DMHF SPA Matrix 1-19-23

SPA Summary	Public Notice Date	Proposed Effective Date	Target Date or Date Submitted to CMS	CMS Approval Date	CMS Approved Effective Date	MCAC Present Date
UT-23-0001 ARPA and HCBS Funding; This amendment clarifies American Rescue Plan Act payments and supplemental payments for home and community-based services for the public health emergency period.	**1-22-23**	**4-1-22**	**1-31-23**			**1-19-23**
UT-23-0002 Targeted Case Management; This amendment removes unnecessary pages from the state plan.	**1-22-23**	**2-1-23**	**2-28-23**			**1-19-23**
UT-23-0003 PHE Signature Waiver; This amendment waives signature requirements for the dispensing of drugs during the public health emergency period.	**N/A**	**3-1-20**	**1-31-23**			**1-19-23**
UT-23-0004 Self-Administered Contraceptive Reimbursement; Medicaid will reimburse up to $20 for pharmacy services required to dispense via standing order or prescribe self-administered hormonal contraceptives, for one annual consultation fee per patient per year. This reimbursement is provided by including an appropriate diagnosis code with the claim for self-administered contraceptive.	**12-25-22**	**1-1-23**	**2-28-23**			**1-19-23**
UT-23-0005 Value-Based Agreements; This amendment facilitates the creation of value-based agreements between the state and pharmaceutical manufacturers, and allows the state to negotiate these agreements in an effort to mitigate the cost of very high-cost pharmaceuticals.	**12-25-22**	**1-1-23**	**2-28-23**			**1-19-23**

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:

Not applicable.

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 this SPA by June 30~~March 31~~, 202~~0~~2, to obtain a SPA effective date of April 1, 2022~~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:

Modification of tribal consultation requirements were approved under an 1135 waiver dated April 10, 2020.

1. During the period of available enhanced ARPA funding, April 1, 2021, through March 31, 2023~~3~~5, 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.~~c. Personal Care Services
    ~~e.~~d. School Based Services
    ~~f.~~e. Rehabilitative Services - Behavioral Health Services
    ~~g.~~f. 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~~2025
        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. Any provider with a negative quarterly paid amount will be excluded from this calculation.

        ~~Effective July 1, 2022, for DSPD claims, the quarterly payments will equal 4.19 percent of the claims (fee for service based on paid 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 $4.19. The exact timing of payments may vary; however, the payments will be based on the example noted. Any provider with a negative quarterly paid amount will be excluded from this calculation.~~

iii. For the final quarter ending March 20242025, any remaining enhanced matched funding ~~any remaining funds~~ available and allowable for expenditure will be paid out to participating providers at a formula driven percentage proportion rate determined by proration of ~~total~~ participation in the program and the above base percentage amounts.

~~ii. Claims for q ending march is denominator numerator is available monies that qtrs. Paid claims what did CMS call that enhanced 10% and use that above check the rule maybe.~~

~~iii.~~iv. 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:

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:

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 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.

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.

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):

   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.

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.

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:

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:

   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

~~LICENSED CERTIFIED REGISTERED NURSE-MIDWIFE~~LICENSED PHARMACIST SERVICES

Payments for cognitive services provided by a licensed pharmacist are based on rates established in the ~~State Medicaid Manual~~Utah Medicaid Pharmacy Services Provider Manual at https://medicaid-manuals.dhhs.utah.gov/#t=Pharmacy%2Fpharmacy_Services.htm.

~~the established fee schedule for selected HCPCS codes unless a lower amount is billed. Selected HCPCS codes are established in compliance with HIPAA requirements. The amount billed cannot exceed usual and customary charges to private-pay patients. Payment for registered nurse-midwife services includes the physician's collaboration fee for the co-management of the case.~~

~~Rate Adjustment for Rural Areas~~

~~Effective October 1, 1991, licensed certified registered nurse-midwives who provide services in rural areas of the State will be paid the lower of usual and customary charges or rate equal to 112% of the established Medicaid fee schedule. Rural areas are defined as areas of the State outside of Weber, Davis, Salt Lake and Utah counties.~~

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PRESCRIBED DRUG SERVICES

LIMITATIONS

7. The State is in compliance with Section 1927 of the Social Security Act. The State will cover drugs of manufacturers participating in the federal rebate program. The State is in compliance with reporting requirements for utilization and restriction to coverage based on the requirements for Section 1927 of the Act. The State has the following policies for the supplemental rebate program for the Medicaid population:

a. ~~a.~~ The State maintains, and updates periodically, a version of the rebate entitled 'Supplemental Rebate Agreement between the State and the drug manufacturer for drugs provided to the Medicaid population and the Sovereign States Drug Consortium Addendum to Member States Agreements'.

b. The State may enter into value-based contracts with manufacturers on a voluntary basis. These contracts will be executed on the model agreement entitled "Value-Based Supplemental Rebate Agreement" submitted to CMS on TBD and authorized for use beginning TBD.

~~b~~c. Pursuant to 42 USC 1396r-8, the State has established a preferred drug list (PDL) with non-preferred drugs identified. The PDL program shall negotiate drug discounts, rebates, or benefits for the Medicaid program.

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