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## **Table of Contents**

**State/Territory Name: Utah**

**State Plan Amendment (SPA) #: 18-0008**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) 179
- 3) Approved SPA Pages

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



**REGION VIII - DENVER**

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October 30, 2018

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

Dear Mr. Checketts:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number (TN) 18-0008. This State Plan Amendment bases pediatric dental fees on total funds rather than state general funds. It also clarifies the state's policy to consider only claims for children who are under 12 years of age.

Please be informed that this State Plan Amendment was approved today with an effective date of January 1, 2019. 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,

A solid black rectangular box used to redact the signature of Richard C. Allen.

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

cc: John Curless, UT  
Craig Devashrayee, UT

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION</b>	1. TRANSMITTAL NUMBER: 18-0008-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 January 1, 2019
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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*)

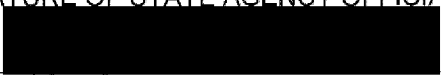
6. FEDERAL STATUTE/REGULATION CITATION:  42 CFR 440.100	7. FEDERAL BUDGET IMPACT: a. FFY 2019    \$+1,650 b. FFY 2020    \$+6,600
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Page 13a of ATTACHMENT 4.19-B	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> )  Page 13a of ATTACHMENT 4.19-B
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10. SUBJECT OF AMENDMENT: Pediatric Dental Fee for Service Supplemental

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  Craig Devashrayee, Manager Technical Writing Unit Utah Department of Health PO Box 143102 Salt Lake City, UT 84114-3102
13. TYPED NAME: Joseph K. Miner, M.D.	
14. TITLE: Executive Director, Utah Department of Health	
15. DATE SUBMITTED: September 17, 2018	
16.	
17. DATE RECEIVED:  September 17, 2018	18. DATE APPROVED:  October 30, 2018

FOR REGIONAL USE ONLY

19. EFFECTIVE DATE OF APPROVED MATERIAL:  January 1, 2019	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME:  Richard C. Allen	22. TITLE:  ARA, DMCHO

PLAN APPROVED - ONE COPY ATTACHED

3. REMARKS

M. DENTAL SERVICES AND DENTURES (Cont.)

Supplemental Payments

These supplemental payments will be calculated each year by using Total Funds equal to \$684,889.

Supplemental payments are distributed annually, typically between April 1 and June 30, in accordance with the calculated distribution amounts.

The supplemental payment pool is distributed based upon the proportion each then currently enrolled pediatric dental care provider received in Medicaid paid claims for members under 12 years of age 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
<b>Pediatric Dental Provider</b>	<b>Paid Claims in Period of Interest</b>	<b>Proportion</b>	<b>Supplemental Payment</b>
A	\$1,000	66.7%	\$66.67
B	\$300	20.0%	\$20.00
C	\$200	13.3%	\$13.33
<b>Total</b>	<b>\$1,500</b>	<b>100.0%</b>	<b>\$100.00</b>

T.N. # 18-0008

Approval Date 10/30/2018

Supersedes T.N. # 17-0018

Effective Date 1-1-19