LEA calendar) will use the weighted average of the other periods to provide compensation to providers paid during this period.

g. LEAs ensure an 85% response rate to the time study moments.

h. The RMTS will generate two Direct Medical Services time study percentages; one for Direct Medical Service Cost Pool and one for the Other Direct Service Cost Pool. Each Direct Medical Services time study percentage will be statewide averages. The direct medical services costs and time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the State of Utah and CMS.

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4. Medicaid Ratio Determination: A Medicaid ratio will be established for each participating LEA. When applied, these ratios will discount the associated Direct Medical Service cost pools by the percentage of Medicaid-enrolled students.
 - a. Medicaid IEP Ratio: The Medicaid IEP Ratio will be used in the calculation of the Medicaid Direct Medical Service costs pursuant to an IEP. The names, gender, and birthdates of students with an IEP identifying a covered service will be identified from the December 1 Count Report and matched against the Medicaid enrollment file to determine the percentage of those that are enrolled for Medicaid. The numerator of the rate will be the number of Medicaid enrolled students with an IEP identifying a covered service and the denominator will be the total number of students with an IEP identifying a covered service. The IEP ratio will be calculated for each LEA participating in the SDS program on an annual basis.

5. Contracted costs: LEAs can include contracted service costs for and contracted clinicians that were included on the Staff Pool List for the RMTS process. The contracted service costs represent the amounts charged to the LEA by the contractor or contracting agency and may include the costs associated with the clinician and any overhead incurred by the contractor that is charged back to the LEA. This cost does not include any overhead or other indirect costs incurred by the LEA to support the contracted clinician.
 - a. Contracted service costs for direct medical services will be a separate line item in the cost report with the application of the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.
 - b. Contracted service costs for direct medical services and administrative services are part of the RMTS and the allocation to direct medical and administrative percentages, the LEA's Unrestricted Indirect Cost Rate, and the LEA's allocation using the Medicaid IEP Ratio.
 - c. The LEA's Unrestricted Indirect Cost Rate is applied to contracted service costs to reflect the overhead and administrative costs incurred by the LEA to support the contracted service clinician and are non-duplicative of any agency indirect costs charged to the LEA by the contractor.

6. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each LEA for Direct Medical Services.

Step 1. The Direct Service Personnel Costs (Salaries + Fringe Benefits + Contract Costs) will be added to the Direct Service Non-Personnel Costs (Materials and Supplies + Depreciation) to determine the Total Direct Services Costs

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Step 2. The Total Direct Services Costs will then be multiplied by the Direct Medical Services Percentage (as determined by the RMTS and applied to the 2 Direct Medical cost pools on a statewide basis) to determine the Total Direct Medicaid Services Costs.

Step 3. The Total Direct Medical Services Costs will be multiplied by the Unrestricted Indirect Cost Rate to determine the total Indirect Costs.

Step 4. The Direct Medical Services Costs will be added to the Indirect Costs to determine the Total Allowable Costs.

Step 5. The Total allowable Costs will be multiplied by the Medicaid Enrollment IEP Ratio (calculated by each LEA) to determine the Total Medicaid Reimbursable Costs.

Step 6. Reconciliation process: The Total Medicaid Interim Payments will be subtracted from the Medicaid Reimbursable Costs to equal the Total Cost Settlement.

E. Certification of Funds Process

Each LEA certifies on an annual basis an amount of the interim payments received during the previous federal fiscal year. In addition, each LEA certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

LEAs are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

F. Annual Cost Report Process

Each LEA will complete an annual cost report for all SDS delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due no later than one year after the close of the quarter ending June 30.

a. The primary purpose of the cost report is to

i. document the LEA's total Medicaid allowable scope of costs for delivering SDS, including direct costs and indirect costs, based on cost allocation methodology procedures

b. Cost reports will be subjected to a comprehensive review process prior to their use in the calculation of the interim rates.

i. The review will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. Awareness of Federal Audit and Documentation Regulations: The State Medicaid agency and any contractors used to help administer any part of the SDS program are

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aware of federal regulations listed below for audits and documentation, and will provide documentation for MERs and any other documentation needed to support SDS claims

- a. 42 CFR 431.107 Required provider agreement
- b. 45 CFR 447.202 Audits
- c. 45 CFR 75.302 Financial management and standards for financial management systems

c. Cost reports will be used to reconcile its interim payments to its total Medicaid-allowable scope of costs based on cost allocation methodology procedures.

i. The reconciliation will be used to ensure the accuracy and appropriateness of the costs and allocation factors.

ii. The annual SDS Cost Report includes a certification of funds statement to be completed, certifying the LEA's actual, incurred costs/expenditures. All filed annual SDS Cost Reports are subject to a desk review by the Division of Integrated Healthcare (DIH) or its designee.

G. The Cost Reconciliation Process

The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SDS Cost Report. The total CMS-reviewed, Medicaid-allowable scope of costs based on CMS-reviewed cost allocation methodology procedures are compared to the LEA's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-reviewed scope of costs, the CMS-reviewed cost allocation methodology procedures, or its CMS-reviewed time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires review from CMS prior to implementation; however, such review does not necessarily require the submission of a new state plan amendment.

H. The Cost Settlement Process

1. For services delivered for a period covering July 1 through June 30, the annual SDS Cost Report is due no later than one year after the close of the quarter ending June 30, with the cost reconciliation and settlement processes completed no later than two years after the fiscal year end.

a. Actual costs will be used to determine whether or not the LEA has an under or overpayment. Actual costs will be calculated for the school year and will then be compared to the interim payments made during that same school year.

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2. If an LEA's interim payments exceed the actual, certified costs of the provider for SDS to Medicaid members, the provider will return the federal share of an amount equal to the overpayment.

3. If the actual, certified costs of an LEA for SDS exceed the interim Medicaid payments, DIH will pay the federal share of the difference to the LEA in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

a. DIH will issue a notice of settlement within 60 days following the completion of the settlement determination that denotes the amount due to or from the provider.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

- a. ____ The individual's total income
- b. ____ 300 percent of the SSI federal benefit rate
- c. ____ Other reasonable amount: _____

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Medicaid State Plan /Additional Information

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 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review

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instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. 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. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

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Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

- The state assures coverage of COVID-19 vaccines and administration of the vaccines.¹
- The state assures that such coverage:
 1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
 2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.
- Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.
- The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.
- The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

¹ The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

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Reimbursement

The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

SPA UT-20-0013 within Section 7.5 of the Medicaid State Plan, is effective March 15, 2020, through the end of the public health emergency period. The payment methodology, found in Section E of the SPA, remains through the end of the public health emergency.

The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

- Medicare national average, OR
- Associated geographically adjusted rate.

The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided:
<https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-mono-clonal-antibodies>.

Second and additional doses - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided.

Inpatient and Outpatient Hospital Services - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. Vaccine administration rates are paid in addition to the Diagnosis Related Group (DRG) reimbursement when the vaccine is administered in conjunction with an inpatient or outpatient hospital visit.

Physician Services - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. These vaccine administration rates are reimbursed separately from and in addition to reimbursement for a comprehensive office visit.

Nursing Facilities - In cases where a vaccine administration fee schedule/rate amount is applicable, COVID-19 vaccine administration will be paid at the national Medicare rate(s), without further geographic adjustment, in effect at the time the service is provided. Payment for vaccine dose administration in nursing facilities is billed through the contracted pharmacy as provider type 60.

The state's fee schedule is the same for all governmental and private providers.

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Indian health service facilities and tribal 638 facilities.

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- The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

Payment for vaccine dose administration through Indian health service facilities and tribal 638 facilities is the All-Inclusive Rate (AIR).

- The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.
- The state's rate is as follows and the state's fee schedule is published in the following location:

Code: 99401
Name: PREVENTIVE MED COUNSEL/RISK INTERVNT INDIV; 15 MIN
Charge Factor: \$37.75
<https://health.utah.gov/stplan/lookup/CoverageLookup.php>

PRA Disclosure Statement 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 unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour 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 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

The state assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

Over-the-counter tests are limited to eight tests per member per month. This limit may be exceeded through a prior authorization.

Applies to the state’s approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

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Reimbursement

___ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

Utah State Plan Section 7 (7.5) Medicaid Disaster Relief for the COVID-19 National Emergency

The state is establishing rates for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

Medicare national average, OR

___ Associated geographically adjusted rate.

___ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the Medicare national average, except for home testing. Payment for COVID-19 home testing follows the lesser of reimbursement logic described in ATTACHMENT 4.19-B, Page 19.

___ The state's fee schedule is the same for all governmental and private providers.

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The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Payment for COVID-19 testing through Indian health service/638 facilities is the All-Inclusive Rate (AIR). For tribal FQHCs, this reimbursement at the AIR for COVID-19 testing is an alternative payment methodology which must pay at least PPS and all providers must agree to receive it.

Additional Information (Optional):

___The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement 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 unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour 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 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021, and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

The state assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional)

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

The state assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

The state has established payment rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies), in accordance with federal statute and ATTACHMENT 4.19-A and 4.19-B of the Medicaid State Plan. Payment rates can be found at <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>

The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

Payment for COVID-19 monoclonal antibodies and their administration is at the national Medicare rate without further geographic adjustment.

The state's rates or fee schedule is the same for all governmental and private providers.

The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Payment for treatment through Indian Health Service facilities is the All-Inclusive Rate (AIR). For tribal FQHCs, this reimbursement at the AIR for COVID-19 treatment is an alternative payment methodology which must pay at least PPS and all providers must agree to receive it.

Additional Information (Optional):

PRA Disclosure Statement 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 unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour 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 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Section 7 – General Provisions
7.5. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

1. The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:
 - a. SPA submission requirements – the agency requests modification of the requirement to submit this SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
 - b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).
 - c. Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Utah Medicaid state plan, as described below:

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This SPA is in addition to all previously-approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

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State/Territory: UTAH

Section A – Eligibility

1. ____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. ____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. ____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. ____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. ____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

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4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

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4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
 - a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
 - a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

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Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

State is requesting to waive signature requirements for the dispensing of drugs during the public health emergency, with the exception of Controlled Schedule 2 (CII) prescriptions.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

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8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

- b. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. ____ The agency increases payment rates for the following services:

Please list all that apply.

- a. ____ Payment increases are targeted based on the following criteria:

Please describe criteria.

- b. Payments are increased through:

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- i. _____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

- ii. _____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
- a. _____ The individual's total income
 - b. _____ 300 percent of the SSI federal benefit rate
 - c. _____ Other reasonable amount: _____
2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

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Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

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