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State/Territory Name: Utah

State Plan Amendment (SPA) #: UT-17-0018

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

June 1, 2017

Nathan Checketts, Medicaid Director
Utah Department of Health
P.O. Box 141000
Salt Lake City, UT 84114-1000

RE: Utah #17-0018

Dear Mr. Checketts:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 17-0018. This State Plan Amendment corrects the State Funds amount on the page because the original amount erroneously reflected the Total Funds amount.

Please be informed that this State Plan Amendment was approved today with an effective date of April 1, 2017. We are enclosing the CMS-179 and the amended plan page(s).

If you have any questions concerning this amendment, please contact Mandy Strom at (303) 844-7068.

Sincerely,

[redacted]

Richard C. Allen
Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: John Curless, UT
Craig Devashrayee, UT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTHCARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
OR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 17-0018-UT
2. STATE: Utah
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTHCARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2017

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.100

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $0
b. FFY 2018 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Page 13a of ATTACHMENT 4.19-B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Page 13a of ATTACHMENT 4.19-B

10. SUBJECT OF AMENDMENT: Pediatric Dental Supplemental Payments

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Joseph K. Miner, M.D.

14. TITLE: Executive Director, Utah Department of Health

15. DATE SUBMITTED: June 1, 2017

16. RETURN TO:
Craig Devashrayee, Manager
Technical Writing Unit
Utah Department of Heath
PO Box 143102
Salt Lake City, UT 84114-3102

17. DATE RECEIVED:
June 1, 2017

18. DATE APPROVED:
June 1, 2017

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2017

20. [redacted] OFFICIAL:
[redacted]

21. TYPED NAME:
Richard C. Allen

22. TITLE:
ARA, DMCHO

PLAN APPROVED – ONE COPY ATTACHED

23. REMARKS

M. DENTAL SERVICES AND DENTURES (Cont.)

Supplemental Payments

These supplemental payments will be calculated each year by using State Funds equal to $206,150. That amount will be used to generate additional matching Federal Funds. The State Funds and the matching Federal Funds combined will equal the Total Amount that will be distributed. The matching Federal Funds will be determined by the FMAP Rate for the then current period. The calculation for the matching Federal Funds = (State Funds Amount / (1 – FMAP Rate) X FMAP Rate).

Supplemental payments will be distributed annually, typically between April 1 and June 30, in accordance with the calculated distribution amounts. The first payment will be made in June 2017.

The supplemental payment pool is distributed based upon the proportion each then currently enrolled pediatric dental care provider received in Medicaid paid claims from the previous April 1 through March 31 period (period of interest). The supplemental payment will be based on a provider's percentage of total Medicaid reimbursement to pediatric dental providers in the period of interest. The following example is for illustrative purposes only:

Supplemental Payment Pool:			$100.00
Pediatric Dental Provider	**Paid Claims in Period of Interest**	**Proportion**	**Supplemental Payment**
A	$1,000	66.7%	$66.67
B	$300	20.0%	$20.00
C	$200	13.3%	$13.33
Total	$1,500	100.0%	$100.00