Medicaid Accountable Base Budget August Research

Meetings Attended in Review of Medicaid Services

1. Kick Off Meeting (Accountable Base Budget: Medicaid Services this Interim) – March 29, 2024
2. Managed Care Plan meeting with Medicaid Policy Team – April 4, 2024
3. Monthly - Managed Care Plan Meeting – April 10, 2024
4. ACO/Dental PRISM Technical Check – April 11, 2024
5. CHIP Cost Sharing Check In Meeting – April 12, 2024
6. ACO Leadership Meeting – April 15, 2024
7. Risk Corridor Discussion – April 17, 2024
8. Discuss Change Healthcare Pharmacy Impacts – April 17, 2024
9. Managed Care Behavioral Health – April 17, 2024
10. CHIP Advisory Council – April 18, 2024
11. Medical Care Advisory Committee (MCAC) – April 18, 2024
12. Weekly UT 1115 Call – April 22, 2024
13. Discuss Pay for Quality Initiations – April 22, 2024
14. ACO Leadership Meeting – April 22, 2024
15. Base Budge Review Meeting (Weekly) – April 22, 2024
16. Hospital Services – April 24, 2024
17. Reports and Your Concerns for Medicaid Services (UOIG) – April 24, 2024
18. Graduate Medical Education – April 24, 2024
19. Managed Care Behavioral Health – April 24, 2024
20. Buy-in/Buy-Out – April 25, 2024
21. Behavioral Health Services – April 26, 2024
22. Accountable Care Organization – April 29, 2024
23. Base Budge Review Meeting (Weekly) – April 29, 2024
24. UMIC Meeting – May 1, 2024
25. Managed Care Behavioral Health – May 1, 2024
26. SFY2025 Quality Discussion – May 7, 2024
27. discuss process of actuarially certifying Medicaid managed care rates – May 8, 2024
28. Other Medicaid services – May 9, 2024
29. MLR discussion with the plans – May 10, 2024
30. Pharmacy carve out study – May 20, 2024
31. ACO Leadership Meeting – May 20, 2024
32. Base Budge Review Meeting (Weekly) – May 20, 2024
33. Managed Care Behavioral Health – May 22, 2024
34. Base Budge Review Meeting (Weekly) – May 30, 2024
35. ACO Leadership Meeting – June 24, 2024
36. ACO Leadership Meeting – July 22, 2024
37. Base Budge Review Meeting (Weekly) – July 22, 2024
38. ACO Leadership Meeting – July 29, 2024
39. Base Budge Review Meeting (Weekly) – July 29, 2024

From: Johnny Valdez <johnny.valdez@ncsl.org>
Sent: Thursday, April 25, 2024 3:11 PM
To: Russell Frandsen <rfrandsen@le.utah.gov>
Cc: Kathryn Costanza <kathryn.costanza@ncsl.org>
Subject: Re: States that cover Medicaid services beyond IEP plans

Hello Russell,

Thank you again for reaching out to NCSL! Below we've provided some resources to answer all of your questions:

- Overview of the "Free Care" policy
- Sources for 50-State Surveys and Detailed Policy Review
- Additional Resources

Overview of the "Free Care" Policy

Prior to 2014, CMS only permitted States to draw down federal funds for medically necessary services provided to Medicaid-enrolled students with individualized education plans or individualized family service plans (IEPs/ISFPs) in a policy known as the “free care” policy. Under the “free care” policy, States could only draw down federal funds for services within IEPs / ISFPs and could ***not*** draw down federal funds for any other Medicaid-covered item or service provided in the school setting to other students.

In 2014, CMS reversed its position on the "free care" policy, allowing states to have additional flexibility in their school-based Medicaid programs. This made federal matching funds available to States that opted to provide school-based services to any Medicaid-enrolled student, even if those services were provided by the school to all students for free. As of October 2023, at least 25 states have taken steps to expand their school Medicaid program to cover services outside of an Individualized Education Plan.

There is no federal Medicaid program definition or benefit category specific to school-based services. CMS and MAPCAC have described school-based services as:

- Any Medicaid-coverable item or service
- Provided in the school setting to children and adolescents who are Medicaid beneficiaries
- Provided by qualified Medicaid providers enrolled in the Medicaid program

Medicaid-coverable services can include a wide variety of health services, including hearing and vision screenings, mental health services or substance use disorder services.

Medicaid-qualified providers can include school-based health centers, school-employed providers, contracted community-based providers, mental health providers, or telehealth providers.

Sources for 50-State Surveys and Detailed Policy Review

The following organizations have conducted 50-state surveys and analyses of state legislation and policies creating school-based health and mental health service programs:

- Healthy Schools Campaign, State Efforts to Expand School Medicaid Through the Free Care Policy Reversal (October 2023) – This survey includes state-by-state analysis of every state that has taken action to leverage Medicaid to fund school-based services and includes links to state legislation, State Plan Amendments, legislative reports and state agency guidance.
- Healthy Students Promising Futures, Map: School Medicaid Programs - This interactive map includes detailed information about states that cover behavioral health services and providers in school settings and the types of providers covered. It also provides an Overview & Methods section that includes state data on covered services, eligibility, billing providers, nursing services and behavioral healthcare.
- School Medicaid Database (February 2023) - A text searchable collection of publicly available documents pertaining to school Medicaid programs in all 50 states and DC.
- Healthy Schools Campaign, State Medicaid & Education Standards for School Health Personnel: A 50-State Review of School Reimbursement Challenges (October 2021) – Report details findings from a 50-state survey regarding Medicaid reimbursement challenges for school-based services, including state-specific examples.

Additional Resources

Technical Assistance Center - The TAC seeks to support state Medicaid agencies in implementing their school-based services programs.

Exploring CMS' Medicaid School-Based Services Technical Assistance Center - an article with resources around the Technical Assistance Center developed by CMS and the U.S. Department of Education.

School Medicaid Fact Sheets: Details on All 50 States (2021) - 50 state snapshot of school Medicaid Programs.

Sincerely,

Johnny Valdez, MA
National Conference of State Legislatures
Policy Analyst
303.856.1380 (o) | 720.308.2595 (m)

From: Russell Frandsen <rfrandsen@le.utah.gov>
Sent: Monday, April 15, 2024 6:07 PM
To: Johnny Valdez <johnny.valdez@ncsl.org>
Subject: [EXTERNAL] RE: States that cover Medicaid services beyond IEP plans

Thanks Johnny!

From: Johnny Valdez <johnny.valdez@ncsl.org>
Sent: Monday, April 15, 2024 3:08 PM
To: Russell Frandsen <rfrandsen@le.utah.gov>
Cc: Stacy Householder <Stacy.Householder@ncsl.org>; Kathryn Costanza <kathryn.costanza@ncsl.org>
Subject: RE: States that cover Medicaid services beyond IEP plans

Hi Russell,

Thank you for reaching out with your request regarding states that cover Medicaid services beyond a student's Individualized Education Program. I am confirming receipt of this request and the Friday, May 3rd deadline.

I can provide you with information on this topic. Please let me know if you have any questions or additions!

Best,
Johnny Valdez, MA
National Conference of State Legislatures
Policy Analyst
303.856.1380 (o) | 720.308.2595 (m)

REPORT TO THE EDUCATION INTERIM COMMITTEE

Medicaid Reimbursement for School-Based Health Services

Prepared by

Utah Department of Health, Division of Medicaid and Health Financing

Utah State Board of Education

Department of Human Services, Division of Substance Abuse and Mental Health

August 15, 2019

UTAH DEPARTMENT OF HEALTH

Utah State Board of Education

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

EXECUTIVE SUMMARY

This report is submitted in response to HB 373 passed during the 2019 General Session of the Utah State Legislature. Section 62A-15-117 reads:

Medicaid reimbursement for school-based health services -- Report to Legislature.
(1) As used in this section, "individualized education program" or "IEP" means a written statement for a student with a disability that is developed, reviewed, and revised in accordance with the Individuals with Disabilities Education Act, 20 U.S.C. Sec. 1400 et seq.
(2) The division shall coordinate with the State Board of Education, the Department of Health, and stakeholders to address and develop recommendations related to:

(a) the expansion of Medicaid reimbursement for school-based health services, including how to expand Medicaid-eligible school-based services beyond the services for students with IEPs; and

(b) other areas concerning Medicaid reimbursement for school-based health services, including the time threshold for medically necessary IEP services.

(3) The division, the State Board of Education, and the Department of Health shall jointly report the recommendations described in Subsection (2) to the Education Interim Committee on or before August 15, 2019.

Medicaid Funding for Services Provided in a School Setting

Medicaid currently pays for Medicaid covered health and related services provided in schools when covered services are provided to Medicaid-enrolled children and adolescents, or when services are provided to a child through his or her individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA, P.L. 101- 476). As part of the activities necessary to administer the Medicaid State Plan, states may also provide Medicaid payments to schools for Medicaid outreach and enrollment activities, as well as other eligible, school-based administrative activities.

Medicaid funding is available to cover services for Medicaid-eligible children in a school setting. Administrative costs must be allocated between the proportions of Medicaid-eligible and non-Medicaid-eligible school children. Medicaid funding may only be used for a Medicaid covered service. Medicaid funding may not be used to cover a non-Medicaid covered service or a non-Medicaid-eligible child

How are Utah Schools Currently using Medicaid Funding?

Since 1988, states have been able to draw down federal funds under Medicaid to pay for school-based health and related services required by IDEA, when provided to Medicaid-eligible children with disabilities. Under IDEA, children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in each child's IEP, or for infants and toddlers (children under age three), the individualized family service plan (IFSP).

The Medicare Catastrophic Coverage Act of 1988, Section 411(k) (12) permits Medicaid to pay for related services included in a Medicaid-eligible recipient's IEP when the services are medically necessary and are covered in the Medicaid State Plan. Effective August 1, 1993, with the approval of the Centers for Medicare and Medicaid (CMS), Utah's Medicaid State Plan was amended to allow coverage of medically necessary services included in the IEPs of Medicaid-eligible children ages 3 through 20.

In **SFY 2018**, Utah Medicaid provided **$33,600,000** to LEAs through the School-Based Skills Development (SBSD) program. Pursuant to the Utah Medicaid State Plan, "Skills development services are medically necessary diagnostic and treatment services provided to children between the ages of 3 and 22 to improve and enhance their health and functional abilities and prevent further deterioration." Services include:

1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, communication deficits, or psycho social impairments; and

2. Information and skills training to the family to enable them to enhance the health and development of the child.

Skills development services are provided by or under the supervision of:

a. A licensed physician, registered nurse, dietician, clinical social worker, psychologist, audiologist, speech and language pathologist, occupational therapist, physical therapist, practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953); or

b. An early childhood special educator certified under Section 53E-3-501 of the Utah Code Annotated, as amended in 1953); or

c. Qualified Intellectual Disabilities professional (QIDP) as defined in 42 CFR 483.430.

Related Services are defined as developmental, corrective and other supportive services required to assist a student with a disability to benefit from special education. Not all related services identified in the Individuals with Disabilities Education Act (IDEA), Part Regulations, 34 CFR Section 300.34 are considered “medically necessary services.”

Currently, school-based skills development services are only provided to students identified by the district as requiring a minimum of 180 minutes of special education and related services (in combination) per day. (Preschool students meet this requirement based on the need for special education services.) Local education agencies (LEAs) provide the required state matching funds through an intergovernmental transfer (IGT) to draw down federal Medicaid funds. Additional information regarding the School-Based Skills Development program is in the Utah Medicaid Provider Manual for the School-Based Skills Development program at: https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/School-Based%20Skills%20Development/School-BasedSkillsDev10-14.pdf

How do Schools Receive Medicaid Funding?

Schools are reimbursed based on a daily bundled rate. Itinerant nursing services are billed on claims submitted directly to Medicaid. Medicaid’s payments to the LEA are subject to reconciliation by the Medicaid agency to determine the provider’s actual allowable costs and establish final payment.

The following information is used to determine a provider’s actual allowable costs:

1. The specific skills development service(s) the provider intends to cover under Medicaid;

2. The names, total annual salary and benefits of all individuals who will directly supervise and/or deliver the covered service(s) (see item C. below); and

3. The total number of Medicaid-eligible and non-Medicaid-eligible students classified as self-contained (those receiving 180 minutes of special education and related services per day).

Time studies are used to determine the time spent by qualified individuals (those identified in 2 above) in covered and non-covered activities. Providers oversee and ensure that, during the time study reporting period, time study participants appropriately document their time in 15-minute increments. Rates for self-contained services may not exceed the provider costs to deliver such services. Rates for itinerant nursing services are based on the Medicaid agencies approved fee schedule for equivalent services.

Claiming Medicaid Match for Administrative Costs

Schools also can receive Medicaid funding for qualifying school-based administrative activities that are considered necessary for the proper and efficient administration of the Medicaid State Plan (CMS 2003). School-based administrative activities generally fall into two categories: outreach and enrollment, and efforts that support the provision of Medicaid-eligible services. Schools can receive federal matching funds for outreach to potentially eligible children and families and for making enrollment determinations, if this function is delegated to the schools by the state Medicaid agency.

Schools also can draw down federal funds for activities that can facilitate children's access to care, including care coordination, referrals, and transportation to and from school on a day a child receives a Medicaid-covered service. For example, some school staff coordinate care for children between the school and other public agencies (such as a state disability services agency) or health care provider. If a child's IEP includes transportation to and from Medicaid-eligible services, then the school is required to provide it and related costs can be claimed as administration or medical assistance. In FY 2018, estimated spending for Medicaid administrative services was $1.2 million. USBE or LEAs also have an option to seek reimbursement from Medicaid for performing administrative activities that directly support the Medicaid program. To do so, an appropriate claiming mechanism must be used. The time study is the primary mechanism for identifying and categorizing Medicaid administrative activities performed by school or school district employees.

To the extent that school employees perform administrative activities that are in support of the state Medicaid plan, federal reimbursement may be available.

The Centers for Medicare and Medicaid provides guidance to states in the Medicaid School Based Claiming Guide at https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/2003-sbs-admin-claiming-guide.pdf.

Medicaid Qualified Providers

In order for schools and practitioners to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the applicable Medicaid provider qualifications and the requirements in 42 C.F.R. § 431.107, including having a provider agreement and a Medicaid provider identification number. Practitioners in schools are also subject to the screening and national provider identification (NPI) requirements in section 1866(j)(2) of the Act and 42 C.F.R. § 455.400 – 455.470. Rendering providers must meet the screening requirements and claims must include the NPI of the physician or other professional who ordered or referred such items or services. Finally, practitioners who furnish services in school settings must meet applicable qualifications established by the state and those qualifications must minimally be the same as those providers who furnish services in other settings in the community

LEAs Must Provide the State Match to Draw Down Medicaid Funds

Providing additional Medicaid funding for the School-Based Skills Development (SBSD) program will require compliance with Section 26-18-21(3) which states:

> The department [UDOH] shall not create a new intergovernmental transfer program after July 1, 2017, unless the department reports to the Executive Appropriations Committee, in accordance with Section 63J-5-206, before submitting the new intergovernmental transfer program for federal approval. The report shall include information required by Subsection 63J-5-102(1)(d) and the analysis required in Subsections (2)(a) and (b).

Recommendations to Increase Medicaid Funding for the SBSD Program

- **Adopt a cost-based reimbursement methodology for LEAs**

The Utah Department of Health is exploring implementation of a cost-based reimbursement methodology for the SBSD program. This methodology will result in increased reimbursement to LEAs. However, the increased reimbursement will require additional match from LEAs.

The overwhelming majority of state Medicaid programs reimburse school-based services using a reconciled cost methodology. Under this method, each LEA uses a cost reporting system to compile and aggregate the costs of providing the services, usually on a quarterly or annual basis.

These costs are then allocated between services that were provided to Medicaid-enrolled students and those that were provided to non-Medicaid-enrolled students. This effort not only requires direct service providers working in schools to maintain

appropriately comprehensive clinical records to support the reported expenditures, but also requires that LEAs maintain sufficient cost data and service utilization documentation to facilitate an accurate allocation of cost to Medicaid consistent with federal cost principles. Schools are strongly encouraged to work with their state's Medicaid program staff and CMS staff to develop an appropriate cost identification and allocation methodology that meets federal requirements. It must also be noted that even though individual claims for services are not submitted to the Medicaid agency in order to request payment, CMS requires that the Medicaid program use its Medicaid Management Information System to record all school-based services. This record is to assure services are documented at the individual level and to provide information necessary to assess the economy and efficiency of the payments. In addition, LEAs must follow documentation standards in their records or Medicaid payments may be disallowed.

- **Remove the requirement for a minimum of 180 minutes per day of combined special education and related services for children age 3-22**

Currently Medicaid only reimburses for children who have at least 180 minutes in the special classroom placement. This is the criteria for Level C children adopted by the USBE and Medicaid at the onset of the SBSD program. The number of children whose services would be eligible for Medicaid reimbursement by removing this minimum requirement would increase. This change will require additional state match from the LEAs.

Behavioral Health Services for Medicaid-Eligible Children in School Settings

A recent joint guidance letter released by Elinore McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, and Calder Lynch, Acting Deputy Administrator and Director Center for Medicaid and CHIP Services, stated the following:

> There is an urgent need to identify children and adolescents who have or are at risk for mental disorders, including SUDs [substance use disorder], and connect these children and adolescents with other services they need. Schools can fill a critical role in both identifying such children and adolescents and connecting them with treatment and other services they need. An estimated ten percent of children and adolescents in the United States have a serious emotional disturbance (SED), yet approximately 80 percent of those children and adolescents with an SED do not receive needed services. Approximately 80 percent of children and adolescents with mental health diagnoses have unmet mental health needs.
>
> Substance use rates among adolescents remain concerning, with over 16 percent of adolescents ages 12 to 17 reporting illicit drug use during 2017,

> and more than 31 percent of adolescents endorsing use of tobacco or alcohol during the same timeframe. Further, during 2017, four percent of 12 to 17 year olds met criteria for a substance use disorder, with 82.5 percent of those adolescents not receiving needed care.
>
> (see https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf)

In Utah, all Medicaid-eligible children are enrolled in a Prepaid Mental Health Plan (PMHP) for mental health and substance use disorder services. The UDOH contracts with the local mental health and substance abuse authorities to create full-risk managed care plans to provide behavioral health services. According to the Division of Substance Abuse and Mental Health School Behavioral Health Services Implementation Manual, "most of the school behavioral health programs in Utah are supported by collaborations at the local level." Local authorities provide the majority of behavioral health services in some schools, and they are currently reimbursed through prepaid mental health contracts to provide services to Medicaid-eligible children.

Recommendations for Behavioral Health Services:

1. If Medicaid-covered behavioral health services, not available through the PMHP, are provided by behavioral health providers, contracted with or employed by the LEA, federal Medicaid funds can be claimed for additional services. However, this provision will require LEAs to provide the additional state match to draw down additional federal funds or an additional appropriation to the Medicaid program to pay for additional behavioral health services.

2. Amend the School-Based Medicaid Program to include "Free Care" as per 12/15/14 letter from CMS to State Medicaid Directors. This change would allow local school districts to receive Medicaid reimbursement funds for allowable services provided to students who do not have an IEP. Districts would need to provide the additional state match to draw down these funds.

Providing Additional Physical Health Services for Medicaid-Eligible Children in School Settings

School-based health centers (SBHCs) provide a variety of health services beyond the first aid treatment provided by a school nurse. Such services may include preventive care (e.g., immunizations), oral health care, behavioral health care, and diagnostic care such as routine screenings (HRSA 2017). They also may provide acute care services, such as treatment for asthma (HRSA 2017).

Some school systems directly employ health professionals to provide these services. Other schools partner with community organizations, health systems, etc. to established

school-based health centers to provide health care services to students (HRSA 2017, SBHA 2017).

According to the 2016–2017 National School-Based Health Care Census, Utah had five school-based health centers:

Sponsor Name	School-Based Health Care Program Name	School-Based Health Care Program City	Operational Status
Intermountain Health Care	IHC Rose Park Family Health Center	Salt Lake City	Open
Intermountain Health Care	Pamela J Atkinson Family Health Center	Salt Lake City	Open
Intermountain Health Care	Intermountain Dixon Health Center	Provo	Open
Southwest Utah Community Health Center	Hurricane Middle School SBHC	Hurricane	Open
Southwest Utah Community Health Center	Family Healthcare	St. George	Open

SBHCs can receive Medicaid payment for Medicaid covered services provided to Medicaid-enrolled children, if the health center is enrolled as a Medicaid provider. In Utah, enrollment in an Accountable Care Organization (ACO) is required in nine counties. In managed care delivery systems, SBHCs can contract with managed care organizations (ACOs) to be included in their provider networks. The majority of Medicaid covered services in all remaining counties are reimbursed on a fee-for-service basis directly by Medicaid.

The chart on the following page shows which in which counties Medicaid requires enrollment in an ACO and which counties are fee-for-service.

Available Health Plans by County					
County	**Steward Health Choice Utah**	**Healthy U**	**Molina**	**Select Health Community Care**	**Fee for Service (FFS) Network**
Website:	healthchoiceut.com	uhealthplan.utah.edu	molinahealthcare.com	selecthealth.org	medicaid.utah.gov
Beaver	•	•	•	•	•
Box Elder	•	•	•	•	
Cache	•	•	•	•	
Carbon		•	•	•	•
Daggett		•	•	•	•
Davis	•	•	•	•	
Duchesne		•	•	•	•
Emery		•	•	•	•
Garfield		•	•	•	•
Grand		•	•	•	•
Iron	•	•	•	•	
Juab	•	•	•	•	•
Kane		•	•	•	•
Millard	•	•	•	•	•
Morgan	•	•	•	•	
Piute		•	•	•	•
Rich	•	•	•	•	
Salt Lake	•	•	•	•	
San Juan		•	•	•	•
Sanpete	•	•	•	•	•
Sevier	•	•	•	•	•
Summit	•	•	•	•	
Tooele	•	•	•	•	
Uintah		•	•	•	•
Utah	•	•	•	•	
Wasatch	•	•	•	•	
Washington	•	•	•	•	
Wayne		•	•	•	•
Weber	•	•	•	•	
Purple-back ground *must* have a health plan. Not highlighted can choose a health plan or use FFS					

Recommendations for Physical Health Services:

- UDOH will coordinate with the ACOs regarding payment for Medicaid covered services that are provided by SBHCs.

- USBE and LEAs will reach out to SBHCs to encourage them to enroll as Medicaid providers and to enroll with Medicaid ACOs.

- UDOH, USBE, DHS and LEAs will continue to work together to implement each of these recommendations.

HEALTHY SCHOOLS CAMPAIGN

Healthy Students, Promising Futures

State Efforts to Expand School Medicaid

Last Updated: March 2024

To address the physical and mental health needs of students, Medicaid will reimburse for the services delivered to ***all*** Medicaid-enrolled students in a school-based setting.

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a state Medicaid director letter reversing the long-standing "free care" policy. This change allows states more flexibility in their school-based Medicaid programs by allowing school districts to bill Medicaid for health services delivered to all Medicaid-enrolled children, not just those with a special education plan documented by an Individualized Education Program (IEP).

This commitment was reinforced in an August 2020 CMS Informational Bulletin: *CMS encourages states to promote the use of schools as a setting in which to provide Medicaid-enrolled children and adolescents with medically necessary Medicaid-covered services.*

In May 2023, CMS released two new documents to guide state decision-making on expanding school Medicaid, as well as provide new options and flexibilities for implementation:

- Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming - clarifies and consolidates CMS guidance on how to meet federal statutory and regulatory requirements and provides direction to state Medicaid agencies and school districts on increasing access to covered services for enrolled students.
- Information on School-Based Services in Medicaid: Policy Flexibilities and Guide on Coverage, Billing Reimbursement, Documentation and School-Based Administrative Claiming - introduces and summarizes the Guide (above) and emphasizes the critical role schools play in promoting the health of students.

With the release of these additional guidance documents, there is no longer any ambiguity: **CMS allows states to make Medicaid reimbursement available for all medically necessary Medicaid-covered services that are provided to *all* Medicaid beneficiaries.**

Additional school Medicaid information is available in Healthy Schools Campaign's
Guide to Expanding Medicaid-Funded School Health Services
and via the Healthy Students, Promising Futures (HSPF) website
and HSPF Learning Collaborative

This is an important opportunity to bring in additional resources to expand access to health services. Early estimates suggest that it is a significant source of new funding for schools. And, as school districts consider how to meet increased demand for mental health services, policymakers are considering every option to build capacity at the state and local levels.

States have pursued different opportunities to strengthen their school Medicaid programs and expand reimbursement for school health services. The chart below outlines some of the known actions to expand coverage for school Medicaid services and to implement the "free care" policy reversal. The actions needed may differ state by state as outlined in a 2020 National Health Law Program (NHELP) review of Medicaid state plans and state Medicaid managed contracts.

As advocates, we continue to work with an array of stakeholders to ensure that children are healthy and ready to learn. Some of the information in this state activity tracker is based on informal conversations with policymakers and advocates.

If you are interested in learning more about the specific school health providers and services covered in your state, view this interactive map. Please reach out to us to learn more and share your experiences.

Jessie Mandle, HSC National Program Director
& Lena O'Rourke, on behalf of Healthy Schools Campaign

Shortened link for this document: http://bit.ly/freecareupdate

Overview of Activity

Type of Activity	States
CMS-approved SPA to expand coverage to all Medicaid-enrolled students	Arizona; California; Connecticut; Colorado; Florida; Georgia**; Illinois; Indiana; Kentucky; Louisiana; Massachusetts; Michigan; Nevada; New Mexico; North Carolina; Oregon
Expanded school-based Medicaid to all Medicaid-enrolled students (no SPA needed).	Arkansas; Minnesota, Missouri+, New Hampshire; North Dakota; South Carolina; Tennessee
SPA submitted to CMS to expand coverage to all Medicaid-enrolled students and pending approval	Virginia
Directed by legislature to expand coverage to all Medicaid-enrolled students	Indiana; New Jersey
Passed legislation related to expanding school Medicaid services	California°; Florida*; New Hampshire; Oregon; Utah°; Virginia
Covers services outside the IEP through partnerships between schools and managed care	Washington
Other opportunities for Medicaid reimbursement in school-based settings	Oklahoma

** Georgia's SPA expands coverage to school nursing services outside of an IEP.

° Legislation is not required in Massachusetts, California and Utah to implement reversal of the "free care" policy; these states took/are taking legislative action for additional reasons. See chart below for details.

+ Arkansas and Missouri cover only certain behavioral health services outside of an IEP.

State Specific Updates

Arkansas

Bottom Line
Arkansas expanded its school Medicaid program to cover mental health services delivered to all Medicaid-enrolled students.

Policy Highlights
Arkansas provider manual allows coverage of up to 10 therapeutic sessions for all Medicaid-enrolled students before a primary care physician referral is required.

Action Taken to Expand School Medicaid
- No SPA needed

State Resources
- Medicaid in the Schools - Department of Education
- Direct Billing: School-Based Mental Health - Department of Education
- School-Based Mental Health - Department of Human Services

Arizona

Bottom Line
Arizona expanded its school Medicaid program to cover all medically necessary services identified in a 504 plan, other individualized health or behavioral health plan, or where medical necessity has otherwise established.

Policy Highlights
With this policy change, reimbursable services must be identified as medically necessary and can include: speech-language pathology services, occupational therapy services, physical therapy services, nursing services, specialized transportation services, behavioral health services, personal care services, audiological services and physician services.

Action Taken to Expand School Medicaid
- Submitted two SPAs to CMS in 2021
- SPAs approved in 2021 (expansion) and October 2021 (reimbursement methodology)

State Resources
- SPA approval letter from CMS (school Medicaid expansion)
- SPA approval letter from CMS (update reimbursement methodology)
- SPA submission
- Arizona Medicaid state plan amendments - search 2021 amendments

California

Bottom Line
California expanded its school Medicaid program to cover all Medicaid-enrolled students. The state added a specific set of benefits, including a wide range of physical, behavioral and mental health services, by expanding the definition of "LEA services" under the EPSDT section of the state plan.

Policy Highlights
California passed legislation in 2015 to expand Medicaid reimbursement. The state submitted a SPA in 2015 to expand the scope of services and types of eligible providers covered in schools, and to allow reimbursement for all Medicaid-enrolled students.

Additional services include respiratory therapy, personal care services, and orientation and mobility assessment. New provider types include registered associate clinical social workers, personal care assistants, and licensed occupational and physical therapy assistants, among others.

The SPA also revises the payment methodology from fee-for-service to Random Moment Time Study (RMTS).

Action Taken to Expand School Medicaid
- Legislation passed in 2015
- Submitted SPA to CMS in 2015
- SPA approved in 2020

State Resources
- SPA approval letter from CMS
- Bill text: SB 276
- Local Educational Agency Medi-Cal Billing Option Program: Onboarding Handbook - Department of Health Care Services (DHCS)
- LEA Medi-Cal Billing Option Program: Implementation Training - DHCS
- Local Educational Agency Medi-Cal Billing Option Program Provider Manual - DHCS

Other Resources
- Expansion of School-Based Health Services in California: An Opportunity for More Trauma-Informed Care for Children - Futures Without Violence and Healthy Schools Campaign

Colorado

Bottom Line
Colorado expanded its school Medicaid program to cover all medically necessary services delivered to all Medicaid-enrolled students and added licensed school psychologists as qualified providers.

Policy Highlights

Colorado conducted a six-week expansion study with eight participating school districts. The study was based on a time study that looked at multiple factors, including Medicaid eligibility, time study response and notification time, and existing allowable providers as well as potential eligible provider groups.

Based on the results of the expansion study, the state moved forward with submitting a SPA in 2019, followed by a second SPA in 2021 to add licensed school psychologists.

Action Taken to Expand School Medicaid

- Conducted RMTS expansion study January-February 2019
- Submitted SPA to CMS in 2019 to expand school Medicaid
- SPA approved in 2020
- Submitted SPA to CMS in 2021 to add licensed school psychologists
- SPA approved in 2022

State Resources

- SPA approval letter from CMS (school Medicaid expansion)
- SPA approval letter from CMS (licensed school psychologists)
- School Health Services Program Manual: Covered Services - School Health Services Program (a joint effort between the Colorado Department of Education and Department of Health Care Policy and Financing)
- Training: School Health Services Program Free Care Plans of Care - Department of Health Care Policy and Financing

Other Resources

- Case Study: Understanding the Financial Impact of Expanding Medicaid Funded School Health Services in Colorado - Healthy Schools Campaign

Connecticut

Bottom Line

Connecticut expanded its School Based Child Health (SBCH) Medicaid program to include health services in a student's 504 plan and to add coverage of certain services.

Policy Highlights

In addition to expanding coverage to 504 plans, Connecticut added behavior modification services for students on the autism spectrum and personal care services.

Action Taken to Expand School Medicaid

- Submitted SPA to CMS in 2016
- SPA approved in 2017

State Resources

- SPA approval letter from CMS
- Medicaid School Based Child Health: User Guide - Department of Social Services

Florida

Bottom Line
Florida expanded its school Medicaid program to cover all medically necessary services delivered to all Medicaid-enrolled students. In addition to removing the IEP restriction, the SPA allows charter and private schools to bill Medicaid for services delivered to all Medicaid-enrolled students.

Policy Highlights
CMS' approval of Florida's SPA in 2017 set the stage for expansion to all Medicaid-enrolled students. However, the IEP restriction was codified in state statute. Florida passed legislation in June 2020 removing this language and allowing for implementation.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2016
- SPA approved in 2017
- Legislation passed in 2020

State Resources
- SPA approval letter from CMS
- Bill text: HB 81

Other Resources
- Medicaid Changes Provide New Opportunities to Access Millions More in Federal Dollars to Expand School-Based Health Services in Florida - Florida Policy Institute

Georgia

Bottom Line
Georgia expanded its school Medicaid program to cover school nursing services delivered to all Medicaid-enrolled students.

Policy Highlights
The SPA removes the IEP requirement for school nursing services and also revises the payment methodology from fee-for-service to Random Moment Time Study (RMTS).

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2017
- SPA approved in 2021

State Resources
- SPA approval letter from CMS

Other Resources
- POLICIES AND PROCEDURES for CHILDREN'S INTERVENTION SCHOOL SERVICES (Revised school Medicaid billing manual; January 2024). Georgia Department of Community Health, Division of Medicaid
- Medicaid and CHIP in Schools: Promoting Student Health Access, Coverage and Insurance Literacy - Voices for Georgia's Children

Illinois

Bottom Line
Illinois expanded its school Medicaid program to cover all medically necessary services allowed under the state's comprehensive EPSDT benefit provided to all students enrolled in Medicaid. Eligible services can be documented in a student's 504 plan, Individualized Health Care Plan (IHCP), or by other methods, such as a doctor's order.

Policy Highlights
In addition to removing the IEP restriction, Illinois updated its list of healthcare provider types permitted to bill Medicaid for providing services within a school setting. The list now includes school psychologists, licensed clinical professional counselors, and licensed marriage and family therapists.

The SPA expands fee-for-service (FFS) claiming outside of IEP/IFSP services to any Medicaid-enrolled student and transitions the state's reimbursement methodology to a cost settlement model.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2021
- SPA approved in 2023

State Resources
- SPA approval letter from CMS / CMS press release
- Illinois Medicaid School-Based Health Services (SBHS) Program Changes / Frequently Asked Questions: School Health and Mental Health Service Providers - State Board of Education
- Program Announcement: Expanded Medicaid Reimbursement for School Districts Providing Physical and Behavioral Health Services for Students - Department of Healthcare and Family Services

Other Resources
- Illinois Receives Federal Approval to Expand Access to School Health Services, Ensuring More Funding for Schools and Kids - Healthy Schools Campaign
- Background and Additional Details about Illinois Department of Healthcare and Family Service Public Notice: School-Based Health Services Reimbursement Methodology - Healthy Schools Campaign

Indiana

Bottom Line
Indiana expanded its school Medicaid program to cover medically necessary school nursing services for students with 504 plans, psychologist testing services, and school-based transportation for qualified Medicaid-enrolled children.

Policy Highlights
In 2021, Indiana passed legislation requiring the state Medicaid agency to submit a SPA to remove the IEP restriction and to allow school psychologists to refer for services.

In addition, school psychologist testing services covered by a range of providers are reimbursable when they are medically necessary and required to determine the health-related services a school shall provide under an educational program or plan as required by IDEA or Section 504.

Action Taken to Expand School Medicaid
- Legislation passed in 2021
- Submitted SPA to CMS in 2023
- SPA approved in 2023

State Resources
- SPA approval letter from CMS
- Bill text: HB 1405

Kentucky

Bottom Line
Kentucky expanded its school Medicaid program to cover medically necessary services provided to all Medicaid-enrolled students. The state's technical assistance guide clarifies that all medically necessary services are covered.

Policy Highlights
The SPA removed the "services included in an IEP only" restriction. A second SPA covered changing from fee-for-service (FFS) reimbursement to a cost reimbursement methodology.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2019 to remove IEP restriction
- SPA approved in 2019
- Submitted SPA in 2020 to implement cost reimbursement methodology
- SPA approved in 2021

State Resources
- SPA approval letter from CMS (school Medicaid expansion)
  - Cabinet for Health and Family Services press release
- SPA approval letter from CMS (cost reimbursement methodology)
  - Notice of intent to submit SPA on cost reimbursement methodology
- Kentucky School Based Services Technical Assistance Guide - Department for Medicaid Services in collaboration with the Department of Education
- Medicaid Letter to Superintendents - Department of Education

Other Resources
- Kentucky Medicaid plan amendment to provide increased access to health services for students - Northern Kentucky Tribune

- Schools can get new Medicaid money for both physical and behavioral health - Kentucky Health News

Louisiana

Bottom Line
Louisiana expanded its school Medicaid program to cover all medically necessary EPSDT services delivered to all Medicaid-enrolled students.

Policy Highlights
The 2015 SPA allows school districts to bill for school-based nursing services delivered to all Medicaid-enrolled students. The 2020 SPA allows school districts to bill for all medically necessary services delivered to all Medicaid-enrolled students.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2015 to expand reimbursement for school nursing services
- SPA approved in 2015
- Submitted SPA to CMS in 2019 to expand reimbursement for all medically necessary services
- SPA approved in 2020

State Resources
- SPA approval letter from CMS (school nursing services)
- SPA approval letter from CMS (all medically necessary services)
    - State Plan Redlined Pages
    - CMS Response
- School-Based Medicaid Services - Department of Education

Massachusetts

Bottom Line
Massachusetts expanded its school Medicaid program to cover an expanded list of health services provided to all Medicaid-enrolled students. The services are a comprehensive but defined benefit package.

Policy Highlights
Massachusetts expanded services covered in a school-based setting to include speech-language pathology, occupational therapy and physical therapy; mental and behavioral health services; skilled nursing services; audiology services; personal care services; medical nutritional counseling; certain physical and behavioral health screenings; fluoride varnish treatment; and ABA therapy services for students with an autism spectrum disorder (ASD) diagnosis.

Notably, CMS approved a new formula for the state share as calculated by CMS. The new formula incorporates two categories of Medicaid-enrolled students: those with IEPs and those

without IEPs. State legislation is pending that will ensure Medicaid reimbursement from school-based services is reinvested in school nursing programming and services.

Action Taken to Expand School Medicaid

- Submitted SPA to CMS in 2016
- SPA approved in 2017; implementation began in 2019-2020 school year
- Legislation introduced in January 2019 - currently pending

State Resources

- SPA approval letter from CMS
- School-Based Medicaid Program Resource Center - MassHealth
- Direct Service Claiming Program Guide - MassHealth
- Bill text: HB 465 and SB 676 (identical language, different titles in House and Senate)

Other Resources

- CMS Approves State Plan Amendment for Massachusetts, Creating New Opportunity for School-based Medicaid - Analysis by Community Catalyst, Healthy Schools Campaign and National Health Law Program

Michigan

Bottom Line

Michigan expanded its school Medicaid program to cover reimbursable services to all Medicaid-enrolled students with documented medical necessity.

Policy Highlights

The SPA expands coverage of services to Medicaid-enrolled students with proper documentation of need.

Action Taken to Expand School Medicaid

- Submitted SPA to CMS in 2018
- SPA approved in 2019

State Resources

- SPA approval letter from CMS
- Medical Services Administration Provider Bulletin - Department of Health & Human Services
- Medicaid Provider Manual - Department of Health & Human Services
- Bill text: SB 149, Section 31n

Other Resources

- Case Study: Expanding Michigan's School-Based Medicaid Program - Healthy Schools Campaign

Minnesota

Bottom Line
Minnesota expanded its school Medicaid program to cover certain medically necessary services, including mental health services, for all Medicaid-enrolled students.

Policy Highlights
Minnesota Medicaid covers rehabilitation services (occupational therapy, physical therapy, speech-language pathology, audiology) and outpatient mental health services (children's therapeutic services and supports, diagnostic assessments, explanation of findings, family psychoeducation, health behavior assessment/intervention, psychological testing, psychotherapy, psychotherapy for crisis), public health nursing clinic services, and interpreter services when needed during a medical service.

Action Taken to Expand School Medicaid
- No SPA needed; policy effective July 1, 2021

State Resources
- Medicaid in Education: Third Party Reimbursement - Department of Education (see in particular School-Based Community Services in the Schools, which outlines the new policy that allows districts to bill outside the IEP, and Medicaid for Schol Mental Health Services)
- School-Based Community Services - Department of Human Services

Missouri

Bottom Line
Missouri's state Medicaid agency, HealthNet, expanded its school Medicaid program to cover behavioral health services delivered to all Medicaid-enrolled students.

Policy Highlights
The policy allows schools to provide and bill for behavioral health services provided to all Medicaid-enrolled students. It also clarifies that community behavioral/mental health providers can provide services in the school setting when a district determines it is appropriate to do so.

Action Taken to Expand School Medicaid
- No SPA needed; adopted policy in April 2018

State Resources
- MO HealthNet: Behavioral Health Services Manual - Department of Social Services
- MO HealthNet: Provider Bulletin: Behavioral Health Services in a School Setting - Department of Social Services
- School-Based Health Center Task Force - Missouri School Boards' Association
- School-Based Health Resources - School-Based Health Alliance of Missouri

Other Resources
- Expanding School-Based Medicaid in Missouri - Healthy Schools Campaign

Nevada

Bottom Line
Nevada expanded its school Medicaid program to cover all medically necessary EPSDT services to all Medicaid-enrolled students.

Policy Highlights
Nevada's school Medicaid program is a fee-for-service (FFS) program that covers all medically necessary EPSDT services to the school-based Medicaid program.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2019
- SPA approved in 2019

State Resources
- SPA approval letter from CMS
- School Health Services Billing Guide
- Medicaid Services Manual Changes Chapter 2800 - School Health Services - Division of Healthcare Financing and Policy

New Hampshire

Bottom Line
New Hampshire expanded its school Medicaid program to include services delivered to all Medicaid-enrolled students.

Policy Highlights
New Hampshire passed legislation in 2017 and implemented a temporary rule in 2018 allowing the state Medicaid agency to reimburse schools for services provided to all Medicaid-enrolled students with a plan of care established by a school district.

The Medicaid to Schools program also allows schools to be reimbursed for such services as children's behavioral health and services under the EPSDT benefit.

Action Taken to Expand School Medicaid
- Legislation passed in March 2017 to expand the school Medicaid program
- Temporary rule put in place in August 2018; final rules have not been published

State Resources
- Bill text: SB 235
- NH Medicaid to Schools Training and Technical Assistance Center
- Medicaid to Schools Resource Page - Department of Health and Human Services
- Medicaid to Schools Technical Assistance Guide - Department of Health and Human Services

Other Resources

- History of New Hampshire's Medicaid to Schools program - New Hampshire Fiscal Policy Institute

New Jersey

Bottom Line *(not expanded)*
New Jersey passed legislation in 2023 directing the state Medicaid agency to expand the school Medicaid program to cover behavioral health services outside of an IEP.

Policy Highlights
The legislation requires the state Medicaid agency to submit a SPA to expand coverage of behavioral health services outside the IEP.

Action Taken to Expand School Medicaid
- Legislation passed in 2023

State Resources
- Bill text: A-3334
- The Kennedy Forum statement on the signing of A-3334

New Mexico

Bottom Line
New Mexico expanded its school Medicaid program to cover all medically necessary services delivered to all Medicaid-enrolled students.

Policy Highlights
New Mexico allows schools to seek reimbursement for covered services provided under a 504 Plan, Individual Health Care Plan (IHCP) or other care plan.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2022
- SPA approved in 2023

State Resources
- SPA approval letter from CMS
- SPA submission

North Carolina

Bottom Line
North Carolina expanded its school Medicaid program to cover Medicaid-enrolled students with a 504 plan, IHP or BIP.

Policy Highlights
Covered services include nursing services, psychological and counseling services, and occupational, speech/language, audiology and physical therapy services. The SPA also added vision and hearing screening services as a covered service and clarified the definition of hearing services.

Action Taken to Expand School Medicaid
- Submitted SPA to CMS in 2018
- SPA approved in 2019

State Resources
- SPA letter of approval from CMS
- Legislative Report on Fiscal Impacts of Expanded Medicaid Coverage for School-Based Health Services - Report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and Fiscal Research Division

Other Resources
- North Carolina Secures School-Based Medicaid Services to Keep Kids Healthy and In the Classroom - Community Catalyst
- Analysis of North Carolina State Plan Amendment for Expansion of School-Based Medicaid - Community Catalyst

North Dakota

Bottom Line
North Dakota expanded its school Medicaid program to cover services delivered to all Medicaid-enrolled students.

Policy Highlights
Medicaid-eligible health services otherwise covered by North Dakota Medicaid may be reimbursed in a school setting so long as they are deemed medically necessary; subject to service authorization requirements and limits; and rendered by practitioners enrolled as North Dakota Medicaid providers who meet the provider qualifications and are delivering services within their authorized scope of practice.

Action Taken to Expand School Medicaid
- No SPA needed

State Resources
- Provider Guidelines, Manuals and Policies - Department of Health & Human Services; see in particular:
  - General Information For Providers
  - General Information For Behavioral Health Services

- Medicaid Reimbursement Fee Schedules - Department of Health & Human Services

Oklahoma

Bottom Line *(not expanded)*
Oklahoma amended its state plan to allow community-based providers to bill for services delivered in schools.

Note: Oklahoma does not allow school districts to bill for services outside the IEP. It is therefore not an expansion of school-based Medicaid through the "free care" policy reversal but may be a limited opportunity to increase the delivery of school health services.

Policy Highlights
The SPA designates schools as a location of service and allows community-based providers who deliver services in schools to bill for those services. The SPA was submitted to differentiate between services provided in a school setting under EPSDT and services provided pursuant to an IEP.

Action Taken to Expand School Medicaid
- SPA submitted to CMS in 2020
- SPA approved in 2020

State Resources
- SPA approval letter from CMS

Oregon

Bottom Line
Oregon expanded its school Medicaid program to cover all medically necessary services delivered to all Medicaid-enrolled students.

Policy Highlights
The SPA expands Medicaid-reimbursable services to all Medicaid-enrolled students with a 504 plan or any other documented individualized health or behavioral health plan, or as otherwise determined medically necessary. Covered services include all medically necessary services delivered by all eligible providers listed in the state plan.

Action Taken to Expand School Medicaid
- Oregon passed legislation in 2017 requiring the state Department of Education to assist schools in funding school nurse services through increased school-based health services Medicaid billing.
- Submitted SPA to CMS in 2019
- SPA approved May 2023

State Resources
- SPA letter of approval from CMS
- Bill text: SB 111

- School-Based Health Services Program - Health Care Authority
- Medicaid in Education - Department of Education
- Overview of School Medicaid Billing Pilot Project (2017-2020) - Department of Education

South Carolina

Bottom Line
South Carolina expanded its school Medicaid program to cover eligible services delivered to all Medicaid-enrolled students with an IHP or ITP.

Medically necessary school-based behavioral health services are available to all Medicaid beneficiaries under the age of 21 years old and diagnosed with mental health and/or SUD(s).

Policy Highlights
Medicaid reimbursement is available on a fee-for-service (carved out) basis for students with IEP, IFSP, IHP or ITP for the following school-based services: rehabilitative therapy services (audiological, physical therapy, occupational therapy, speech and language pathology); nursing services for children under 21 years.

Medicaid-reimbursed school-based rehabilitative behavioral health services are required to be included in the IEP, IFSP, ITP or IPOC. Rehabilitative behavioral health services are covered for students through managed care (carved in) unless the beneficiary is enrolled in fee-for-service Medicaid.

Services rendered subsequent to and as a result of an anomaly discovered during an EPSDT exam are reimbursable but the exam is not.

Action Taken to Expand School Medicaid
- No SPA needed; implementation underway

State Resources
- Local Education Agencies Services Provider Manual - Department of Health and Human Services

Tennessee

Bottom Line
Tennessee expanded its school Medicaid program to cover medically necessary behavioral health services for all Medicaid-enrolled students. All school-based services in Tennessee are reimbursed to the school districts through contracts with managed care companies.

Policy Highlights
Tennessee's school Medicaid program (TennCare) is "carved in" to its Medicaid managed care system. All students with TennCare are enrolled in one of four managed care plans that operate on a statewide basis. School districts likely have students enrolled in each MCO and

should contract with all four MCOs to maximize the ability to bill for eligible healthcare services.

To bill Medicaid, school districts must contract directly with the Medicaid managed care plans, and the managed care plans must cover all medically necessary services in the student's IEP and specific nursing services in an IHP.

As of July 2023, medically necessary, covered behavioral health services are not required to be in the student's IEP to be reimbursed by Medicaid. If *any* Medicaid-enrolled student receives a medically necessary behavioral health service, and if the school has a contract with the student's Medicaid managed care plan, that service can be reimbursed.

Action Taken to Expand School Medicaid

- No SPA needed
- Revised July 2023 billing manual effectuates the policy change and provides clear guidance

State Resources

- TennCare Billing Manual: Tennessee School Districts - Department of Education

Utah

Bottom Line *(not expanded)*
Utah passed legislation in 2019 directing the Department of Health and State Board of Education to develop recommendations to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.

Policy Highlights
The legislation required state agencies to report recommendations; this was completed in 2019.

A separate bill requires the Department of Health to develop a proposal and submit a state plan amendment to allow the state Medicaid program to be billed for certain mental health services provided in a public school.

Action Taken to Expand School Medicaid

- State bills (2019)
- Legislative report (2019)

State Resources

- Bill text: HB373 (recommendations to expand Medicaid reimbursement)
- Legislative report on Medicaid Reimbursement for School Health Services - Submitted in response to HB 373; Department of Health (Division of Medicaid and Health Financing), State Board of Education, Department of Human Services (Division of Substance Abuse and Mental Health)
- Bill text: SB106 (mental health services)

Virginia

Bottom Line
Virginia expanded its school Medicaid program to cover all eligible services for all Medicaid-enrolled students.

Policy Highlights
The SPA allows schools to bill Medicaid for services outside an IEP, including ESPDT services, mental health services, nursing services and others, when medical necessity has been established.

Action Taken to Expand School Medicaid
- Passed legislation in 2021 requiring the state Medicaid agency to pursue a SPA and to provide technical assistance to the state Department of Education and school districts on implementation
- Submitted SPA to CMS in 2021
- SPA approved in 2023

State Resources
- SPA approval letter from CMS
- Bill text: SB 1307

Other Resources
- New legislation set to impact Virginia DMAS (Department of Medical Assistance Services) - State of Reform

Washington

Bottom Line
Washington expanded its school Medicaid program to cover services outside a student's IEP if the school district contracts directly with a managed care organization to do so.

As of May 2023, seven out of the nine Educational Service Districts (ESDs) and one school district are licensed behavioral health agencies and are contracted with Medicaid MCOs.

Policy Highlights
Washington allows school districts to contract directly with Medicaid managed care organizations (MCOs) to bill for services outside of an IEP, including behavioral health services. Services delivered through these contracts are reimbursable for all students.

Examples of services that schools may receive reimbursement for include vision and hearing screenings, diabetes and asthma treatment for students with 504 plans, behavioral health services, immunizations, and any other non-IEP/IFSP Medicaid-covered health service.

For mental health services, school districts can become licensed behavioral health agencies to provide specific mental health, substance use disorder, problem gambling, or any combination of these types of services.

Note: Washington did not expand the ability of school districts to bill for services outside of a student's IEP, so it is not an expansion of school-based Medicaid through the "free care" policy reversal. However, this does create an important opportunity to increase reimbursement by managed care organizations to school districts for the delivery of school health services.
Action Taken to Expand School Medicaid ● No SPA needed
State Resources ● Medicaid-Funded School-Based Health Care Services and Supports (summary of programs and information) - Health Care Authority ● Medicaid School-Based Behavioral Health Services and Billing Toolkit - Health Care Authority
Other Resources ● Building Cross-Sector Collaboration to Support School Behavioral Health Services: Washington's Children's Regional Behavioral Health Pilot Program - Healthy Schools Campaign

Healthy Schools Campaign

Healthy Schools Campaign (HSC) engages stakeholders and advocates for policy changes at local, state and national levels to ensure that all students have access to healthy school environments, including nutritious food, physical activity and essential health services, so they can learn and thrive. HSC's Healthy Students, Promising Futures initiative supports states and school districts in expanding access to Medicaid-funded school health services. To learn more, visit healthyschoolscampaign.org and healthystudentspromisingfutures.org.

HSC thanks Community Catalyst for its support in developing this document.

OFFICE OF THE
STATE AUDITOR

Department of Health and Human Services

Audit Management Letter

For the year ended June 30, 2023

Report No. 23-17
March 8, 2024

Office of the State Auditor

Audit Leadership:
John Dougall, State Auditor
Bertha Lui, CPA, Audit Director
Abby Potter, CPA, Audit Supervisor

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OFFICE OF THE
STATE AUDITOR

Management Letter No. 23-17

March 8, 2024

Tracy S. Gruber, Executive Director
Department of Health and Human Services
195 North 1950 West
Salt Lake City, UT 84116

Dear Director Gruber:

This management letter is issued as a result of our audit of the State of Utah's basic financial statements as of and for the year ended June 30, 2023. It is also issued as a result of the Department of Health and Human Services' (DHHS) portion of the statewide federal compliance audit (Single Audit) for the year ended June 30, 2023. Our audit was conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Our final reports on internal controls and on compliance required under *Government Auditing Standards* and federal *Uniform Guidance* will be issued under separate cover. These reports will also provide further detail as to considerations made during the course of the audit regarding internal controls and compliance, both at the financial statement and at the federal program level, and the limited purposes of those considerations. The purpose of this letter is to communicate with DHHS management concerns identified during the course of our audit.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees to prevent or to detect and correct on a timely basis misstatements, errors, or instances of noncompliance. A material weakness in internal control is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that material misstatements, errors, or noncompliance are not prevented or are not detected and corrected on a timely basis.

Based on the audit procedures performed, we identified a certain deficiency in internal control which we consider to be a material weakness (Findings 1 and 2). We also identified deficiencies in internal control which, while not considered material, we consider to be significant enough to merit the further attention of management and those charged with governance (Findings 3, 4, 5, and 6). We also identified Findings 3 and 4 as instances of noncompliance which we are required to report under *Uniform Guidance*.

DHHS's written responses to and Corrective Action Plans for these findings will be included in the final reports identified in the second paragraph above.

The purpose of this communication is solely to describe the scope of our testing of internal control over compliance and the results of that testing and not to provide an opinion on the effectiveness of the DHHS's internal control over compliance. Accordingly, this communication is not suitable for any other purpose. However, pursuant to *Utah Code* Title 63G Chapter 2, this report is a matter of public record, and as such, its distribution is not limited.

We appreciate the courtesy and assistance DHHS personnel extended to us during the course of our audit, and we look forward to a continuing professional relationship. If you have any questions, please contact me.

Sincerely,

Bertha Lui, CPA
Audit Director
801-808-0481
blui@utah.gov

cc: Nate Winters, Deputy Director, DHHS
Nate Checketts, Deputy Director, DHHS
David Litvack, Deputy Director, DHHS
Jennifer Strohecker, State Medicaid Director, DHHS
Tonya Myrup, Division Director, Child and Family Services, DHHE
Noel Taxin, Division Director, Family Health, DHHS
Don Moss, Executive Finance Director, DHHS
Randall Loveridge, Director of Internal Audit, DHHS

Findings & Recommendations

Finding 1. Foster Care Eligibility Reviews Not Adequately Completed

(Finding Type: Material Internal Control Weakness)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 93.658 Foster Care Title IV-E
Federal Award Number: 2201UTFOST
2301UTFOST
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: 2022-006

For 17 of 60 (28%) cases reviewed, there was no evidence that DHHS had reviewed the initial Title IV-E Foster Care eligibility decisions. Federal regulation 2 CFR 200.303 requires that "the non-federal entity must establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award."

In response to a prior year audit finding, DHHS hired an employee in January 2023 to complete the review of eligibility determination. However, the review only covered new cases initiated during the current year, but not the existing cases initiated in prior years. These existing cases have never been reviewed to ensure proper eligibility decisions were made. However, benefit payments were incurred and paid during the year. Given the large number of cases requiring eligibility decisions the current team receives, the control was not properly designed and implemented to complete these reviews in a timely manner. Unreviewed or untimely reviews of eligibility decisions could lead to improper eligibility determinations and inappropriate benefit payments.

Recommendations:

We recommend DHHS allocate sufficient resources to expand the existing review or modify the control to ensure eligibility decisions are reviewed in a timely manner.

DHHS's Response:

The department acknowledges the need for continuous effort on the internal control assessment and reasonable implementation for this area. Procedures exist and review was performed to assist with proper IV-E eligibility determination.

Corrective Action Plan:

The Division of Child and Family Service (DCFS) will continue efforts for accurate IV-E eligibility determination. The department and DCFS will further consider reasonable control circumstances for IV-E eligibility determination.

Contact Person: Tenille Tingey, DCFS Financial Manager, 385-270-3322

Anticipated Correction Date: Fiscal Year 2024

Finding 2. Lack of Controls over Food Benefit Payments

(Finding Type: Material Internal Control Weakness)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 10.557 Women Infants & Children
Federal Award Number: Various
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: N/A

DHHS did not verify food benefit expenditure detail received from its third-party service organization, along with request for reimbursing program funds, to ensure expenditures were made for allowable activities and costs before making payment. Federal regulation 2 CFR 200.303 states that "the non-federal entity must establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award." DHHS has controls in place to ensure that benefit distribution information, such as eligible participants and food plans, is properly sent to its third-party service organization. However, DHHS did not verify the third-party service organization's expenditure details to ensure that benefit payments made were in compliance with the allowable costs and allowable activities requirements before reimbursement. As a result, inaccurate, incomplete, or false payments may be paid without detection.

Recommendations:

We recommend DHHS establish a system of reviewing its third-party service organization's expenditure details to ensure that program funds are paid for allowable activities and costs.

DHHS's Response:

The department recognizes the need to review food benefit expenditure information received from the WIC third-party host processing vendor. WIC procedures are established which support proper performance for food benefit redemption.

Corrective Action Plan:

The Division of Family Health (DFH) will continue efforts to ensure proper management of the WIC program. The department and DFH will consider possible improvements for managing third party food benefit redemptions.

Contact Person: Mykio Saracino, Assistant Office Director, 385-228-4798

Anticipated Correction Date: December 31, 2024

Finding 3. Noncompliance with Required Audit of MCO Encounter and Financial Data

(Finding Type: Significant Deficiency, Reportable Noncompliance)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 97.778 Medicaid Assistance Program (Medicaid Title XIX)
Federal Award Number: Various
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: 2022-009

DHHS did not have a well-established process of recording or reviewing independent periodic audits of encounter and financial data for managed care organizations (MCO) as required in Federal regulation 42 CFR 438.602(e) & (g). Per Federal regulation (2 CFR 200.303), non-federal entities must "establish and maintain effective internal controls over the Federal award that provide reasonable assurance that the non-Federal entity is managing the Federal award in compliance with…terms and conditions of the federal awards." DHHS performs periodic audits of all MCO Medical Loss Ratio (MLR) reports, and they incorrectly believed that the control they had in place was sufficient. The audits of MLR reports were found not to be independent audits of encounter and financial data as DHHS assumed. Therefore, there was no control or compliance occurring for the required audits. For fiscal year 2023 they started to implement corrections to contract out the periodic audits to a third-party auditor, but these audits were not yet complete.

Recommendations:

We recommend DHHS finish establishing a process to perform and post independent periodic audits as directed by Federal regulation 42 CFR 438.602(e) & (g) and establish an effective internal control over this new process.

DHHS's Response:

The Division of Integrated Healthcare (DIH), Office of Managed Healthcare (OMH) agrees with this finding and recommendation.

Corrective Action Plan:

The department started encounter data validation audits August 22, 2023. These audits are being conducted by the department's contracted auditor. The department is currently having discussions with CMS about the types of audits that satisfy the financial audit part of the regulatory requirement. When the results from the encounter data and financial audits are completed by the department's contracted auditor, they will be posted to the department's website.

Contact Person: Greg Trollan, Office Director, Office of Managed Healthcare, 801-538-6088

Anticipated Correction Date: December 31, 2024

Finding 4. Noncompliance with Timing of Health and Safety Surveys

(Finding Type: Significant Deficiency, Reportable Noncompliance)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 93.778 Medicaid Assistance Program
Federal Award Number: Various
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: N/A

12 of the 14 facilities sampled for Medicaid Health and Safety Surveys were performed between 18.63 months and 59.5 months, including 10 sampled facilities over 28 months, from the last survey date. Federal regulation 42 CFR 442.15 requires that surveys of facilities are to be conducted "to determine compliance with the requirements at a survey interval of no greater than 15 months." According to DHHS, the surveys were backlogged due to the COVID-19 pandemic, in addition to a staffing shortage amidst a hiring freeze. The existing staff was unable to maintain regular certifications and address the backlog within the required timeline. If surveys are not completed, facilities could become

noncompliant with health and safety requirements without detection, thus potentially endangering patients.

Recommendations:

We recommend DHHS create a plan to clear the backlog and maintain proper timing to complete the Health and Safety Survey.

DHHS's Response:

The Division of Licensing and Background Checks (DLBC), Office of Licensing (OL) agrees with this finding and recommendation.

Corrective Action Plan:

DLBC/OL is taking the following steps to achieve compliance with required survey timeframes:

1. Increase Health Facility Licensing fees by 43% to facilitate the hiring of 4 additional staff.
2. Dedicate one-time funds for contracting with a third-party surveyor to help address Health and Safety survey backlog.
3. Work with the DHHS, Office of Innovation to review the health facility team's processes to improve efficiencies.
4. Organize a separate complaint investigation unit to help expedite complaint and survey completion.

Contact Person: Simon Bolivar, Office Director, Office of Licensing, 801-803-4618

Anticipated Correction Date: July 1, 2024

Finding 5. Untimely Implementation of Provider Eligibility Requirement Changes

(Finding Type: Significant Deficiency)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 93.778 Medicaid Assistance Program
Federal Award Number: Various
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: N/A

DHHS did not properly review and approve 1 of 42 Medicaid provider applications reviewed during the audit. Per Federal regulations (2 CFR 455 Subpart E), providers must be screened, and their license and certifications must be verified before they are initially validated or revalidated. Effective July 1, 2021, requirements for Case Managers provider group were updated to require a Case Manager Certificate to be eligible for providing Medicaid services. Because DHHS did not implement the requirement in the system until June 15, 2022, the system did not have the proper criteria to determine provider eligibility during the period of delayed implementation. As a result, DHHS risks using Medicaid funds on ineligible providers.

Recommendations:

We recommend that DHHS implement procedures to ensure that eligibility requirements are implemented promptly after new eligibility requirements are announced by State Medicaid.

DHHS's Response:

The Division of Integrated Healthcare (DIH), Office of Medicaid Operations (OMO) agrees with this finding and recommendation.

Corrective Action Plan:

The Division of Integrated Healthcare has a standard operating procedure to ensure timely compliance for new Medicaid rules, regulations, policy changes and other operational requirements. As additional system requirements are identified, that information is entered into the Division's tracking system called "SPOT". SPOT is an effective "ticket" system that manages future enhancements, change requests, defects, and other system needs. Prioritization and escalation of the "ticket" ensures that complex or high priority items receive the necessary attention promptly. During the time of the audit finding, DIH was involved in the final stages of PRISM testing and go-live activities and could not make any system changes or it would have potentially impacted the release of the PRISM system. The effective date of the SPOT standard operating procedure was April 3, 2023. Utah Medicaid is in compliance with the audit recommendation.

Contact Person: Shandi Adamson, Office Director, Office of Medicaid Operations, 801-793-7261

Anticipated Correction Date: April 3, 2023

Finding 6. Pharmacy Rebate Invoices Not Checked for Accuracy and Timeliness

(Finding Type: Significant Deficiency)

Federal Agency: Department of Health and Human Services
Assistance Listing Number and Title: 93.778 Medicaid Assistance Program
Federal Award Number: Various
Questioned Costs: N/A
Pass-through Entity: N/A
Prior Year Single Audit Report Finding Number: N/A

Pharmacy rebates invoiced quarterly in fiscal year 2023 were not reviewed to ensure invoices are accurate and sent in a timely manner within 60 days after the end of the quarter. According to Federal regulation 2 CFR 200.303, non-federal entities must "establish and maintain effective internal controls over the Federal award that provide reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and terms and conditions of the federal awards." Although DHHS had sufficient internal controls over rebates in prior years, the control deficiency was a result of staff turnover during the year, combined with inadequate communication and training of the new staff. Lack of review may result in pharmacy invoices not sent in accordance with federal guidance.

Recommendations:

We recommend that controls be reinstated, and that the responsible employee be given proper training to correctly determine whether pharmacy rebates are reviewed for accuracy and timeliness.

DHHS's Response:

The Division of Integrated Healthcare (DIH), Office of Financial Services (OFS) agrees with this finding and recommendation.

Corrective Action Plan:

We will immediately reinstate the controls and provide training to the responsible employee and the backup to monitor the accuracy and timeliness of the rebates. We will ensure that this training includes a standard operating procedure detailing how these reviews will be conducted.

Contact Person: Jamie Sorenson, Office Director, Office of Financial Services, 385-290-5380

Anticipated Correction Date: March 31, 2024

Former Medicaid Member Online Survey Report

December 2023

Prepared for

Utah Department of Health and Human Services

Lighthouse Research & Development, Inc.
www.go-lighthouse.com
801.446.4000

Former Medicaid Member Online Survey Report

TABLE OF CONTENTS

Introduction

Lighthouse Research & Development, Inc. was contracted by the Utah Department of Health and Human Services (DHHS) to conduct a survey with former Medicaid members.

Project Objectives

The main objective of the online survey research was to gather perceptions of the Medicaid program. Specific objectives for the project included:

- Identify reasons respondents are no longer enrolled in Medicaid
- Determine if respondents currently have health insurance coverage
- Identify reasons respondents did not complete eligibility renewal
- Evaluate customer service interactions with Utah Department of Workforce Services
- Evaluate the Medicaid enrollment and renewal processes
- Discover respondents' overall satisfaction with Medicaid health coverage
- Determine if respondents would re-enroll in Medicaid if eligible
- Identify the best aspects of Medicaid
- Discover the areas in which Medicaid needs to improve

Project Overview

The online research project consisted of a survey designed to gather formation from former Medicaid members. The scope of work for the research project included the following:

- Project consultation with Utah DHHS personnel
- Programming of the online survey instrument
- Completion of 1,000 surveys
- Analysis of the data, including percentages of results and coding of open-ended responses
- A written report describing the results of the survey including research methodology, an executive summary, and a detailed description of the results

Research Methodology

The research methods used to complete the project are outlined in detail below.

Sampling Procedures

Sample of former Medicaid members was provided by DHHS and used for data collection. Individuals were then invited to participate via email.

Data Collection

Lighthouse Research completed a total of 1,003 surveys, allowing for an overall confidence level of 95% with a margin of error of ±3.08%.

Lighthouse Research conducted a pretest of the survey instrument with a small sample of former members to determine the need for any modifications to the survey instrument. Following the pretest, minor adjustments were made to the survey before proceeding with data collection.

All interviews were automatically given a numeric code upon entry into the system to assist in the data analysis. All data collection for this survey was completed between October 11 and 17, 2023.

The online survey was programmed in a Computer-Assisted Web Interviewing (CAWI) format. Using the CAWI system, survey responses were entered directly into the database by the respondent as the survey was in progress.

Data Analysis

The data analysis provides the following statistics upon which the written interpretative report is based:

- The frequency and valid percent of responses to each of the survey questions
- Responses to open-ended questions, coded for multiple mentions

Organization of the Report

The remainder of the report is organized under the following areas:

- Executive Summary
- Detailed Results
- Segment Analysis
- Appendices

The Executive Summary section of this report includes an overview of the research findings and analysis from the survey.

The Detailed Results section includes charts and a written description of the results for that topic. The Detailed Results section also includes average means and medians that exclude those respondents who selected *don't know* and *wouldn't say*.

The Segment Analysis section contains the results of the cross-tabular analysis and indicates significant differences in responding among respondents.

The Appendices section of the report provides a copy of the survey questionnaire with frequencies of responses.

The following report represents the deliverable for this contract and is presented respectfully to the project sponsors.

Executive Summary

The following summary represents the most pertinent findings of the survey research.

Reasons for Disenrollment

Respondents most frequently said they or the members of their household are no longer enrolled in Medicaid because **their household income was too high for Medicaid eligibility limits**.

Respondents most frequently said they or the members of their household currently have **employer-provided** insurance or are **uninsured**.

What is the current status of health coverage for you or the members of your household?

Top Mentions

Employer-provided	Uninsured	Marketplace Insurance	Medicare
39%	30%	15%	7%

43% of respondents completed the Medicaid renewal process this year.

- ✓ Respondents who completed the renewal most frequently said they **submitted forms but were told they don't qualify**.
- ✓ Respondent who did *not* complete the renewal most frequently said they **do not need Medicaid** or that they **never received renewal documents from DWS**.

Customer Service Perceptions

In the last year, 58% of respondents said they reached out to DWS with a question, complaint, or problem. Of these, 39% had a resolution **the same day or the next day**.

How long did it take DWS to resolve your question, complaint, or problem?

Same or next day	2 to 7 days	8 to 14 days	More than 2 wks	Still waiting
39%	19%	8%	12%	21%

Evaluation of Processes

The table below illustrates respondents' perceptions of various Medicaid processes. Participants most frequently said these processes were **difficult**.

Respondents' Perceptions of Medicaid Processes

	Very Easy	Somewhat Easy	Somewhat Difficult	Very Difficult
Renewal process	6%	19%	27%	22%
Documentation	11%	26%	31%	22%
Forms	11%	29%	29%	15%

Medicaid Program Perceptions

When rating their impression of Medicaid, 33% of respondents gave a rating of **"9"** or **"10"** on the 0-to-10 rating scale. Respondents gave an average mean rating of **6.88** and a median rating of **7.00**

58% of respondents said they would **definitely** re-enroll in Medicaid if it were possible.

If you could re-enroll yourself or your household member(s) in Medicaid today, would you?

Definitely not	Probably not	Undecided	Probably	Definitely
4%	5%	12%	21%	58%

Most frequently, respondents said:

- ✓ **Cost** and **coverage** are the best things about Medicaid
- ✓ **Eligibility and income requirements** is an area in which Medicaid needs to improve

Segment Analysis Summary

Respondent with children in the home were more likely to:

- ✓ Have employer-provided health insurance
- ✓ Have attempted to renew their household's Medicaid coverage
- ✓ Give higher impression ratings to Medicaid's health coverage

Respondents who attempted to renew their Medicaid coverage were more likely to:

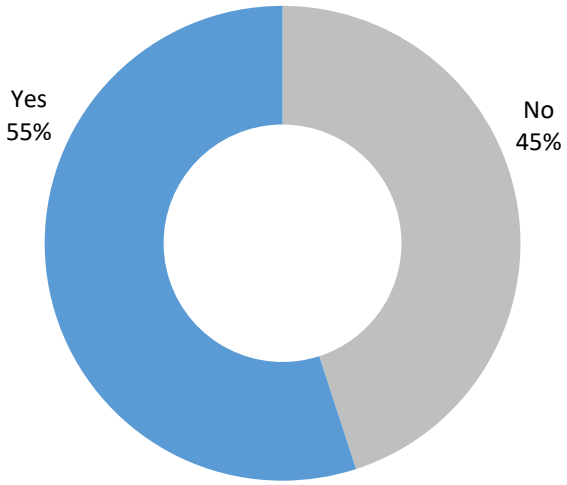
- ✓ Say they are uninsured
- ✓ Have contacted DWS in the last year with a question, complaint, or problem
- ✓ Say they are still waiting for problem resolution after reaching out to DWS

Detailed Results

Reasons for Disenrollment

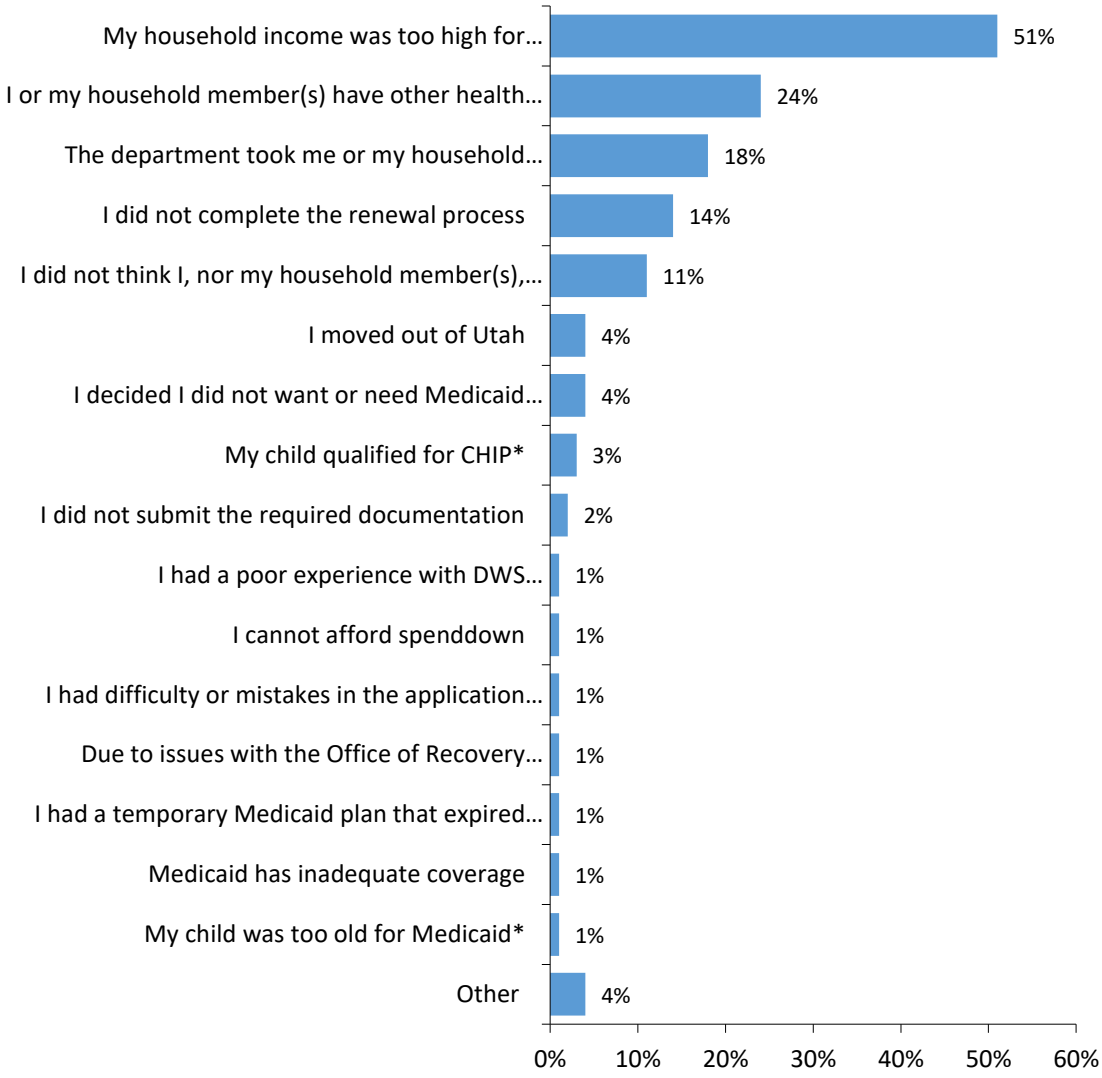
As Figure 1 illustrates, 55% of respondents reported having children under the age of 18 who live in their homes and were on Medicaid last year.

Figure 1
Do you have children under the age of 18 who live in your home and were on Medicaid in the last year?



As Figure 2 illustrates, respondents most frequently reported their **household income was too high for Medicaid eligibility limits** as the reason they or their family members are no longer enrolled in Medicaid.

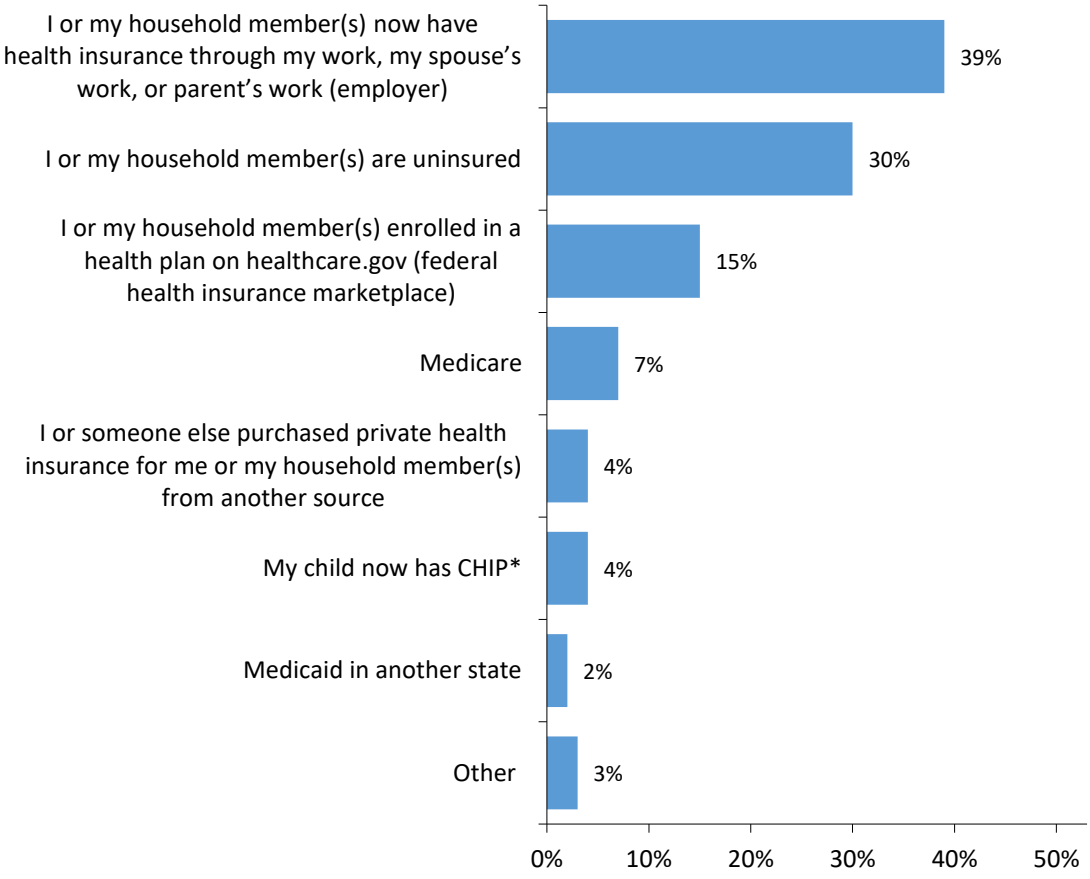
Figure 2
From your point of view, which of the following describes the reasons you or another family member in your household is no longer enrolled in Medicaid?



**Asked only of respondents with children under age 18 who live in their homes and were on Medicaid last year*

When asked about their current healthcare coverage, respondents most frequently said they or the members of their household have **employer-provided health insurance** or are **uninsured**. Please see Figure 3 for details.

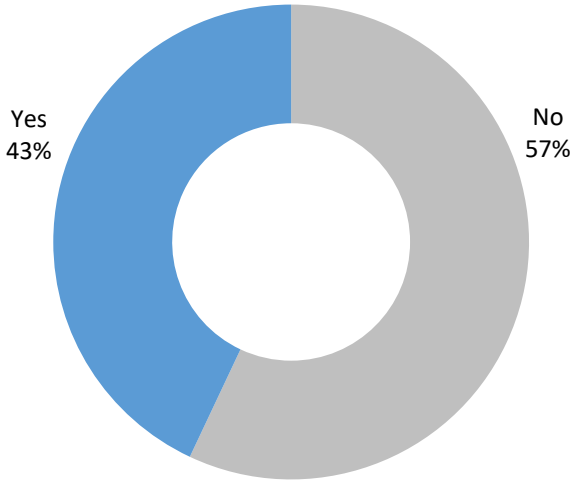
Figure 3
What is the current status of health coverage for you or the members of your household?



**Asked only of respondents with children under age 18 who live in their homes and were on Medicaid last year*

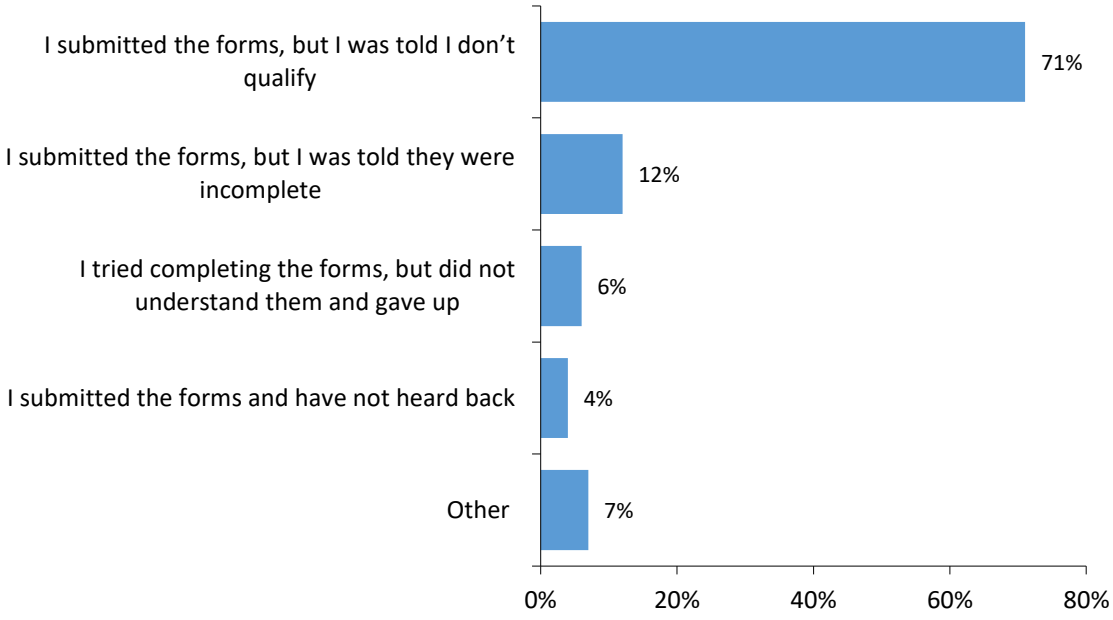
As Figure 4 illustrates, 57% of respondents said they did *not* attempt to renew their Medicaid coverage this year.

Figure 4
Did you attempt to renew your Medicaid coverage?



Of respondents who did attempt to renew their Medicaid coverage, 71% said they **submitted the forms, but were told they don't qualify**. Please see Figure 5.

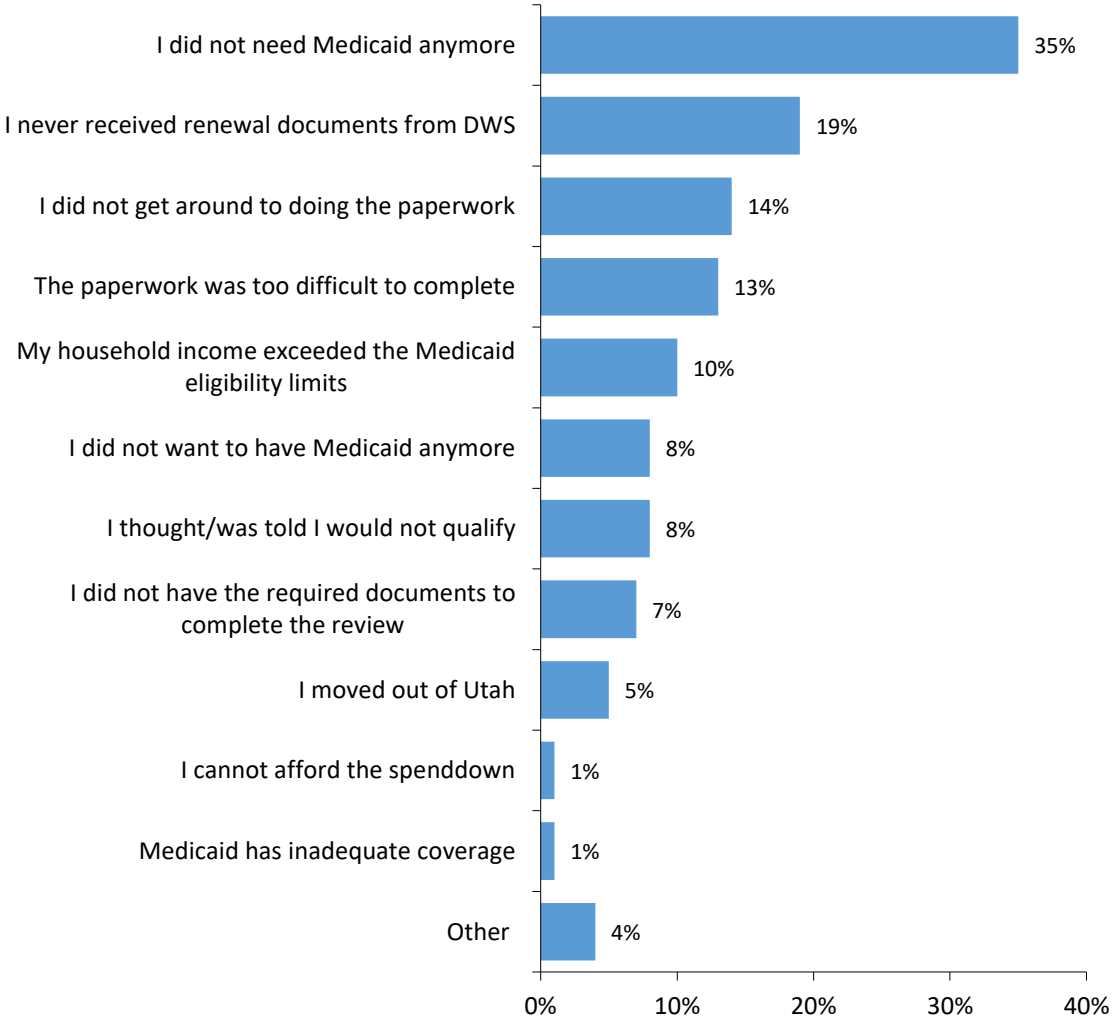
Figure 5
Which of the following best describes your attempt to renew your Medicaid coverage?



Note: Percentages in the above chart are based on respondents who attempted to renew their Medicaid coverage.

Of respondents who did *not* attempt to renew their Medicaid coverage, 35% said they **did not need Medicaid anymore**, while one-fifth (19%) said they **never received renewal documents from DWS**. For details, please see Figure 6.

Figure 6
Which of the following describe WHY you did not complete your renewal?

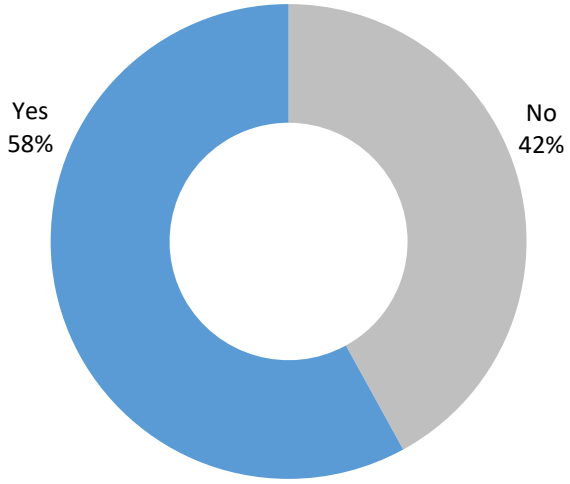


Note: Percentages in the above chart are based on respondents who did not attempt to renew their Medicaid coverage.

Customer Service Perceptions

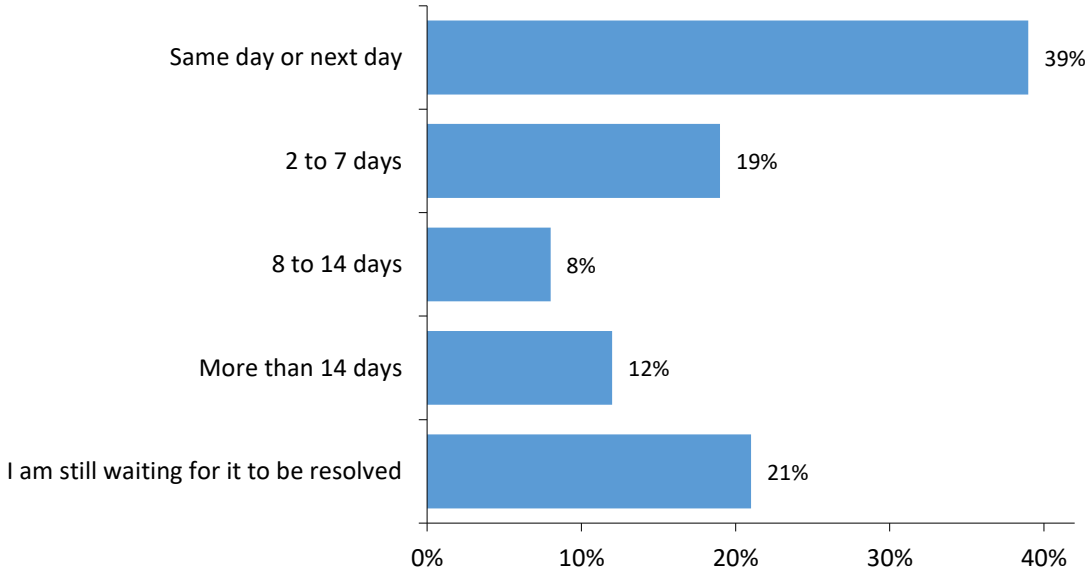
As Figure 7 illustrates, 58% of respondents said they contacted DWS with a question, complaint, or problem in the last year.

Figure 7
In the last year, did you call the Department of Workforce Services (DWS) with a question, complaint, or problem?



Of those who contacted DWS, 39% said their issues were resolved **the same day or the next day** (39%). One-fifth of respondents *each* said their issues were resolved within the week (19%) or that they are still waiting for resolution (21%). For further details, please see Figure 8.

Figure 8
How long did it take DWS to resolve your question, complaint, or problem?

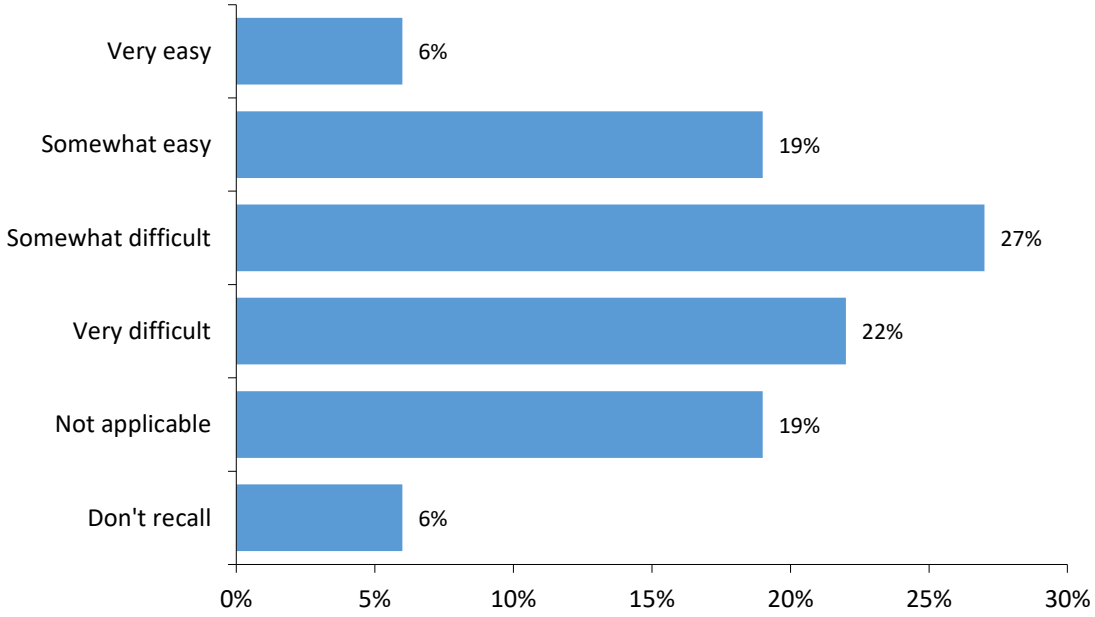


Note: Percentages in the above chart are based on respondents who contacted DWS with a question, complaint, or problem in the past year.

Evaluation of Processes

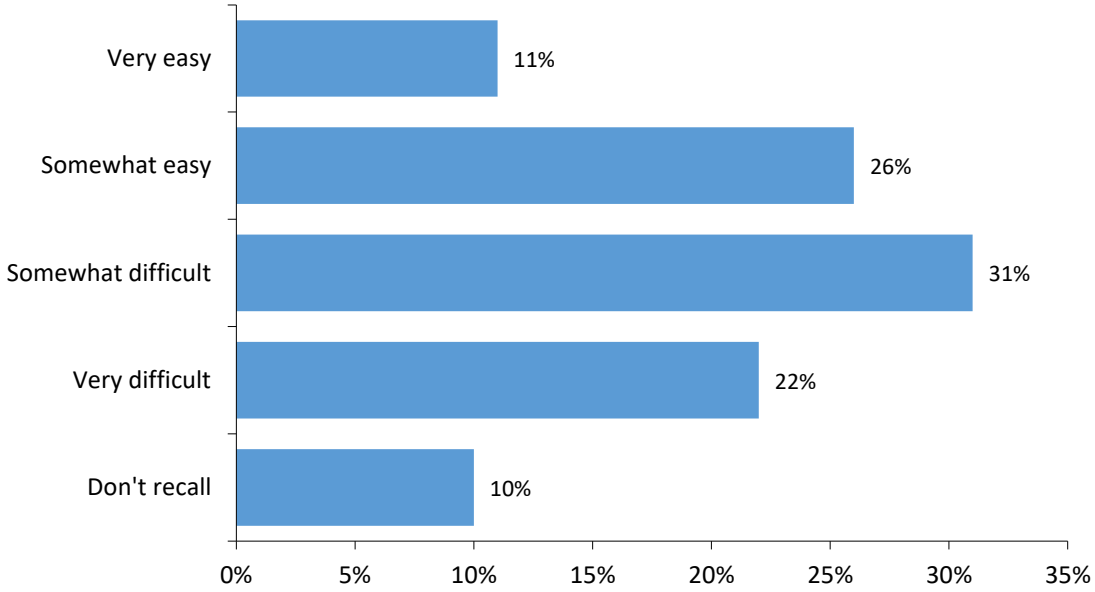
When asked about the Medicaid renewal process, one-half of participants (50%) said they consider the process to be **difficult**, while one-quarter (25%) said they consider the process to be **easy**. Please see Figure 9.

Figure 9
Thinking about Medicaid's RENEWAL PROCESS, was it…?



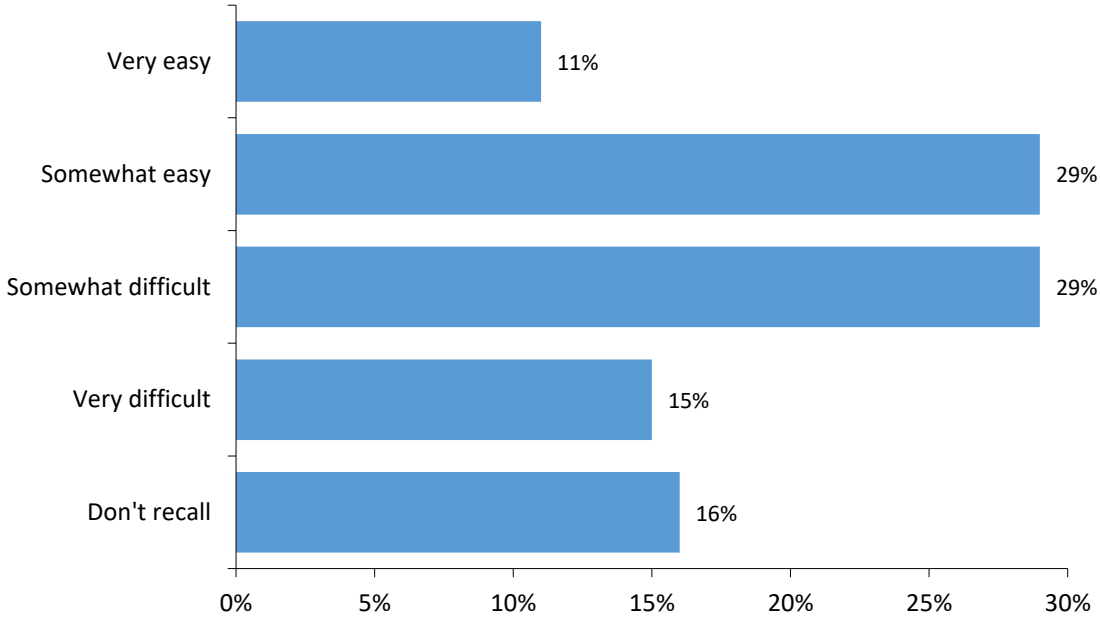
As Figure 10 illustrates, 53% of respondents said they consider Medicaid's documentation process to be **difficult**, while 37% said they consider it to be **easy**. Please see Figure 10.

Figure 10
Thinking about Medicaid's renewal and enrollment process, DOCUMENTATION was requested, like pay stubs or other paperwork. In your opinion, was turning in this paperwork…?



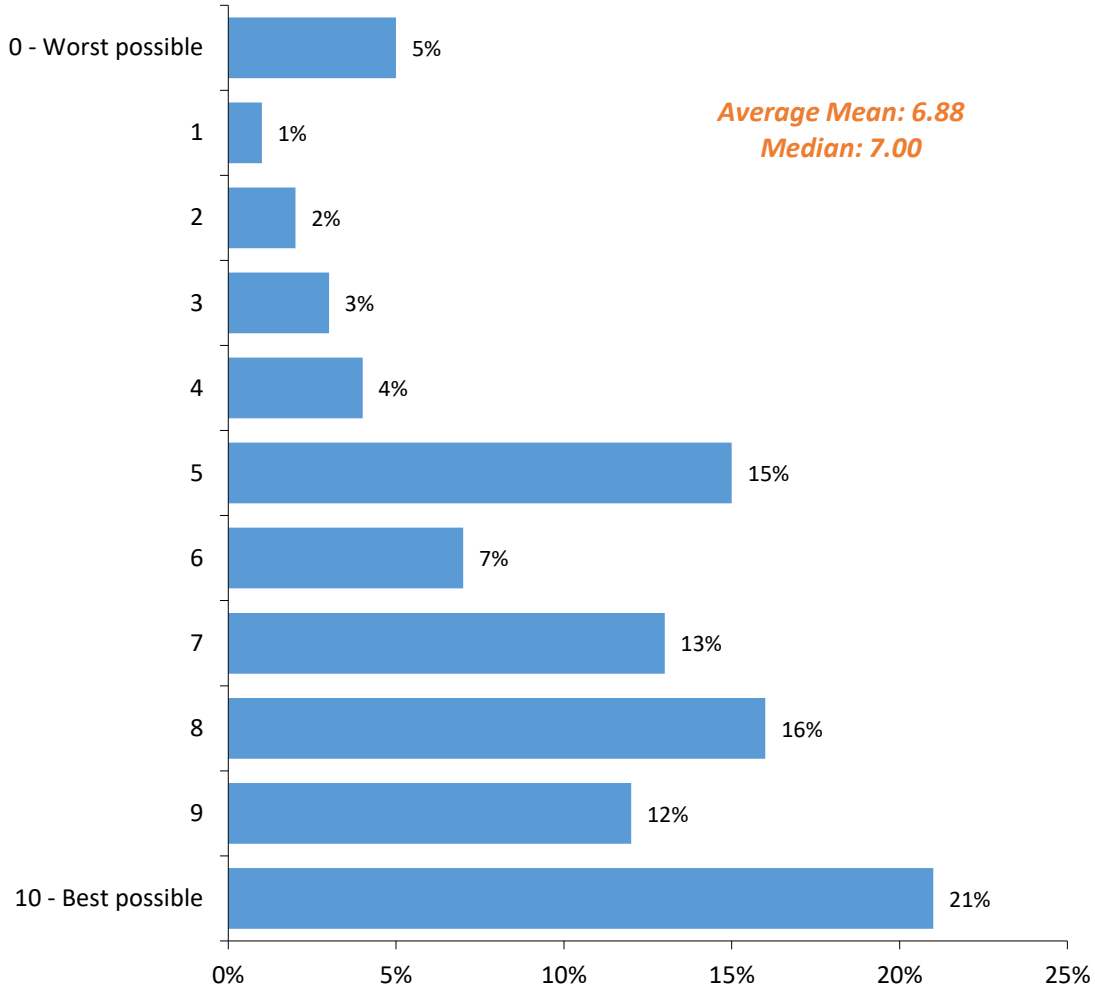
As Figure 11 illustrates, 44% of respondents said they consider it **difficult** to review and fill out the Medicaid forms, while 40% said they consider this process to be **easy**.

Figure 11
When thinking about the FORMS provided by DWS to renew coverage, was filling out the review forms…?



When rating Medicaid's healthcare coverage, one-third of respondents gave a rating of **"9" or "10 – best possible."** On average, participants gave a rating of **6.88** on the zero-to-ten scale to describe Medicaid coverage overall. For details, see Figure 12.

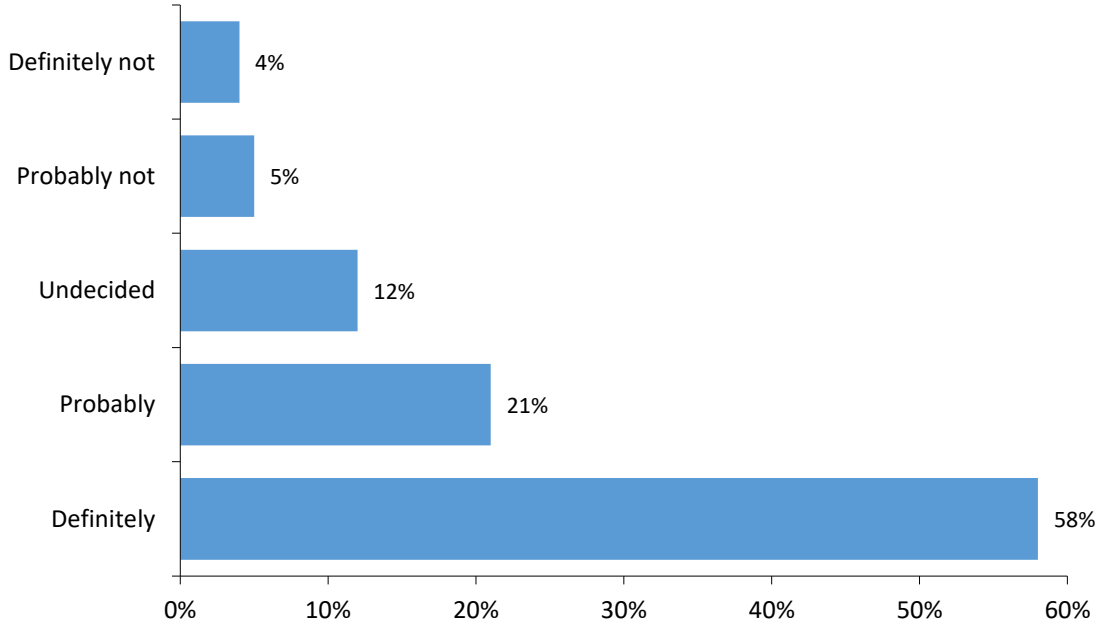
Figure 12
How would you rate Medicaid health coverage?



Medicaid Perceptions

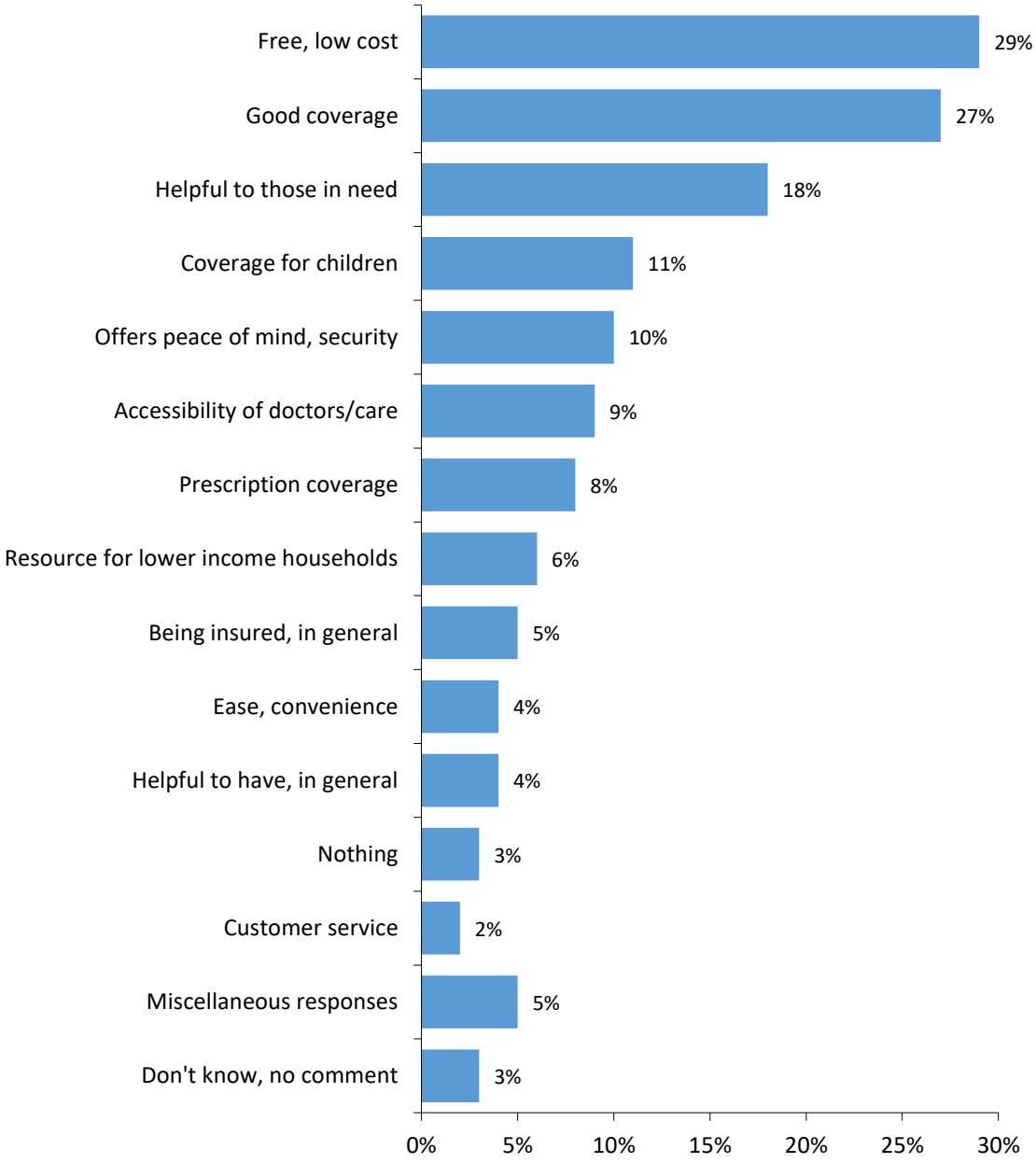
As Figure 13 illustrates, 58% of respondents said if they could re-enroll themselves in Medicaid today, they would **definitely** do so, while 21% said they probably would do so.

Figure 13
If you could re-enroll yourself or your household member(s) in Medicaid today, would you?



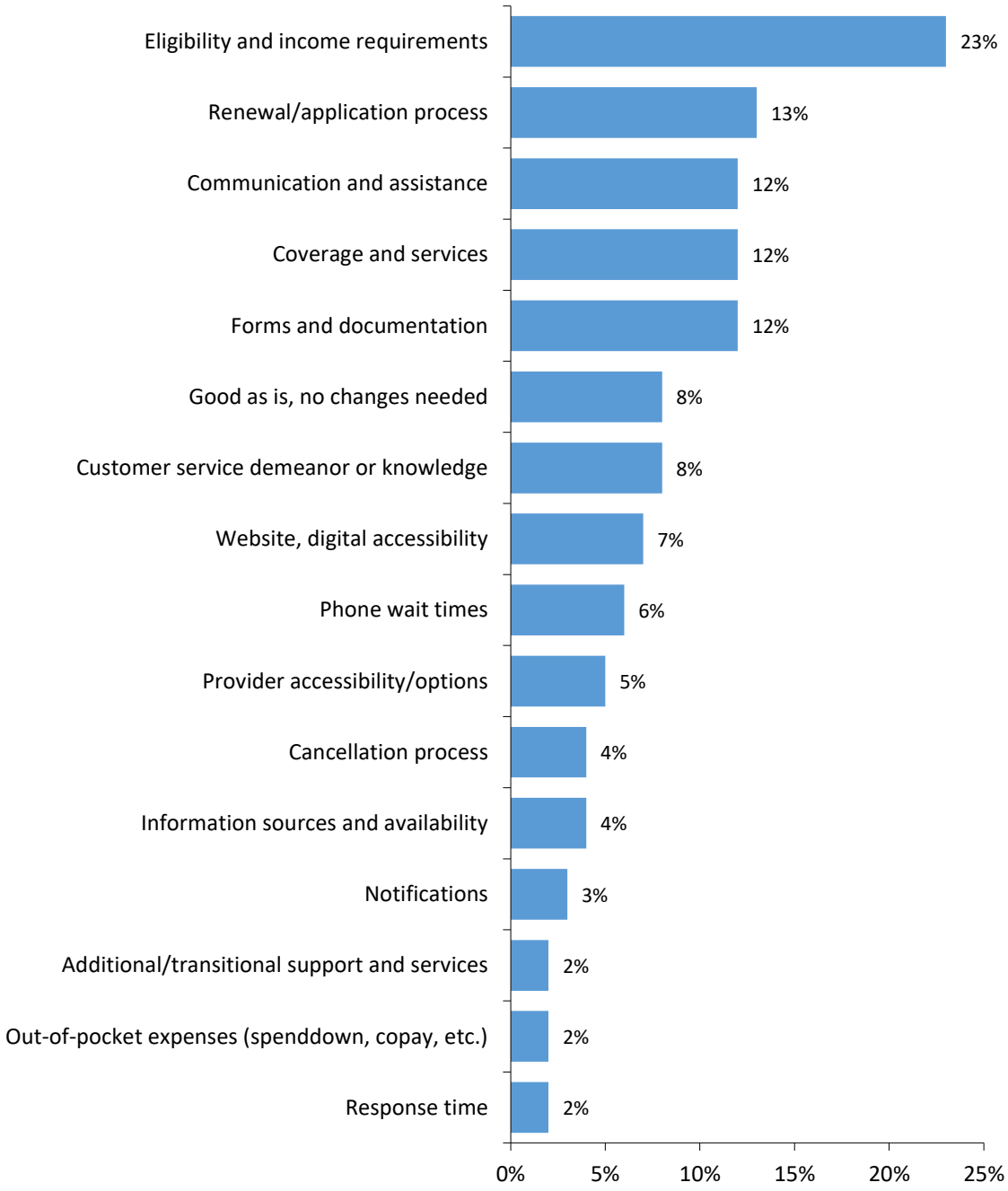
When asked to identify the best thing about Medicaid, respondents most frequently mentioned the **cost** (29%) and **coverage** (27%). For details, please see Figure 14.

Figure 14
In your opinion, what is the best thing about Medicaid?



When asked to identify areas in which Medicaid needs to improve, respondents most frequently commented on the **eligibility and income requirements** (23%).

Figure 15
What does Medicaid need to improve?
Top Mentions



Segment Analysis

In this section of the report, similarities and differences among segments within the survey population are examined. The following descriptions and charts present the statistically significant differences among respondents by segment. These include the following:

- Presence of children in the home
- If they tried to renew Medicaid

Statistical significance is defined as a difference in value that is too large to be attributed to chance alone, thus describing the relationship that exists between the demographic variable of interest and the survey responses.

Methodology

Different methods were applied depending on whether the data was categorical or scalar in nature.

For categorical data, Pearson's Chi-Squared Test was utilized to determine whether the frequencies under consideration differed significantly by segment variable. In cases where a large number of segments renders the expected counts too low for a standard chi-squared test, Monte-Carlo simulation under the null hypothesis was used to create simulated p-values. Among the results established that varied by segment, a Post-Hoc Fisher's Exact Test was performed to determine what particular differences are driving the trend.

For scalar data, a Kruskal-Wallis One-Way ANOVA was used, which tests segmented data against the hypothesis that they come from the same distribution. Kruskal-Wallis is robust against non-normality, unequal variances, outliers, and a variety of other problems. In cases where there were two-part segments, Kruskal-Wallis is equivalent to the Wilcoxon Rank-Sum Test, the standard for comparison tests, so it was unnecessary to change our methods. A Post-Hoc Dunn's test was applied to those that were significant under Kruskal-Wallis, once again narrowing down the source of the differences detected in the broader test.

In order to avoid the multiple comparisons problem (in which asking many questions statistically leads to the possibility of proportionally many false positives), the false discovery rate was controlled using the Benjamini-Hochberg adjustment.

It is possible to detect a difference in the general trend without finding specific pairwise differences in a segment. "Blank" tables with no green or red markers of significance are in this category, with a statistically significant trend, but without a statistically significant direct comparison.

How to Interpret the Tables

For the tables in this section, the coloring is based off of pairwise tests, which means that they are comparing the groups in a given row against each other, rather than measuring the total trend. If looking at age, for example, the colors would not illustrate general trends, but instead highlight specific age ranges compared directly to another (i.e. 18 to 24 year olds compared to 40 to 44 year olds). These comparisons narrow down the sources of the trends, and produce specific statements about differences between groups. The intended intuition when looking at the tables is that red means it is significantly lower, and green means it is significantly higher. The darker the green, the more groups it is significantly higher than, and the darker the red, the more groups it is significantly lower than. The specific methodology used is described below:

For each row, every segment part is compared against each other segment, and a net score is calculated. For each other segment a part is significantly higher than, the net score increases by one. For each other segment a part is significantly lower than, the net score is decreased by one. In a row with four groups, if a given segment is significantly higher than all three others, it has a net score of 3, and if there are no other significant differences, every other group will have a net score of -1. Coloring is then done based off of this net score as seen in the key below:

Color Scheme Key

Score ≤-4	-3	-2	-1	0	1	2	3	Score ≥ 4

The intention is not to provide a perfect visual representation of every pairwise relation, as due to combinatoric principles, the number of potential relations can become very high, but to provide a high-level visual representation which should give the proper intuitions about the data. In a table with two columns, visual clutter is avoided by only showing the light green rather than both light green and light red, because in these tables it is binary. If one is green, i.e. significantly higher, then the other must be significantly lower.

Significant Differences by Presence of Children

In this portion of the report, differences are examined according to whether or not respondents have a child under the age of 18 in their household.

Respondents with children in their home were more likely than those without children to say they currently have insurance through their work, their spouse's work, or a parent's work, while those without children were more likely to currently have Medicare.

Segment Analysis Table 1
What is the current status of health coverage for you or the members of your household?
Statistically higher percentages are highlighted in green

	Children in Home	No Children in Home
	n=549	*n=454*
I or my household member(s) now have health insurance through my work, my spouse's work, or parent's work (employer)	48%	28%
I or my household member(s) are uninsured	30%	30%
I or my household member(s) enrolled in a health plan on healthcare.gov (federal health insurance marketplace)	15%	16%
Medicare	1%	15%
I or someone else purchased private health insurance for me or my household member(s) from another source	3%	6%
Medicaid in another state	1%	2%
Social Security Disability Insurance	0%	1%
Other	3%	4%

Respondents with children in the home were more likely than those without children to say "yes," they attempted to renew their Medicaid coverage.

Segment Analysis Table 2
Did you attempt to renew your Medicaid coverage?
Statistically higher percentages are highlighted in green

	Children in Home	No Children in Home
	n=478	*n=383*
Yes	55%	44%
No	45%	56%

Respondents with children in the home were more likely than those without children to say Medicaid's renewal process was "somewhat easy," while those without children were more likely to say this was "not applicable."

Segment Analysis Table 3
Thinking about Medicaid's renewal process, was it very easy, somewhat easy, somewhat difficult, or very difficult?
Statistically higher percentages are highlighted in green

	Children in Home	No Children in Home
	n=549	*n=454*
Very easy	7%	6%
Somewhat easy	22%	15%
Somewhat difficult	30%	24%
Very difficult	21%	24%
Not applicable	14%	24%
Don't recall	6%	7%

When asked about their experience filling out the review forms, respondents with children were more likely to say it was "somewhat easy" or "somewhat difficult," while those without children were more likely to say they "don't recall."

Segment Analysis Table 4
When thinking about forms provided by DWS to renew coverage, was filling out the review forms very easy, somewhat easy, somewhat difficult, or very difficult?
Statistically higher percentages are highlighted in green

	Children in Home	No Children in Home
	n=549	*n=454*
Very easy	11%	11%
Somewhat easy	32%	26%
Somewhat difficult	32%	26%
Very difficult	13%	17%
Don't recall	12%	20%

When rating Medicaid health coverage, on average, respondents with children in the home gave higher ratings than did those without children.

Segment Analysis Table 5
How would you rate Medicaid health coverage?
0-to-10 scale, 0=worst possible, 10=best possible
Statistically higher averages are highlighted in green

	Children in Home	No Children in Home
	n=549	*n=454*
Mean	7.13	6.57
Median	8.00	7.00

Significant Differences by Renewal Attempt

In this portion of the report, differences are examined according to whether or not respondents attempted to renew Medicaid.

When asked whether specific items describe the reasons they are no longer enrolled in Medicaid:

- Respondents who tried to renew were more likely to select:
  - "My household income was too high for Medicaid eligibility limits."
  - "The department took me or my household member(s) off, but I am not sure why."
  - "My child qualified for the Children's Health Insurance Program (CHIP)."
- Respondents who did not try to renew were more likely to select:
  - "I or my household member(s) have other health insurance now."
  - "I moved out of Utah."
  - "I decided I did not want or need Medicaid anymore."

Segment Analysis Table 6
From your point of view, which of the following describe the reasons you or another family member in your household is no longer enrolled in Medicaid?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=264-433	*n=214-428*
My household income was too high for Medicaid eligibility limits	63%	48%
I or my household member(s) have other health insurance now	8%	39%
The department took me or my household member(s) off, but I am not sure why	26%	11%
I did not think I, nor my household member(s), qualified for Medicaid	6%	10%
I moved out of Utah	0%	8%
I decided I did not want or need Medicaid anymore	0%	5%
My child qualified for the Children's Health Insurance Program (CHIP)	10%	3%
I did not submit the required documentation	3%	1%
I had a poor experience with DWS representatives	2%	1%
Due to issues with the Office of Recovery Services (ORS)	1%	1%
I had difficulty or mistakes in the application process	1%	0%
I cannot afford spenddown	1%	1%
I had a temporary Medicaid plan that expired	1%	1%
Medicaid has inadequate coverage	0%	1%
The child(ren) no longer lives in my home	0%	1%
Other	4%	3%

When asked what the current status of health coverage is for them and the members of their household:

- Respondents who tried to renew were more likely to select:
  - "I or my household member(s) are uninsured."
  - "My child now has CHIP."
- Respondents who did not try to renew were more likely to select:
  - "Have health insurance through my work, my spouse's work, or parent's work."
  - "Medicaid in another state."

Segment Analysis Table 7

What is the current status of health coverage for you or the members of your household?

Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=264-433	*n=214-428*
I or my household member(s) now have health insurance through my work, my spouse's work, or parent's work (employer)	28%	52%
I or my household member(s) are uninsured	39%	16%
I or my household member(s) enrolled in a health plan on healthcare.gov (federal health insurance marketplace)	18%	15%
Medicare	8%	7%
I or someone else purchased private health insurance for me or my household member(s) from another source	4%	4%
My child now has CHIP	14%	3%
Medicaid in another state	0%	4%
Social Security Disability Insurance	1%	0%
Other	3%	4%

Respondents who tried to renew were more likely than those who did not try to renew to say "yes," they did call the Department of Workforce Services in the last year.

Segment Analysis Table 8
In the last year, did you call the Department of Workforce Services (DWS) with a question, complaint, or problem?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=433	*n=428*
Yes	72%	50%
No	28%	50%

Among respondents who called the Department of Workforce Services, those who did not try to renew were more likely to say their question, complaint, or problem was resolved the same or next day, while those who did try to renew were more likely to say they are "still waiting for it to be resolved."

Segment Analysis Table 9
How long did it take DWS to resolve your question, complaint or problem?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=311	*n=214*
Same day or next day	32%	49%
2 to 7 days	21%	19%
8 to 14 days	9%	8%
More than 14 days	13%	11%
I am still waiting for it to be resolved	25%	13%

Respondents who did not try to renew were more likely to say the renewal process is "very easy," while those who did not try to renew were more likely to say it is "somewhat" or "very" difficult.

Segment Analysis Table 10
Thinking about Medicaid's renewal process, was it very easy, somewhat easy, somewhat difficult, or very difficult?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=433	*n=428*
Very easy	5%	9%
Somewhat easy	23%	19%
Somewhat difficult	34%	18%
Very difficult	31%	11%
Not applicable	4%	34%
Don't recall	3%	8%

Respondents who tried to renew were more likely to say turning in the paperwork is "very difficult."

Segment Analysis Table 11
Thinking about Medicaid's renewal process, documentation was requested, like pay stubs or other paperwork. In your opinion, was turning in this paperwork very easy, somewhat easy, somewhat difficult, or very difficult?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=433	*n=428*
Very easy	11%	14%
Somewhat easy	30%	25%
Somewhat difficult	31%	28%
Very difficult	24%	18%
Don't recall	3%	16%

Respondents who tried to renew were more likely to say that filling out the forms was “somewhat easy,” “somewhat difficult,” or “very difficult,” while those who did not renew could not recall.

Segment Analysis Table 12
When thinking about forms provided by DWS to renew coverage, was filling out the review forms very easy, somewhat easy, somewhat difficult, or very difficult?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=433	*n=428*
Very easy	12%	13%
Somewhat easy	34%	27%
Somewhat difficult	32%	24%
Very difficult	18%	11%
Don't recall	4%	25%

Respondents who tried to renew were more likely to say they would “definitely” re-enroll themselves or their household member in Medicaid if they could, while those who did not try to renew were more likely to be “undecided” or say they “definitely” or “probably” would not.

Segment Analysis Table 13
If you could re-enroll yourself or your household member(s) in Medicaid today, would you?
Statistically higher percentages are highlighted in green

	Renewal Attempt	No Renewal Attempt
	n=433	*n=428*
Definitely not	2%	8%
Probably not	2%	9%
Undecided	8%	15%
Probably	18%	22%
Definitely	70%	46%

APPENDIX A: SURVEY RESULTS

The Medicaid program would like your help. Our records show that one or more of the people in your household was enrolled in Medicaid in the last year but is not in the program now. We would like to understand the reasons why you or another member of your household are no longer enrolled in this program.

The answers you give us will be kept private and will have no effect on your ability to apply for Medicaid in the future.

The information gathered from this survey will help us improve services. Your participation is completely voluntary.

SECTION 1: WHY DISENROLLED?

1. Do you have children under the age of 18 who live in your home and were on Medicaid in the last year?

	n=1003	%
Yes	549	55%
No	454	45%

2. From your point of view, which of the following describe the reasons you or another family member in your household is no longer enrolled in Medicaid? Please select all that apply.

	n=1003	%
My household income was too high for Medicaid eligibility limits	515	51%
I or my household member(s) have other health insurance now	238	24%
The department took me or my household member(s) off, but I am not sure why	179	18%
I did not complete the renewal process	142	14%
I did not think I, nor my household member(s), qualified for Medicaid	114	11%
I moved out of Utah	39	4%
I decided I did not want or need Medicaid anymore	36	4%
I did not submit the required documentation	20	2%
I had a poor experience with DWS representatives	11	1%
I cannot afford spenddown	9	1%
I had difficulty or mistakes in the application process	9	1%
Due to issues with the Office of Recovery Services (ORS)	8	1%
I had a temporary Medicaid plan that expired (COVID-19, Pregnant Woman, etc.)	7	1%
Medicaid has inadequate coverage	7	1%
The child(ren) no longer lives in my home	5	0%
I have re-enrolled in Medicaid	0	0%
Other (specify)	36	4%

Options Presented Only for Respondents Who Said "Yes" to Q1	**n=549**	**%**
My child qualified for the Children's Health Insurance Program (CHIP)	35	6%
My child was too old for Medicaid	15	3%

3. What is the current status of health coverage for you or the members of your household? Please select all that apply.

	n=1003	%
I or my household member(s) now have health insurance through my work, my spouse's work, or parent's work (employer)	394	39%
I or my household member(s) are uninsured	303	30%
I or my household member(s) enrolled in a health plan on healthcare.gov (federal health insurance marketplace)	151	15%
Medicare	73	7%
I or someone else purchased private health insurance for me or my household member(s) from another source	39	4%
Medicaid in another state	16	2%
Social Security Disability Insurance	5	0%
Other (specify)	33	3%

Option Presented Only for Respondents Who Said "Yes" to Q1	n=549	%
My child now has CHIP	45	8%

4. *If NOT "I did not complete the renewal process" to Q2:* Did you attempt to renew your Medicaid coverage?

	n=861	%
Yes	433	50%
No	428	50%

5. *If "yes" to Q4:* Which of the following best describes your attempt to renew your Medicaid coverage?

	n=424	%
I tried completing the forms, but did not understand them and gave up	25	6%
I submitted the forms, but I was told they were incomplete	52	12%
I submitted the forms, but I was told I don't qualify	301	71%
I submitted the forms and have not heard back	18	4%
Other (specify)	28	7%

6. *If "I did not complete the renewal process" to Q2 or "no" to Q4, ask:* Which of the following describe WHY you did not complete your renewal? Please select all that apply.

	n=570	%
I did not need Medicaid anymore	199	35%
I never received renewal documents from DWS	106	19%
I did not get around to doing the paperwork	81	14%
The paperwork was too difficult to complete	73	13%
My household income exceeded the Medicaid eligibility limits	57	10%
I did not want to have Medicaid anymore	45	8%
I thought/was told I would not qualify	45	8%
I did not have the required documents to complete the review	41	7%
I moved out of Utah	26	5%
I cannot afford the spenddown	7	1%
Medicaid has inadequate coverage	7	1%
Other (specify)	22	4%

SECTION 2: CUSTOMER SERVICE

7. In the last year, did you call the Department of Workforce Services (DWS) with a question, complaint, or problem?

	n=1003	%
Yes	584	58%
No	419	42%

8. *If "yes" to Q7:* How long did it take DWS to resolve your question, complaint, or problem?

	n=584	%
Same day or next day	228	39%
2 to 7 days	112	19%
8 to 14 days	49	8%
More than 14 days	72	12%
I am still waiting for it to be resolved	123	21%

9. Thinking about Medicaid's **RENEWAL PROCESS**, was it…?

	n=1003	%
Very easy	65	6%
Somewhat easy	190	19%
Somewhat difficult	274	27%
Very difficult	225	22%
Not applicable	186	19%
Don't recall	63	6%

10. Thinking about Medicaid's renewal and enrollment process, **DOCUMENTATION** was requested, like pay stubs or other paperwork. In your opinion, was turning in this paperwork…?

	n=1003	%
Very easy	115	11%
Somewhat easy	258	26%
Somewhat difficult	313	31%
Very difficult	216	22%
Don't recall	101	10%

11. When thinking about the **FORMS** provided by DWS to renew coverage, was filling out the review forms…?

	n=1003	%
Very easy	112	11%
Somewhat easy	294	29%
Somewhat difficult	290	29%
Very difficult	151	15%
Don't recall	156	16%

SECTION 3: MEDICAID PROGRAM

12. Using a scale of 0 to 10, where 0 is the worst possible and 10 is the best possible, how would you rate Medicaid health coverage?

	n=1003	%
0 - Worst possible	50	5%
1	12	1%
2	23	2%
3	35	3%
4	40	4%
5	148	15%
6	70	7%
7	131	13%
8	164	16%
9	116	12%
10 - Best possible	214	21%
Mean	*6.88*	
Median	*7.00*	

13. If you could re-enroll yourself or your household member(s) in Medicaid today, would you?

	n=1003	%
Definitely not	45	4%
Probably not	54	5%
Undecided	119	12%
Probably	207	21%
Definitely	578	58%

14. In your opinion, what is the best thing about Medicaid?

Coded for All Mentions	n=1003	%
Free, low cost	288	29%
Good coverage	271	27%
Helpful to those in need	183	18%
Coverage for children	112	11%
Offers peace of mind, security	103	10%
Accessibility of doctors/care	86	9%
Prescription coverage	76	8%
Resource for lower income households	56	6%
Being insured, in general	54	5%
Ease, convenience	38	4%
Helpful to have, in general	37	4%
Nothing	26	3%
Customer service	20	2%
Miscellaneous responses	47	5%
Don't know, no comment	28	3%

15. What does Medicaid need to improve?

Coded for All Mentions	n=1003	%
Eligibility and income requirements	226	23%
Renewal/application process	134	13%
Communication and assistance	123	12%
Coverage and services	120	12%
Forms and documentation	118	12%
Good as is, no changes needed	82	8%
Customer service demeanor or knowledge	80	8%
Website, digital accessibility	66	7%
Phone wait times	57	6%
Provider accessibility/options	46	5%
Cancellation process	40	4%
Information sources and availability	40	4%
Notifications	29	3%
Additional/transitional support and services	25	2%
Out-of-pocket expenses (spenddown, copay, etc.)	16	2%
Response time	16	2%
Everything, needs to be improved in general	14	1%
Medicaid/coverage for all	14	1%
Accessibility, in general	10	1%
Increase number of caseworkers/DWS employees	10	1%
Stigma, prejudice	8	1%
ORS involvement/issues	7	1%
Miscellaneous responses	87	9%
Don't know, no comment	67	7%

That completes our survey. Thank you for your time and feedback! For more information about the Medicaid program or this survey, please call 1-866-608-9422.

Attachment F - Quality Pool

Article 1: Quality Incentive Pool

1.1 Purpose of the Quality Incentive Pool

(A) The Parties agree and understand that the Department has established a quality incentive pool to support the following initiatives in the Department's Quality Strategy:

(1) Better Care through an annual evaluation of plan performance on ACO Quality Measures and the Non-ACO Quality Measures Table; and

(2) Better Health to promote preventive care for women and children.

(B) The Parties agree and understand that the quality incentive pool is subject to CMS approval consistent with federal regulations under 42 CFR § 438. If the program is approved by CMS it will not be auto-renewed.

1.1.1 Goal of the Quality Incentive Pool

(A) The Parties agree and understand that the goals of the quality incentive pool are to improve quality using the following measurement areas:

(1) Timely and accurate encounter data submission to support the outcome of quality reporting;

(2) Member engagement;

(3) Achievement of health plan accreditation;

(4) Improvement on Healthcare Effectiveness Data and Information Set (HEDIS®) W30 (well-child visits in the first 15 and 16th to 30th months of life);

(5) Improvement on HEDIS® WCV (child and adolescent well-care visits for children 3-21 years of age);

(6) Improvement on HEDIS® CIS (childhood immunization status) combination 3; and

(7) Improvement on HEDIS® IMA (immunizations for adolescents).

(B) The Contractor shall have the opportunity to receive financial rewards if the Contractor meets specific performance benchmarks or improvement targets for the HEDIS® measures.

1.2 Quality Incentive Pool Size and Eligibility

1.2.1 Quality Incentive Pool Size

The total funding available for the quality incentive pool in SFY 2024 is 4.3% of the actual SFY 2024 Risk-Adjusted Base Capitation Payments paid in SFY 2024 for services in SFY 2024.

1.2.2 Quality Incentive Pool Eligibility

(A) There shall be two phases in determining the proportion of funds available for the Contractor:

(1) Phase 1 allows the Contractor to earn funds based on performance on seven quality incentive areas as noted in Article 1.1.1 of this attachment. The Contractor shall be eligible for a proportion of the pool based on their share of SFY 2024 Risk-Adjusted Base Capitation Payments. The proportion the Contractor earns within Phase 1 shall be based on performance outlined in Article 1.3 of this attachment.

(2) Phase 2 allows the Contractor to earn any remaining funds that were not allocated to the Health Plans in Phase 1. The funds shall be paid proportionally to the funds earned in Phase 1. The Contractor will not be eligible to receive more than 5% of its SFY 2024 Risk-Adjusted Base Capitation Payments through both the Phase 1 and Phase 2 distributions.

1.3 Measurements and Targets

1.3.1 Measure Overview

(A) The Contractor shall adhere to the contractual timelines to submit data, reports, or attestations and follow the guidance in the technical specification document for format, templates, and submission requirements. Unless submission failure falls within an exception set out in this Attachment, the Contractor shall not be eligible for quality incentive pool payments if required submissions are late or incomplete.

(B) The quality incentive pool payments shall be based on the Contractor's performance in ten areas. Each measure corresponds to a portion of the quality incentive pool that may be earned during phase 1 for successfully achieving the target goals outlined in Article 1.1 of this attachment. Table 1 outlines the percentage of Risk-Adjusted Base Capitation Payments associated with each measure, which called the "measure share." The measure share equals the maximum percentage of eligible Risk-Adjusted Base Capitation Payments that may be earned during phase 1 for successfully achieving each measure.

Table 1

Domain	Measure	Measure Share
Encounter Data	Encounter Data Timeliness and Accuracy	0.60%
Member Engagement	Member Engagement Panel	0.40%
	Member Engagement Initial Contact	0.40%
	Member Engagement Elimination of Access Barriers	0.40%
Accreditation	Commitment to become NCQA Accredited	0.50%
Improvement on HEDIS® Measures	HEDIS® W30 - 0-15 Months	0.25%
	HEDIS® W30 - 16-30 Months	0.25%
	HEDIS® WCV	0.50%
	HEDIS® CIS	0.50%
	HEDIS® IMA	0.50%
Total		4.30%

Each measure is described in more detail in the following sections.

1.3.2 Encounter Data Timeliness and Accuracy

(A) Consistent with Article 12.3.2(A) of Attachment B, the Contractor shall conduct an Encounter Data validation each quarter. To facilitate the validation, the Department shall send the Contractor an Encounter Data validation

questionnaire and an Encounter Data submission detail file containing all accepted Encounter Data for the specified quarter that may be used for rate setting. The Department shall ensure that the same query used to supply Encounter Data to its actuary is used to prepare the submission detail file.

(B) Each quarter, the Contractor shall complete a timely validation process. The Department waives requirement in this section for the first two quarters of SFY 2024 due to the implementation of the Department's new Medicaid Management Information System (PRISM). In order to achieve a targeted measure share of 0.60%, the Department will use a measure share of 1.2% for quarters 3 and 4 and then do an overall reconciliation when making the quarter 4 calculation to ensure that the overall measure share is 0.60% based on the Risk-Adjusted Base Capitation Payments. Before the start of quarter 3, the Department and the contractor shall meet and re-evaluate this requirement for quarters 3 and 4.

Table 2

Metric	Total Measure Share	SFY 2024 Q1 (% earned)	SFY 2024 Q2 (% earned)	SFY 2024 Q3 (% earned)	SFY 2024 Q4 (% earned)
Encounter Data Timeliness and Accuracy	0.60%	Waived	Waived	1.2% of Q3 Risk-Adjusted Base Capitation Payments	1.2% of Q3 Risk-Adjusted Base Capitation Payments

(C) The Contractor's eligibility to receive all or none of the available funding for each quarter shall be determined on a pass/fail basis. If the Contractor requests to re-open a previously validated quarter, the Department shall consider the Contractor failed on the entire measure and receive no funding for this measure during the performance year. The Department shall recoup all quarterly payments made to the Contractor when it has failed a measure in that quarter.

1.3.3 Encounter Data Timeliness and Accuracy Measurement Process

(A) The Department shall provide the Contractor a data set containing the same data used by the Department for the construction of the Medicaid data books

within 45 days of the end of each quarter. The Department shall ensure that the quarterly data sets are run using the same query that is used to provide the data to the Department's contracted actuary.

(B) If the Contractor identifies missing data, the Contractor shall notify the Department of the missing data within 30 calendar days.

(i) If the missing data is due to failure of the Contractor to submit encounters, the Contractor shall be permitted to submit the missing data if it meets the requirements found in Article 12.3.1(E) of Attachment B and Article 12.3.1(F) of Attachment B.

(ii) If the missing data does not meet the requirements found in Article 12.3.1(E) of Attachment B and Article 12.3.1(F) of Attachment B, the Contractor shall still submit the data to the Department; however, it shall not be used for rate setting.

(iii) If the missing data is due to the Department not submitting the data in the quarterly data set, the Department shall provide the Contractor with a revised file for validation within 30 days of the missing data being identified. The Contractor shall have an additional 30 days to validate the revised data set.

(C) If an issue is identified including but not limited to issues that are outside of the control of the Contractor, errors in data extraction/submission by the Department, the Department may extend the timelines outlined in Article 1.3.3 of this attachment and shall confirm the extension in writing.

(D) The Contractor shall submit a written attestation to the Department that the data set delivered to the Contractor is complete and accurate.

1.3.4 Encounter Data Timeliness and Accuracy Payments

(A) Upon receipt of the Contractor's written attestation, the Contractor shall qualify for the quarterly amount outlined in Article 1.3.2(B) of this attachment. The Department shall release the quarterly amount to the Contractor within 30 calendar days of receipt of the attestation.

(B) The quarterly payment shall be made using the following formula:

$$Payment = measure\ share * Risk - Adjusted\ Base\ Capitation\ Payments$$

(C) The quarterly Risk-Adjusted Base Capitation Payments shall be the data available through the end of each quarter.

(D) For the final quarter, the quarterly Risk-Adjusted Base Capitation Payments shall be the data available through July 31, 2024. The final quarterly payment shall also include adjustments to previous quarters based on capitation adjustments to those prior quarters received before July 31, 2024.

1.3.5 Member Engagement

(A) The Contractor shall actively solicit member feedback to identify and address disparities, improve service delivery, and increase customer satisfaction and member engagement. The Contractor may use this member engagement project to also meet the requirement to develop a Non-Clinical Performance Improvement Plan (PIP). As part of this effort, the Contractor shall be measured on three requirements:

(1) Member Engagement Panel: The Contractor shall convene a Member Engagement Panel.

(2) Member Engagement Initial Contact: Consistent with section 3.5.1(B) of Attachment B, the Contractor shall make an initial contact with new Enrollees within 10 business days after the Contractor has been notified through the Eligibility Transmission of the Enrollee's enrollment in the Contractor's Health Plan.

(3) Member Engagement Access Barriers: The Contractor shall identify and develop tools to address access barriers for its Enrollees.

(B) Each outcome's success shall be determined on a pass/fail basis each quarter where the Contractor shall receive all or none of the available funding for that measure for that quarter.

Table 3

Metric	Total Measure Share	SFY 2024 Q1 (% earned)	SFY 2024 Q2 (% earned)	SFY 2024 Q3 (% earned)	SFY 2024 Q4 (% earned)
Member Engagement Panel	0.40%	0.40% of Q1 Risk-Adjusted	0.40% of Q2 Risk-Adjusted	0.40% of Q3 Risk-Adjusted	0.40% of Q4 Risk-Adjusted

		Base Capitation Payments	Base Capitation Payments	Base Capitation Payments	Base Capitation Payments
Member Engagement Initial Contact	0.40%	0.40% of Q1 Risk-Adjusted Base Capitation Payments	0.40% of Q2 Risk-Adjusted Base Capitation Payments	0.40% of Q3 Risk-Adjusted Base Capitation Payments	0.40% of Q4 Risk-Adjusted Base Capitation Payments
Member Engagement Elimination of Access Barriers	0.40%	0.40% of Q1 Risk-Adjusted Base Capitation Payments	0.40% of Q2 Risk-Adjusted Base Capitation Payments	0.40% of Q3 Risk-Adjusted Base Capitation Payments	0.40% of Q4 Risk-Adjusted Base Capitation Payments

1.3.6 Member Engagement Panel Composition

(A) The Contractor shall establish a Member Engagement Panel that meets the following requirements:

(1) At least 8 Medicaid members who to the degree possible:

(i) represent various Medicaid programs:

(a) parents of Medicaid eligibles.

(b) adult expansion members.

(c) individuals with disabilities.

(ii) represent the cultural diversity of the Contractor's population by including representation of various races, ethnicities, and spoken languages.

(iii) represent the geographic diversity of the Contractor’s population, including representation from counties other than Salt Lake, Davis, Weber, and Utah.

1.3.7 Member Engagement Panel Activities

(A) In the first quarter, the Contractor shall:

(1) establish a quarterly meeting schedule, including meeting dates, times, and formats (in-person, virtual, or hybrid);

(2) develop a clear panel charter, outlining the panel's purpose, scope, and roles, as well as setting expectations for member participation and responsibilities;

(3) create a list of potential focus areas related to member experience, such as:

(i) access to care;

(ii) eligibility process;

(iii) health plan enrollment;

(iv) customer service;

(v) co-pays; or

(vi) member communication;

(4) develop guidelines and procedures for collecting, analyzing, and integrating feedback from panel members on the identified focus areas;

(5) set up communication channels and tools for panel members to easily share ideas, updates, and feedback outside of scheduled meetings; and

(6) identify key stakeholders and partners that the panel will collaborate with throughout the project.

(B) In the second quarter, the Contractor shall:

(1) collect Information about current initiatives related to member engagement;

(2) conduct panel meeting(s) to discuss relevant topics in-depth and identify priorities;

(3) encourage the panel to choose 1-2 focus areas from the identified topics, based on their significance and potential for improvement; and

(4) develop targeted questions and discussion points related to the chosen focus areas, facilitating comprehensive feedback collection from panel members.

(C) In the third quarter, the Contractor shall:

(1) conduct panel meeting(s);

(2) based on the feedback collected in the previous quarter, determine the next steps for addressing the identified concerns and opportunities in the 1-2 focus areas;

(3) assess the potential impact of the proposed changes on current services, considering factors such as cost, feasibility, barriers, and anticipated improvements in member engagement and satisfaction;

(4) develop specific recommendations and action plans for each focus area, outlining the proposed changes, their expected outcomes, and the resources required for implementation;

(5) present the recommendations and action plans to the committee for discussion, ensuring that all panel members have an opportunity to provide input and voice their concerns or suggestions; and

(6) document the feedback received by the panel regarding the recommendations and action plans. Revise recommendations based on the panel's feedback.

(D) In the fourth quarter, the Contractor shall:

(1) conduct panel meeting(s);

(2) implement member engagement initiative(s);

(3) meet with the panel to share how member engagement was utilized to inform change;

(4) discuss a new topic for member input;

(5) monitor the progress of implemented shorter-term initiatives, using established key performance indicators (KPIs) and data collection methods to track improvements in consumer engagement and satisfaction;

(6) establish process to monitor longer-term initiatives;

(7) identify any challenges or barriers arising during the implementation process, and how to overcome them; and

(8) establish a process for conducting a thorough evaluation of the implemented initiatives, assessing the overall effectiveness leveraging qualitative and quantitative analysis in addressing the concerns and opportunities identified in the chosen focus areas.

1.3.8 Member Engagement Quarterly Reporting

(A) By the 15th of the month following each quarter, the Contractor shall submit the following reports in a Department specified format based on its Member Engagement Activities:

(1) a report detailing the Contractor's Member Engagement Panel activities;

(2) a report describing the Contractor's efforts regarding initial Enrollee contact; and

(3) a report documenting the barriers identified, tools used to address barriers, and success of the tools used to address barriers.

1.3.9 Member Engagement Payments

(A) Upon Department review and acceptance of each quarterly report, the Contractor shall qualify for the quarterly amounts outlined in Article 1.3.5(B) of this attachment of this attachment. The Department shall release the quarterly amount to the Contractor within 30 calendar days of receipt of each quarterly report.

(B) The quarterly payment shall be made using the following formula:

$$Payment = measure\ share * Risk - Adjusted\ Base\ Capitation\ Payments$$

(C) For quarters 1 – 3, the quarterly Risk-Adjusted Base Capitation Payments shall be the data available through the end of each quarter.

(D) For the final quarter, the quarterly Risk-Adjusted Base Capitation Payments shall be the data available through July 31, 2024. The final quarterly payment shall also include adjustments to quarters 1 – 3 based on capitation adjustments to those prior quarters received before July 31, 2024.

1.3.10 Health Plan Accreditation

(A) The Contractor shall maintain or work towards achieving health plan accreditation during SFY 2024 to meet this benchmark. The Contractor shall be

deemed to meet the benchmark if they are accredited or if they attest that they will be accredited by one of the accrediting bodies chosen on the attestation form by July 1, 2027.

(B) This measure is a pass/fail measure and the Contractor shall receive the available funding if the Contractor is already accredited or based on:

(i) its submitted attestation of accreditation; and

(ii) an annual report detailing planned activities for that year and a quarterly report demonstrating progress toward achieving health plan accreditation.

(C) The payment shall be made using the following formula:

$$Payment = measure\ share * Risk - Adjusted\ Base\ Capitation\ Payments$$

(D) The Department shall make the payment between July 01, 2024 and September 30, 2024 after receiving the attestation or confirmation from the Contractor.

1.3.11 Improvement on HEDIS® Measures

(A) For each of the five HEDIS® measures, the Department will determine the following values for the Contractor:

(1) The “Contractor base” is the Contractor’s CY 2023 HEDIS® result as published in CY 2023.

(2) The “Contractor target” is the lower of:

(i) the nationwide average CY 2023 HEDIS® result as published in CY 2024; and

(ii) the “Contractor base” plus 5%.

(3) The “Contractor performance” is the Contractor’s CY 2023 HEDIS® result as published in CY 2024.

(B) For each measure, the funding received by the Contractor for the measure shall be determined in order as follows:

(1) If the Contractor's performance is above the Contractor target, the Contractor shall receive the total funding available.

(2) If the Contractor's performance is below the Contractor base, the Contractor shall receive none of the funding available.

(3) If the Contractor's performance is between the Contractor base and the Contractor target, the Contractor will receive a proportion of the funding available to it equal to:

$$Contractor\ share\ earned\ = \frac{Contractor\ performance - Contractor\ base}{Contractor\ target - Contractor\ base}$$

1.3.12 HEDIS® Calculation

(1) After the close of the fiscal year, the Department shall determine the quality incentive pool size available for the Contractor based on the proportion of the Contractor's share of SFY 2024 Risk-Adjusted Base Capitation Payments.

(2) The Department shall determine the proportion of each HEDIS® improvement measure met by the Contractor and the share of the total quality incentive pool earned.

1.3.13 Phase 2

(1) The Department shall determine the total payout earned by the Contractor in Phase 1 across all 10 measures and the final funding available for Phase 2.

(2) The Department shall redistribute the Phase 2 amount using the Contractor's share of Phase 1 quality payments by September 30, 2024.

1.4 Final Determinations

The Department shall make all final determinations on Contractor performance and capitation withhold calculations, including the total amount withheld and earned based on the Contractor's performance. The Department shall work with the Contractor to address any disputes regarding whether or not the Contractor qualifies for any portion of the quality incentive pool. Department decisions are final and not subject to administrative appeal.

Medicaid.gov
Keeping America Healthy

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State

Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State

Quarter Ending September 2022

View cost sharing and copayment information.

State

Alabama

Ingredient Cost

Ingredient cost is the lower of:

- Alabama average acquisition cost (AAC), or if not available, wholesaler acquisition cost (WAC) -4% for brand drugs and WAC +0% for generic drugs
- FUL
- U&C
- Average sale price (ASP) plus 6% (blood clotting factors)

Dispensing Fee

Professional dispensing fee is $10.64

State Maximum Allowance Cost (MAC)

No

State

Alaska

Ingredient Cost

Ingredient cost is:

- National Averaged Drug Acquisition Cost (NADAC)
- Gross Amount due
- U&C
- Submitted Ingredient Cost
- WAC plus 1%
- Federal upper limit (FUL).

Dispensing Fee

Professional dispensing fee is:

- $21.28 (pharmacy not located on the road system);
- $13.36 (pharmacy located on the road system);
- $16.58 (mediset pharmacy);
- $10.76 (out-of-state pharmacy)

State Maximum Allowance Cost (MAC)

No

State

Arizona

Ingredient Cost

Ingredient cost is:

- U&C
- The AHCCCS Maximum Allowable Cost (MAC)
- NADAC
- Contracted rates between AHCCCS and the FFS Pharmacy Benefit Manager

Dispensing Fee

Professional dispensing fee is:

- $10.11 for CMS Covered Outpatient Drugs including specialty medications;
- $15.34 for compounded prescriptions

State Maximum Allowance Cost (MAC)

Yes

State

Arkansas

Ingredient Cost

Ingredient cost is lower of:

- NADAC; or
- state AAC; or
- FUL

Dispensing Fee

Professional dispensing fee is:

- $9.00 for brand and non-preferred brands;
- $10.50 for preferred brand and generics

State Maximum Allowance Cost (MAC)

No

State

California

Ingredient Cost

Ingredient cost is:

The “drug’s ingredient cost” means the lowest of:

- NADAC;
- or when no NADAC is available, the WAC plus 0%; or
- FUL; or
- The Maximum Allowable Ingredient Cost (MAIC).

Dispensing Fee

Professional dispensing fee is:

- $13.20 for claims less than 90,000
- $10.05 for claims 90,000 or more

State Maximum Allowance Cost (MAC)

Yes

State

Colorado

Ingredient Cost

Ingredient cost for all drugs for retail pharmacies, rural, mail order, specialty, government, institutional and long term care pharmacies shall be based upon the lower of:

- The U&C charge to the public or
- The allowed ingredient cost.

The allowed ingredient cost is the lesser of AAC, NACAC, or submitted ingredient cost. If AAC and NADAC are not available the allowed ingredient cost is the lesser of MAC or the submitted drug ingredient cost.

Physician-administered drugs (PAD) are reimbursed at ASP -3.3%, excepting injectable opioid antagonists, which are reimbursed at ASP +2.2%. PADs without ASP are reimbursed at WAC.

Dispensing Fee

The professional dispensing fees for all pharmacies except government and rural pharmacies shall be tiered based upon annual total prescription volume. The dispensing fees shall be tiered at:

- Less than 60,000 total prescriptions filled per year = $13.40
- Between 60,000 and 90,000 total prescriptions filled per year = $11.49
- Between 90,000 and 110,000 total prescriptions filled per year = $10.25
- Greater than 110,000 total prescriptions filled per year = $9.31

The determination of total prescription volume shall be completed by surveying pharmacies on an annual basis. Pharmacies failing to respond to the survey shall be reimbursed the $9.31 professional dispensing fee.

The tiered professional dispensing fee shall not apply to government pharmacies which shall instead be reimbursed a $0.00 professional dispensing fee.

The tiered professional dispensing fee shall not apply to rural pharmacies, which shall instead be reimbursed a $14.14 professional dispensing fee.

The enhanced professional dispensing fee for clotting factor drugs shall be $0.03 per unit

State Maximum Allowance Cost (MAC)

No

State

Connecticut

Ingredient Cost

Ingredient cost is lowest of:

The usual and customary

- NADAC
- FUL or
- (WAC) plus zero (0) percent
- PAD is 100% of the Medicare Average Sale Price (ASP)

Dispensing Fee

Professional dispensing fee is $10.75

State Maximum Allowance Cost (MAC)

NO

State

Delaware

Ingredient Cost

Ingredient cost is the lowest of:

- U&C
- NADAC
- WAC for legend drugs
- WAC -2% for non-legend drugs
- Delaware Maximum Allowable Cost
- AAC

Dispensing Fee

Professional dispensing fee is $10.00

State Maximum Allowance Cost (MAC)

Yes

State

District of Columbia

Ingredient Cost

Ingredient cost is:

- Brand Name Drugs: the lesser of the pharmacies' U&C, AAC, or WAC.
- Multiple Source Drugs: the lesser of FUL, NADAC, WAC, the pharmacy's U&C, or the District Maximum Allowable Cost (DMAC).
- 340B purchased drugs, Federal Supply Schedule (FSS), nominal price: AAC

Dispensing Fee

Professional dispensing fee is $11.15

State Maximum Allowance Cost (MAC)

Yes

State

Florida

Ingredient Cost

Ingredient cost is lower of:

- NADAC,
- WAC plus 0%
- SMAC,
- provider's U&C

Dispensing Fee

Professional dispensing fee is $10.24

State Maximum Allowance Cost (MAC)

Yes

State

Georgia

Ingredient Cost

Reimbursement for legend and non-legend drugs shall not exceed the lowest of:

- The Georgia Maximum Allowable Cost (GMAC),

- The Georgia Estimated Actual Acquisition Cost (GEAC),
- FUL,
- The usual and customary charge or the submitted ingredient cost

The Select Specialty Pharmacy Rate (SSPR)

Dispensing Fee

Professional Dispensing fee is $10.63 for pharmacies

State Maximum Allowance Cost (MAC)

Yes

State

Hawaii

Ingredient Cost

For single source drugs:

- Submitted ingredient cost
- Provider's U&C
- WAC
- NADAC

For multiple source drugs:

- Submitted ingredient cost
- Provider's U&C
- WAC
- FUL
- SMAC
- NADAC

Dispensing Fee

Professional Dispensing fee is $10.76 per prescription

State Maximum Allowance Cost (MAC)

Yes

State

Idaho

Ingredient Cost

Ingredient cost is:

- AAC, or where there is no AAC reimbursement is WAC

Dispensing Fee

Professional dispensing fees:

- Less than 39,999 claims a year = $15.11
- Between 40,000 and 69,999 claims per year = $12.35
- 70,000 or more claims per year = $11.51

State Maximum Allowance Cost (MAC)

Yes

State

Illinois

Ingredient Cost

Ingredient cost is lower of:

The pharmacy's usual and customary charge to the general public.

Single source drugs: the lower of:

- National Average Drug Acquisition Cost, if available
- Wholesale acquisition cost of national drug code on claim minus 4.4%
- The State upper limit

Multiple source drugs: the lower of:

- National Average Drug Acquisition Cost, if available
- Wholesale acquisition cost of national drug code on claim minus 17.5%
- The federal upper limit
- The State upper limit

Dispensing Fee

Professional dispensing fees:

- Critical Access Pharmacies PDF is $15.55 for both single source and multiple source drugs
- For all other pharmacies, PDF is $8.85 for both single source and multiple source drugs

State Maximum Allowance Cost (MAC)

Yes

State

Indiana

Ingredient Cost

Ingredient cost is lower of:

- NADAC;
- State MAC;
- The FUL; or
- WAC

Dispensing Fee

Professional dispensing fee is $10.48

State Maximum Allowance Cost (MAC)

Yes

State

Iowa

Ingredient Cost

Ingredient cost is:

- AAC as determined from surveys or where there is no AAC reimbursement is WAC

Dispensing Fee

Professional dispensing fee is $10.38

State Maximum Allowance Cost (MAC)

No

State

Kansas

Ingredient Cost

Ingredient cost is the lower of:

- NADAC,

- WAC,
- FUL,
- SMAC,
- Submitted Ingredient Cost, or
- The U&C

DAW

Payment for Dispense as Written 1 (DAW1) –will be reimbursed the drug ingredient cost plus a professional dispensing

fee of $10.50. The drug ingredient cost reimbursement shall be the lowest of:

- The National Average Drug Acquisition Cost (NADAC) of the drug; or
- Wholesale Acquisition Cost (WAC) + 0%; or
- The provider's usual and customary (U & C) charge to the public, as identified by the claim charge. No dispensing fee given; or
- d) Pharmacy submitted ingredient cost.

Dispensing Fee

Professional dispensing fee is $10.50

State Maximum Allowance Cost (MAC)

Yes

State

Kentucky

Ingredient Cost

Ingredient cost for:

Legend, non-legend, specialty drugs, and long-term care is the lower of:

- NADAC,
- WAC plus 0%,
- The FUL,
- The State MAC, or
- U&C).
- ASP plus 6% is included in the lower of logic for clotting factor and physician administered drugs

340B purchased drugs, FSS, nominal price:

- AAC

Dispensing Fee

Professional dispensing fee is $10.64

State Maximum Allowance Cost (MAC)

Yes

State

Louisiana

Ingredient Cost

Ingredient cost for brand is the lower of:

- NADAC,
- WAC, or
- U&C

Ingredient cost for generics is the lower of:

- NADAC,
- WAC,
- FUL, or
- U&C

Dispensing Fee

Professional dispensing fee is:

- $10.99

State Maximum Allowance Cost (MAC)

No

State

Maine

Ingredient Cost

Ingredient cost is lower of:

Generic Drugs –

- NADAC,

- FUL,
- WAC,
- The State MAC,
- The Submitted Ingredient Cost dispensing fee,
- U&C,
- GAD, or
- AWP – 16.67%

Brand-name Drugs -

- NADAC,
- WAC,
- The State MAC,
- The Submitted Ingredient Cost dispensing fee,
- U&C,
- GAD, or
- AWP – 16%

Specialty Pharmacy Providers -

- NADAC,
- FUL,
- WAC,
- The State MAC,
- The Submitted Ingredient Cost dispensing fee,
- U&C,
- GAD, or
- AWP – 16.67%

Dispensing Fee

Professional dispensing fee is $11.89

State Maximum Allowance Cost (MAC)

Yes

State

Maryland

Ingredient Cost

Ingredient cost is lower of:

- NADAC,
- WAC plus 0%,
- FUL,
- State AAC,
- U&C

Dispensing Fee

Professional dispensing fee is:

- $10.67 for covered outpatient legend and non-legend drugs dispensed by a retail community pharmacy; specialty drugs not dispensed by a retail community pharmacy but dispensed primarily through the mail; for clotting factor drugs from specialty pharmacies, hemophilia treatment centers (HTC) and Centers of Excellence; Drugs purchased through the Federal Supply Schedule (FSS); Drugs purchased at Nominal Price (outside of 340B or FSS).
- $11.67 for drugs not dispensed by a retail community pharmacy (i.e., institutional or long-term care facility pharmacies)
- $12.12 for 340B covered entities and Federally Qualified Health Centers (FQHCs)

State Maximum Allowance Cost (MAC)

NO

State

Massachusetts

Ingredient Cost

Ingredient cost is lowest of:

- FUL
- WAC
- NADAC
- U&C

340B drugs is the AAC of the drug

Non - 340B Clotting factor is lowest of:

- NADAC
- WAC
- ASP + 6%
- U&C

340B Clotting Factor is Ceiling Price

Dispensing Fee

Professional Dispensing fee is:

- $10.02
- $10.02 for non-340B Clotting Factor
- $10.02 plus 2.75 cents per unit for 340B Clotting Factor

State Maximum Allowance Cost (MAC)

No

State

Michigan

Ingredient Cost

Ingredient cost is:

- NADAC
- WAC
- MAC
- U&C

Dispensing Fee

Professional dispensing fee is:

- $20.02 for specialty drugs
- $10.80 for drugs preferred on PDL
- $10.64 for drugs not on PDL
- $9.00 for drugs on PDL but non-preferred

State Maximum Allowance Cost (MAC)

Yes

State

Minnesota

Ingredient Cost

Ingredient cost is the lower of:

- NADAC
- the State MAC
- U&C

For drugs for which NADAC is not reported and the maximum allowable cost is not calculated:

- WAC -2%

The ingredient cost is adjusted to account for the Minnesota Wholesale Drug Tax.

Dispensing Fee

Professional dispensing fee is $10.48

The professional dispensing fee for prescribed over-the-counter drugs that are not "covered outpatient drugs" is $3.65. The dispensing fee is prorated based on the percent of the package dispensed when the pharmacy dispenses a quantity less than the manufacturer's package size.

State Maximum Allowance Cost (MAC)

Yes

State

Mississippi

Ingredient Cost

Ingredient cost is lesser of:

- NADAC, or
- WAC plus 0% no NADAC is available, or
- A rate set by the Division of Medicaid's rate-setting vendor when no NADAC or WAC are available, or
- The provider's usual and customary charge.
- PAD - CADDs reimbursed the lesser of the National Average Drug Acquisition Cost (NADAC), the Wholesale Acquisition Cost (WAC) + 0% or the providers' usual and customary charges to the general public

Dispensing Fee

Professional dispensing fee is $11.29

Professional dispensing fee for specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail is $61.14.

State Maximum Allowance Cost (MAC)

No

State

Missouri

Ingredient Cost

Ingredient cost is lower of:

- AWP minus 10.43%, or
- WAC plus 10%

Dispensing Fee

Dispensing fee is $4.09

State Maximum Allowance Cost (MAC)

No

State

Montana

Ingredient Cost

Ingredient cost is lower of:

- AAC,
- Submitted Ingredient Cost,
- WAC, or
- FUL

Dispensing Fee

Professional dispensing fee is:

- $11.41 for pharmacies with annual prescription volume > 70,000
- $13.49 for pharmacies with annual prescription volume 40,000 – 69,999
- $15.57 for pharmacies with annual prescription volume 0 – 39,999

State Maximum Allowance Cost (MAC)

No

State

Nebraska

Ingredient Cost

Ingredient cost is the lower of:

- NADAC,
- FUL,
- MAC, or
- U&C.

If NADAC pricing is not available:

- WAC plus 0% will be included in the lower of logic (legend, non-legend, specialty drugs, long-term care);
- ASP plus 6% and when ASP is unavailable, WAC plus 6.8% or manual pricing at actual acquisition cost (physician administered drugs);
- AAC (340B purchased drugs, FSS, nominal price); the lesser of NADAC, WAC plus 0%, ASP plus 6%, FUL (clotting factor).

Dispensing Fee

Professional dispensing fee is $10.02

State Maximum Allowance Cost (MAC)

Yes

State

Nevada

Ingredient Cost

Ingredient cost is the lower of:

- NADAC,
- FUL,
- SMAC, or
- U&C

Dispensing Fee

Professional Dispensing Fee is $10.17

State Maximum Allowance Cost (MAC)

Yes

State

New Hampshire

Ingredient Cost

Ingredient cost is lower of:

- NADAC
- WAC +0%
- SMAC
- FUL
- U&C

Dispensing Fee

Professional dispensing fee is:

- $10.47

State Maximum Allowance Cost (MAC)

Yes

State

New Jersey

Ingredient Cost

Ingredient cost is:

- NADAC,
- WAC minus 2%,
- SWP minus 19%,

Ingredient cost for PAD shall be the lowest of:

- a drug or Long-Acting Reversible Contraceptive (LARC) Wholesale Acquisition Cost (WAC) less a discount of one (1) percent,
- FUL

- SUL
- the actual drug acquisition cost, as billed in the submitted charge field (in the case of a drug dispensed from 340B inventory, this will be the 340B acquisition price).

Dispensing Fee

Professional dispensing fee is:

- $10.92

State Maximum Allowance Cost (MAC)

No

State

New Mexico

Ingredient Cost

Ingredient cost is lower of:

- FUL
- NADAC
- WAC Plus 6%
- Ingredient Cost
- U & C

Dispensing Fee

Professional Dispensing fee is $10.30

State Maximum Allowance Cost (MAC)

No

State

New York

Ingredient Cost

Ingredient cost is:

- NADAC
- WAC less 3.3% (brand)
- WAC less 17.5% (generic)
- FUL

- SMAC
- U&C

Dispensing Fee

Professional Dispensing fee is $10.18

State Maximum Allowance Cost (MAC)

Yes

State

North Carolina

Ingredient Cost

Ingredient cost is the lower of:

- NADAC,
- MAC,
- U&C,or
- GAD

If NADAC pricing is not available:

- WAC plus 0% will be included in the lower of logic (legend, non-legend, specialty drugs, long-term care);
- ASP plus 6% or if ASP is unavailable, AWP minus 10% (physician administered drugs);
- WAC plus 6% (physician administered contraceptive drugs);
- AAC (340B purchased drugs, FSS, nominal price);
- The lower of NADAC, MAC or U&C (clotting factor)

Dispensing Fee

Tiered professional dispensing fee:

- $13.00 when 85% or more of claims per quarter are for generic or preferred brand drugs
- $7.88 when less than 85% of claims per quarter are for generic or preferred brand drugs and
- $3.98 for non-preferred brand drugs.
- Clotting factor: HTC $0.04 per unit and non-HTC $0.025 per unit

State Maximum Allowance Cost (MAC)

Yes

State

North Dakota

Ingredient Cost

Ingredient cost for legend, non-legend, specialty drugs, long-term care, physician administered drugs, clotting factor is the lower of:

- NADAC,
- WAC,
- MAC,
- U&C

The lower of logic also includes:

- AAC (340B, 340B physician administered drugs, FSS, Nominal Price);
- 340B contract pharmacies not covered;
- Invoice pricing (investigational drugs).
- For PADs, reimbursement will be the lesser of the Medicare Fee Schedule and all of the logic as outlined above.

Dispensing Fee

Professional dispensing fee is $12.46; plus $0.15 per pill (pill splitting)

State Maximum Allowance Cost (MAC)

Yes

State

Ohio

Ingredient Cost

Ingredient cost is lower of:

- NADAC PDF or;
- U&C

If NADAC is not available, AAC is the lesser of:

- WAC (WAC plus 0%);
- SMAC;
- Provider's U&C

- Drugs purchased by 340B covered entities through the federal 340B program will be paid at ingredient cost 340B AAC
- Drugs purchased by 340B CE's outside of the federal 340B program = AAC

FSS – paid at AAC

NP- paid at AAC

Specialty drugs – AAC

Clotting Factor will be the lesser of:

- Payment limit shown in Medicare Part B pricing file, minus the furnishing fee
- Provider's U&C

Provider Administered Drugs (other than VCF vaccines) :

- SMAC
- Payment limit shown in the current Medicare Part B drug pricing file;
- 107% of WAC
- 85.6% of AWP

Dispensing Fee

Professional dispensing fee is tiered:

Less than 49,999 prescriptions per year = $13.64 Between than 50,000 and 74,999 prescriptions per year = $10.80;

Between than 50,000 and 74,999 prescriptions per year = $9.51;

100,000 or more prescriptions per year = $8.30

State Maximum Allowance Cost (MAC)

Yes

State

Oklahoma

Ingredient Cost

The ingredient cost for Brand Name Drugs is the lower of:

- NADAC; or
- WAC

The ingredient cost for Generic Drugs is the lower of:

- State MAC,
- NADAC, or
- WAC

Dispensing Fee

Professional dispensing fee is $10.87

State Maximum Allowance Cost (MAC)

Yes

State

Oregon

Ingredient Cost

Ingredient cost is the lower of:

- Oregon-specific AAC file,
- NADAC,
- WAC plus 0%, or
- U&C

Dispensing Fee

Professional Dispensing Fee varies by claims volume;

- less than 30,000 claims a year is $14.30;
- between 30,000 and 69,999 claims per year is $11.91;
- 70,000 or more claims per year is $9.80

State Maximum Allowance Cost (MAC)

No

State

Pennsylvania

Ingredient Cost

Ingredient cost for brand drugs is the lower of:

- Provider's U&C to the general public,
- NADAC or

- In the absence of a NADAC, Wholesale Acquisition Cost (WAC) minus 3.3%

Ingredient cost for generic is the lower of:

- Provider's U&C to the general public,
- NADAC or
- In the absence of a NADAC, WAC minus 50.5%
- FUL
- State MAC

Dispensing Fee

Professional Dispensing fee is:

- $10.00

State Maximum Allowance Cost (MAC)

Yes

State

Rhode Island

Ingredient Cost

Ingredient cost is the lower of:

- NADAC,
- WAC plus 0%,
- FUL,
- SMAC,
- FDB SWD minus 19%, or
- U&C

Dispensing Fee

Professional Dispensing Fee is:

- $8.96;
- $7.90 (Beneficiaries residing in a long-term care facility)

State Maximum Allowance Cost (MAC)

Yes

State

South Carolina

Ingredient Cost

Ingredient cost is lower of:

- NADAC,
- If a NADAC does not exist, WAC minus 0%,
- SMAC, or
- U&C

Dispensing Fee

Professional Dispensing fee is $10.50

State Maximum Allowance Cost (MAC)

Yes

State

South Dakota

Ingredient Cost

Ingredient cost is:

- U&C,
- SMAC,
- NADAC, or
- WAC

Dispensing Fee

Professional Dispensing fee is $10.50

State Maximum Allowance Cost (MAC)

Yes

State

Tennessee

Ingredient Cost

Ingredient cost is:

- FUL; or

- AAAC, if there is no FUL or if the AAAC is lower than the FUL, or
- NADAC, if there is no AAAC or if the NADAC is lower than the AAAC; or
- WAC minus three percent for brand-name drugs or WAC minus six percent for generic drugs, if there is no AAAC or NADAC; or
- U&C

Dispensing Fee

Professional Dispensing fee is:

- For ambulatory pharmacies, the professional dispensing fee will be tiered based on annual prescription volume. The tiers are:
- $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year;
- $8.37 for pharmacies with a prescription volume of 65,000 or more claims per year.
- $11.98 for pharmacies that opened within one year of the State's cost-of-dispensing survey.
- 340B
- For claims submitted as 340B claims, the professional dispensing fee is set at $15.40.
- For claims submitted as non-340B claims, the professional dispensing fee is set at $11.98.
- Long-term care pharmacies is set at $11.98
- Specialty pharmacies:
- For non-specialty drugs dispensed by in-state specialty pharmacies is set at $11.98.
- The professional dispensing fee for specialty drugs (regardless of which type of pharmacy dispenses them) is set at $45.94.
- Blood Clotting Factors dispensing fee of $172.69
- For Out-of-State Pharmacies:
- Prescription volume of less than 65,000 claims per year and that are located in border areas closer to TennCare members than Tennessee pharmacies are, the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $11.98.
- For all other out-of-state pharmacies serving TennCare members (including out-of-state specialty pharmacies), the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $8.37.
- The professional dispensing fee for specialty drugs dispensed by out-of-state pharmacies is set at $45.94.
- The professional dispensing fee for blood clotting factors and other blood products dispensed by out-of-state pharmacies is set at $172.69.

- Pharmacies that Fail to Respond to a Mandatory Pharmacy Reimbursement Survey:
- Failure to provide a useable response to two mandatory surveys, the professional dispensing fee is set at the State's lowest calculated rate of $8.37.
- Failure to provide a useable response to three mandatory surveys, the professional dispensing fee is set at $5.00.
- A pharmacy that receives a lower dispensing fee because of failure to provide a useable response to a mandatory survey may resume receiving its usual dispensing fee by submitting a useable response to the next mandatory survey.
- Reimbursement for compounded prescriptions:

Level 1 (0-15 minutes) – $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year, and $10.00 for pharmacies with a prescription volume of 65,000 or more claims per year / Level 2 (16-30 minutes) – $15.00 / Level 3 (31 or more minutes) – $25.00

State Maximum Allowance Cost (MAC)

NO

State

Texas

Ingredient Cost

Ingredient costs of legend and nonlegend drugs:

- Retail = NADAC
- Long term care (LTC) = (NADAC minus 2.4%)
- Specialty = (NADAC minus 1.7%)

If NADAC is not available for a specific drug:

- Retail = (WAC minus 2%)
- LTC = (WAC minus 3.4%)
- Specialty = (WAC minus 8%)
- 340B is based on state's estimate of the 340 ceiling price

Dispensing Fee

Professional Dispensing fee is:

- ((Acquisition Cost + Fixed Component) divided by (1 – the percentage used to calculate the Variable Component)) - Acquisition Cost) + Delivery Incentive + Preferred Generic Incentive

State Maximum Allowance Cost (MAC)

No

State

Utah

Ingredient Cost

Ingredient cost is the lesser of:

- Utah Estimated Acquisition Cost (UEAC),
- FUL,
- Utah Maximum Allowable Cost National Average Drug Acquisition Cost (NADAC), or
- Submitted Ingredient Cost

Dispensing Fee

Professional Dispensing fee is:

- $9.99 (urban) located in Utah;
- $10.15 (rural) located in Utah.
- $9.99 for out of state pharmacies
- $716.54 for hemophilia clotting factor dispensed by the contracted pharmacy and in accordance with the hemophilia disease management program

State Maximum Allowance Cost (MAC)

Yes

State

Vermont

Ingredient Cost

Ingredient cost will be reimbursed the lowest of:

- NADAC + PDF; ;
- WAC + 0% + PDF; ;
- SMAC + PDF;
- FUL + PDF;
- AWP-19% + PDF;
- Submitted Ingredient Cost + Submitted dispensing fee;
- Provider's U&C charges; or

- Gross Amount Due

Dispensing Fee

Professional Dispensing fee is:

- for a retail community pharmacy, institutional or long term care pharmacy is $11.13.
- for specialty drugs including but not limited to biologics and limited distribution drugs is $17.03.

State Maximum Allowance Cost (MAC)

Yes

State

Virginia

Ingredient Cost

Ingredient cost for legend, non-legend, specialty drugs, long-term care is the lower of:

- NADAC,
- WAC,
- FUL, or
- U&C

Ingredient cost for other drugs:

- Lower of NADAC, WAC, U&C (clotting factor);
- AAC (340B, 340B physician administered drugs, FSS, Nominal Price);
- ASP plus 6% (physician administered drugs)

Dispensing Fee

Professional dispensing fee is $10.65

State Maximum Allowance Cost (MAC)

No

State

Washington

Ingredient Cost

Ingredient cost for covered outpatient drugs is the lowest of:

- NADAC
- MAC

- U&C charge to non-Medicaid population
- WAC (if NADAC does not exist)
- AAC (if requested by provider and submits proof of invoice)

Ingredient cost for other drugs:

- AAC (340B, 340B PADs, 340B contraceptives)
- ASP+6% (PADs)
- Lesser of NADAC, MAC, U&C, WAC (ASP not published, no assigned HCPCS)
- MAC (contraceptives)

Dispensing Fee

- High-volume pharmacies (over 35,000 Rxs/yr) $4.24/Rx
- Mid-volume pharmacies (15,001-35,000 Rxs/yr) $4.56/Rx
- Low volume pharmacies (15,000 Rxs/yr and under) $5.25/Rx
- Unit Dose Systems $5.25/Rx

State Maximum Allowance Cost (MAC)

Yes

State

West Virginia

Ingredient Cost

Ingredient cost is the lower of:

- NADAC;
- If no NADAC, then WAC+0% ;
- FU ;
- SMAC;
- Submitted ingredient cos;
- Provider's U&C

340B Purchased drugs:

Drugs purchased by CE's reimbursed lower of AAC plus the PDF

Drugs purchased outside of 340B program by CEs will be reimbursed lower of:

- NADAC;

- No NADAC, then WAC plus 0%;
- FUL;
- SMAC
- Submitted ingredient cost;
- Provider's U&C

FSS: AAC

NP: AAC

Specialty drugs & drugs not dispensed by a retail community pharmacy will be reimbursed the lower of:

- NADAC;
- No NADAC, then WAC plus 0%;
- FUL;
- SMAC
- Submitted ingredient cost;
- Provider's U&C

Clotting Factor is reimbursed at WAC plus 0%.

Dispensing Fee

Professional Dispensing fee is:

- $10.49

State Maximum Allowance Cost (MAC)

Yes

State

Wisconsin

Ingredient Cost

Ingredient cost is lower of:

- NADAC
- U&C
- If NADAC is not available,
- WAC

- SMAC
- Provider's U&C;
- 340B covered entity (including I/T/U) pharmacies will receive AAC ingredient cost (not to exceed the 340B ceiling price) plus PDF
- Drugs purchased outside of 340B program by CE's = AAC
- Specialty drugs based on State SMAC

Lower of SMAC or

Provider's U&C

- FSS - reimbursed ingredient cost (AAC)
- NP - reimbursed ingredient cost (AAC)

Dispensing Fee

Professional Dispensing fee is based on annual prescription volume:

- Less than 34,999 prescriptions per year $15.69;
- $35,000 or more prescriptions per year is $ 10.51;
- Non-tribal FQHC $24.92
- $0.015 per unit (for repackaging);
- $7.79 (compound drug fee);
- $9.45 to $40.11 (pharmaceutical care dispensing fee)

State Maximum Allowance Cost (MAC)

Yes

State

Wyoming

Ingredient Cost

Ingredient cost for legend, non-legend, specialty drugs, long term care pharmacies, and clotting factor is the lower of:

- NADAC;
- No NADAC WAC plus 0%
- FUL;
- SMAC;

- Ingredient Cost submitted;
- GAD;
- Provider's U&C

(Reimbursement for claims that pay GAD or U&C do not include the $10.65 PDF).

340B purchased products shall bill no more than AAC.

Drugs purchased outside of 340B program and dispensed by 340B contact pharmacies are not covered.

FSS = No more than the AAC for the cost of the drug.

Nominal Price = No more than AAC for the drug.

PADs submitted under the medical benefit will be reimbursed 100% of ASP. PADs without an ASP will be reimbursed at WAC plus 0%.

Dispensing Fee

Professional Dispensing fee is $10.65

State Maximum Allowance Cost (MAC)

Yes

Questions regarding the topics on this page? Email RxDrugPolicy@cms.hhs.gov.

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Page last updated on November 16, 2022

Accountable Budget Process Questions for Medicaid Services

Purpose: The Accountable Budget Process is intended to allow legislators a more thorough review of line item or program purposes, outcomes, spending, and finance in the legislative interim session.

1. Why is the state involved? List the specific statute, rule, or other authority that authorizes this function. 26B-3-108. Administration of Medicaid program by department
2. What are this function's intended outcomes and how do managers measure progress toward those outcomes? Health of Medicaid members Please report on the function's:
   a. Performance measures and results for the past five years (if fewer than five years are available, provide as many years as are available).

Measure	Target	FY19	FY20	FY21	FY22	FY23
Percentage of children 3-17 years of age who had an outpatient visit with a primary care practitioner or OB/GYN and who had evidence of BMI percentile documentation	70%	74%	77%	77%	70%	
The percentage of adults 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled	65%	66%	61%	68%	65%	
Annual state general funds saved through preferred drug list	$16 mil	$22.5 mil	$22. 2 mil	$22. 4 mil	$22.3 mil	$22.8 mil
Percent of members/patients/clients that report adequate access to DHHS Medicaid program services	85%					83%
Percent of Medicaid adult members that receive services from an integrated health plan or other integrated model	50%				44%	34%
Average decision time on pharmacy prior authorizations	24 days					10.3 days
Average decision time on medical prior authorizations	7 days		3.95	6.8	5.02	3.67
Percent of clean claims adjudicated by PRISM within 30 days of submission	90%	N/A	N/A	N/A	N/A	N/A

People receiving supports in their home or a family member's home rather than a residential setting	57%					53%
Percent of Medicaid adults and adolescents with major depressive episodes who receive treatment	56.3% acute phase 33.2% continuation phase		43%	54%	56%	57%
Annual State general funds saved through preferred drug list	$20 mil	$22.5 mil	$22.2 mil	$22.4 mil	$22.3 mil	$22.8 mil
Percent of Medicaid members who promptly receive outpatient treatment after visiting a hospital for mental health issues		14%	16%	14%	12%	

b. Internal budget process.
Budget is based on the CHIP and Medicaid consensus process.

c. Budget controls (internal financial controls). (See UCA 63J-1-903)(11)) DIH employs the following budget controls to ensure proper purchases and payments are made, according with available funds and budgets:

i. All purchases begin with an internal purchase order that requires the signatures of the requester, financial reviewer, and authorizing manager.
ii. The purchase order is also reviewed for compliance with purchasing rules and other applicable rules.
iii. Those making purchases do not have access to the state FINET system in which payments for purchases are processed.
iv. Before payment is made, receipt of goods and services is required.
v. Trends and monthly forecasts are used to analyze costs and assure that purchases support the mission of DIH and comply with state purchasing rules.
vi. Revenue collections are monitored to ensure they stay within the authorized appropriations for the fiscal year
vii. Updated internal revenue and expenditure forecasts are created each month to ensure DIH stays within budget.
viii. Consensus meetings are held twice per year (once in the fall and once during the legislative session) to evaluate and adjust the budget based on projected expenditures.
ix. Edits are in place in PRISM to ensure provider payments are appropriate.

x. Contract monitoring and management

3. What are the significant expenditures that support this function and how do they help achieve the desired outcomes? The significant expenditures consist of fee-for-service payments made to providers and capitations made to managed care entities for medical expenses of the Medicaid population. These expenses help improve the health of the Medicaid population by providing access to necessary medical services.
4. What are the significant funds or accounts available to support this function? What are the revenue sources for each fund or account? Are there any challenges associated with those revenue sources?
    a. State General Fund
    b. Income Tax Fund
    c. Tobacco Settlement (GFR)
    d. Expansion Fund - revenue sources includes sales tax, general fund appropriations, and hospital assessments
    e. Assessment Funds (Nursing Home, Ambulance, Hospital) - revenue sources include collections from assessments to nursing home, ambulance, and hospital providers
    f. Federal Medicaid Funds - revenue source is Title XIX federal funding
    g. Intergovernmental Transfers - revenue source is state share provided by government owned entities
    h. Pharmacy rebates - revenue source is rebates provided by pharmaceutical companies for drugs dispensed through the Medicaid pharmacy program
5. Does this function have statutory nonlapsing authority? (See UCA 63J-1 Part 6)
   Medicaid does not have statutory nonlapsing authority. The Integrated Healthcare Services line item does however have nonlapsing authority from intent language (ref # CI18).
   If so:
   a. Provide justification for the statutory nonlapsing authority. N/A
   b. Is the function saving money over multiple years to pay for an anticipated expense? If so, how much, for what, and on what schedule? (See JR3-2-709) N/A
6. Is this function authorized to establish and charge a service fee or a regulatory fee? If so:
   We do not charge fees on the program side of Medicaid (the fee schedule for Medicaid consists of the Provider Enrollment Fee, but it falls on the administrative side).
   a. Provide a copy of the fee schedule. N/A
   b. Describe the methods used to determine the amount of each fee. N/A
   c. Provide the function's estimated cost related to each fee. (See JR3-2-501(3)(d) and UCA 63J-1-504) N/A

MEDICAID PHARMACY REIMBURSEMENT STAKEHOLDER MEETING

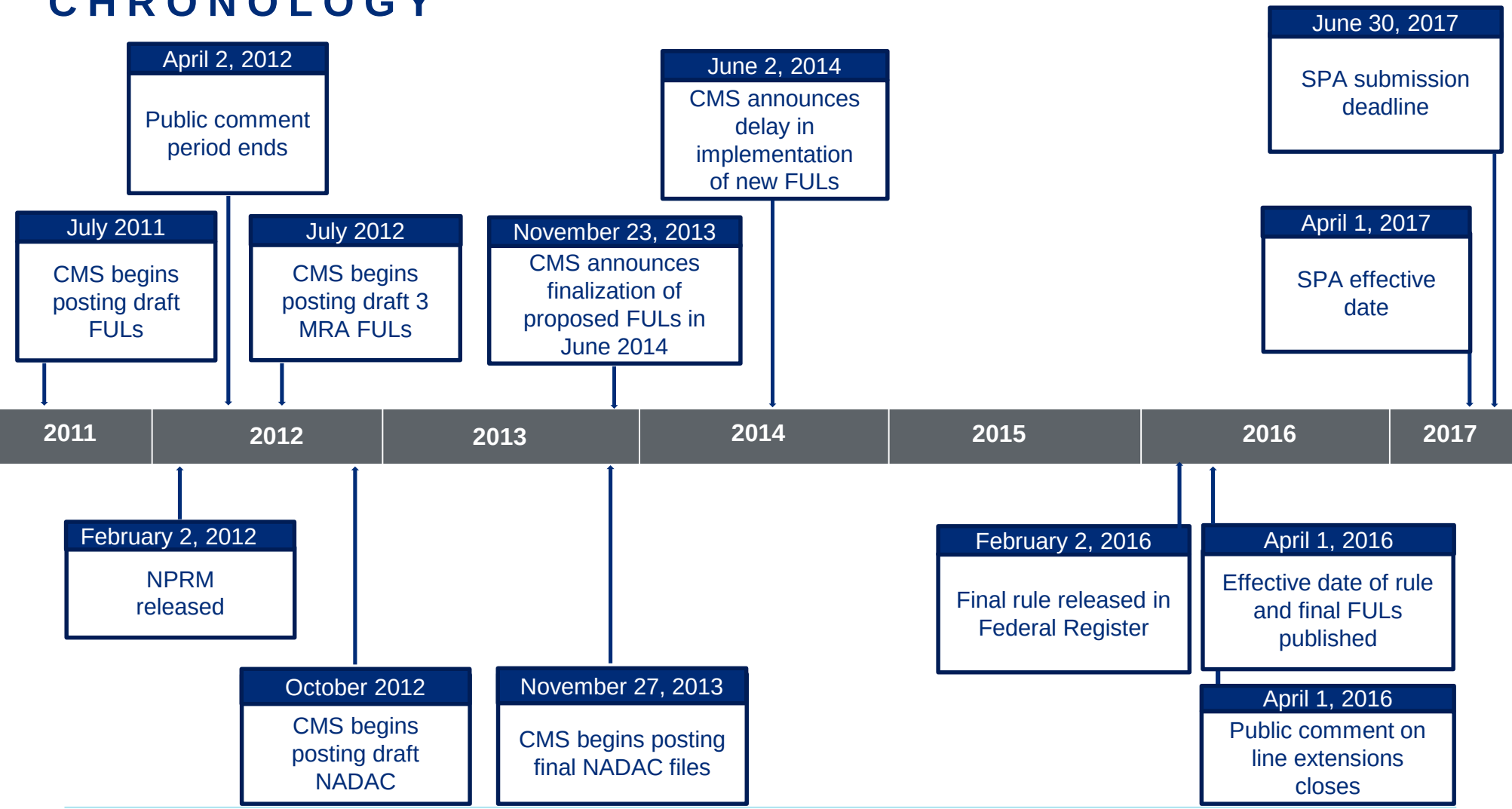
OHIO DEPARTMENT OF MEDICAID

December 6, 2016

Presenters
Scott Banken, CPA, MBA
Shawna Kittridge, RPh, MHS
Ralph Magrish, MPA

OVERVIEW OF COVERED DRUGS FINAL RULE

OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE CHRONOLOGY



OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE
FFS REIMBURSEMENT REQUIREMENTS

Federal Covered Outpatient Drugs final rule – February 1, 2016

Effective April 1, 2017, ODM will be changing its covered outpatient drug reimbursement methodology to comply with the federal rule

- Ingredient cost reimbursement will move from estimated acquisition cost (EAC) to actual acquisition cost (AAC)
- Professional dispensing fees will be implemented

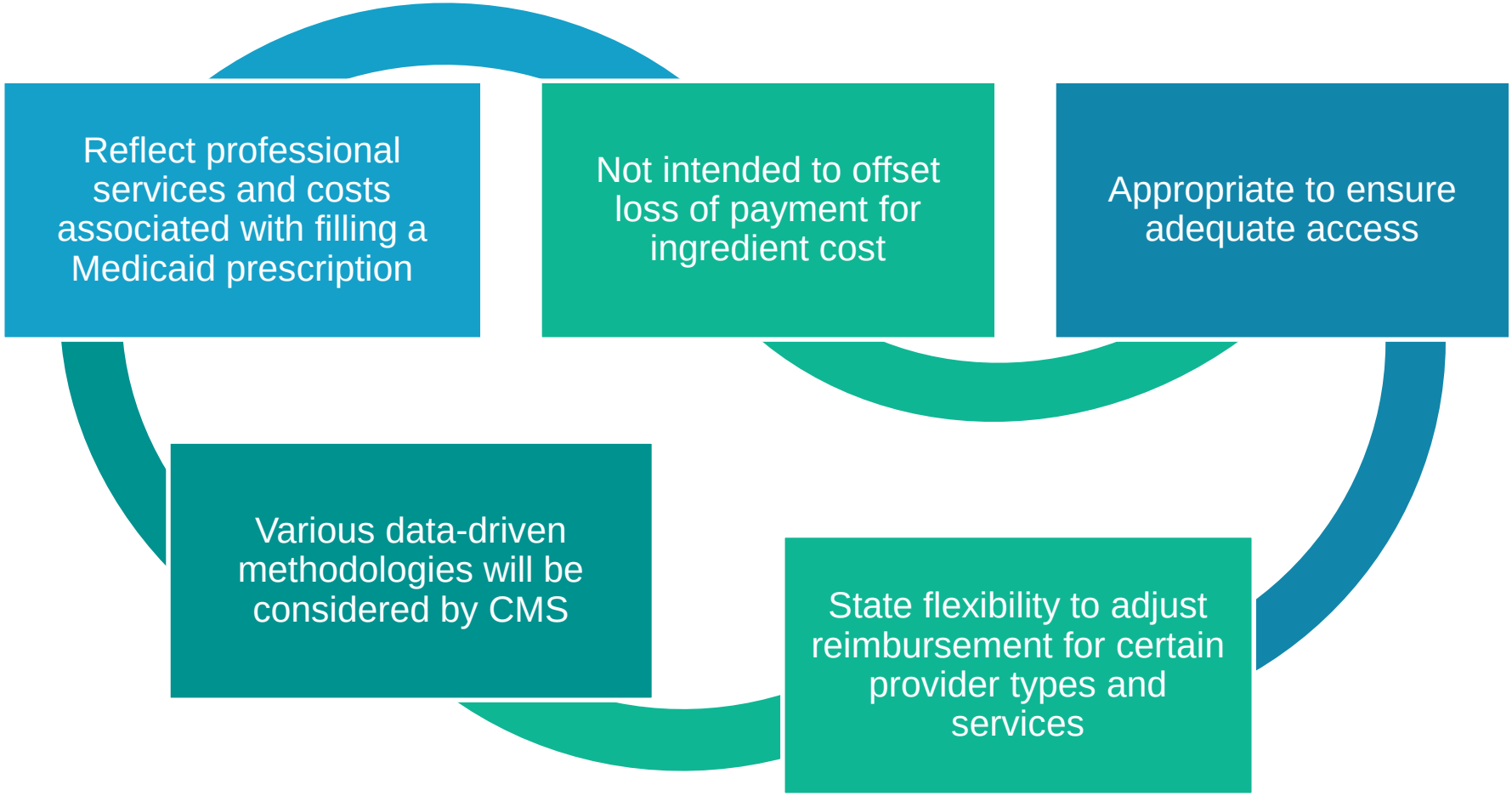
ODM must demonstrate a process that meets compliance with final rule

- Requires Medicaid programs review and potentially reform pharmacy reimbursement methodologies
- Each state is responsible for establishing payment methodology
  - Based on AAC + professional dispensing fee
- Effective date April 1, 2016
  - States have until June 2017 to submit State Plan Amendment (SPA)

OVERVIEW OF COVERED OUTPATIENT DRUGS FINAL RULE
FFS REIMBURSEMENT REQUIREMENTS

PROFESSIONAL DISPENSING FEE ANALYSIS

PROFESSIONAL DISPENSING FEE ANALYSIS
FINAL RULE REQUIREMENTS



PROFESSIONAL DISPENSING FEE ANALYSIS
CMS DEFINITION

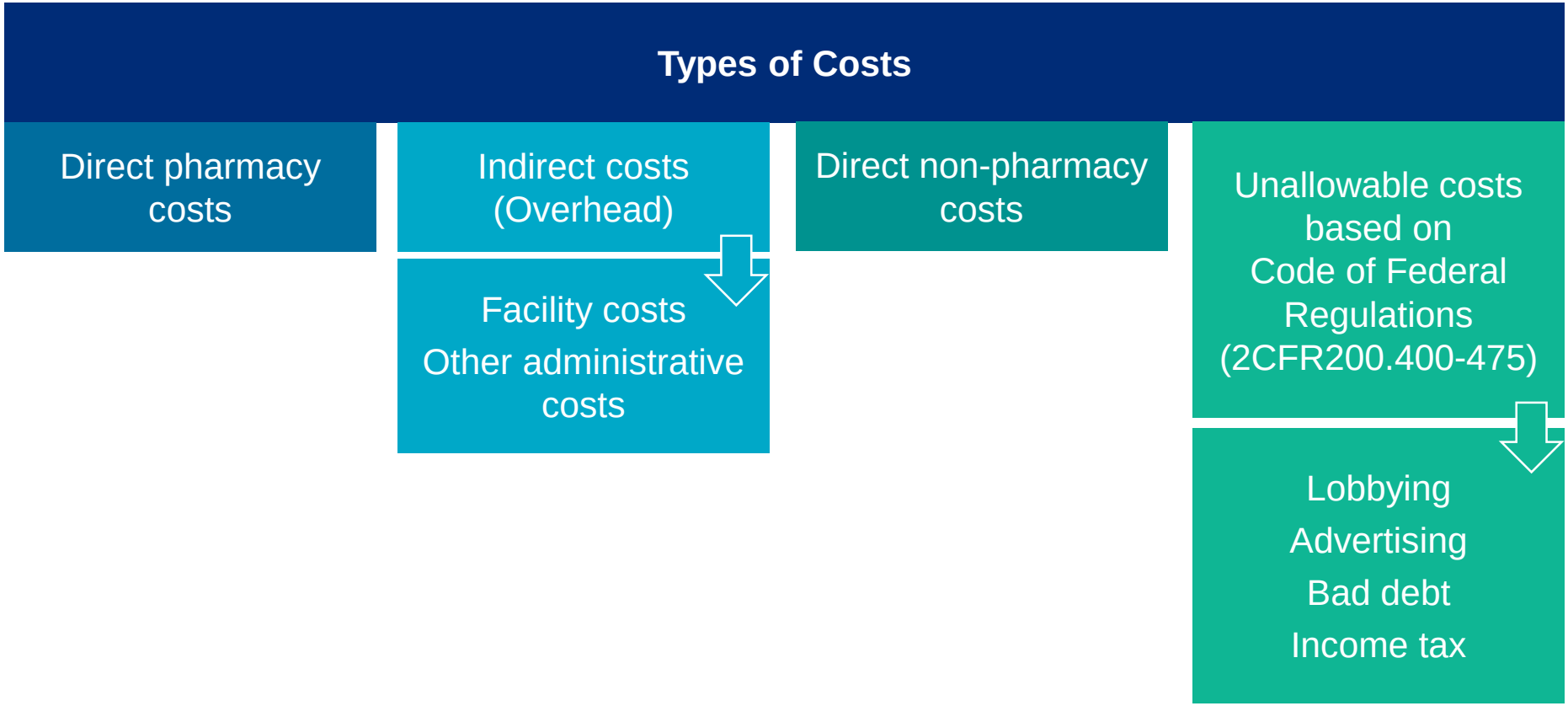
Professional dispensing fee does not include:

Administrative costs incurred by the state in the operation of the covered outpatient drug benefit, including systems costs for interfacing with pharmacies	The Preamble of the final rule clarifies that CMS does not identify profit in the definition of professional dispensing fee

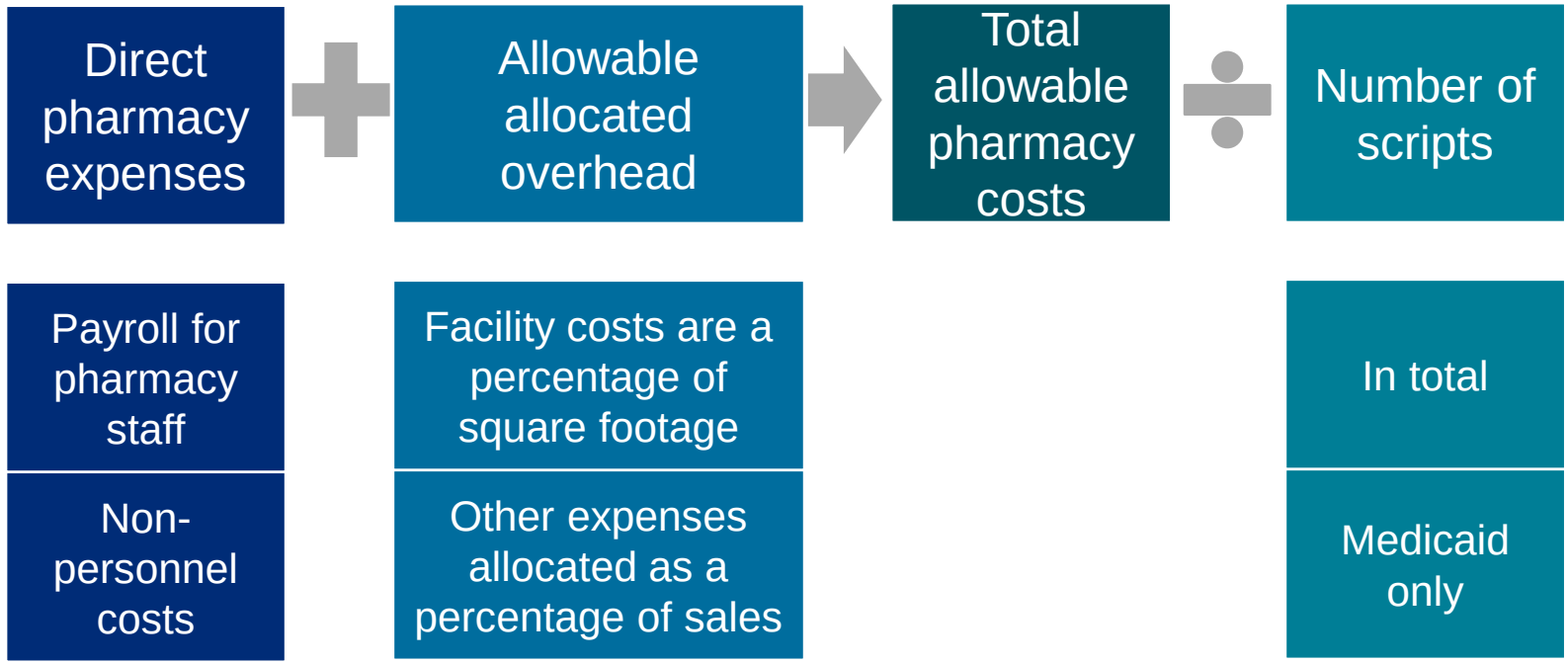
States retain the flexibility to create a differential professional dispensing fee reimbursement per provider delivery type

PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY METHODOLOGY

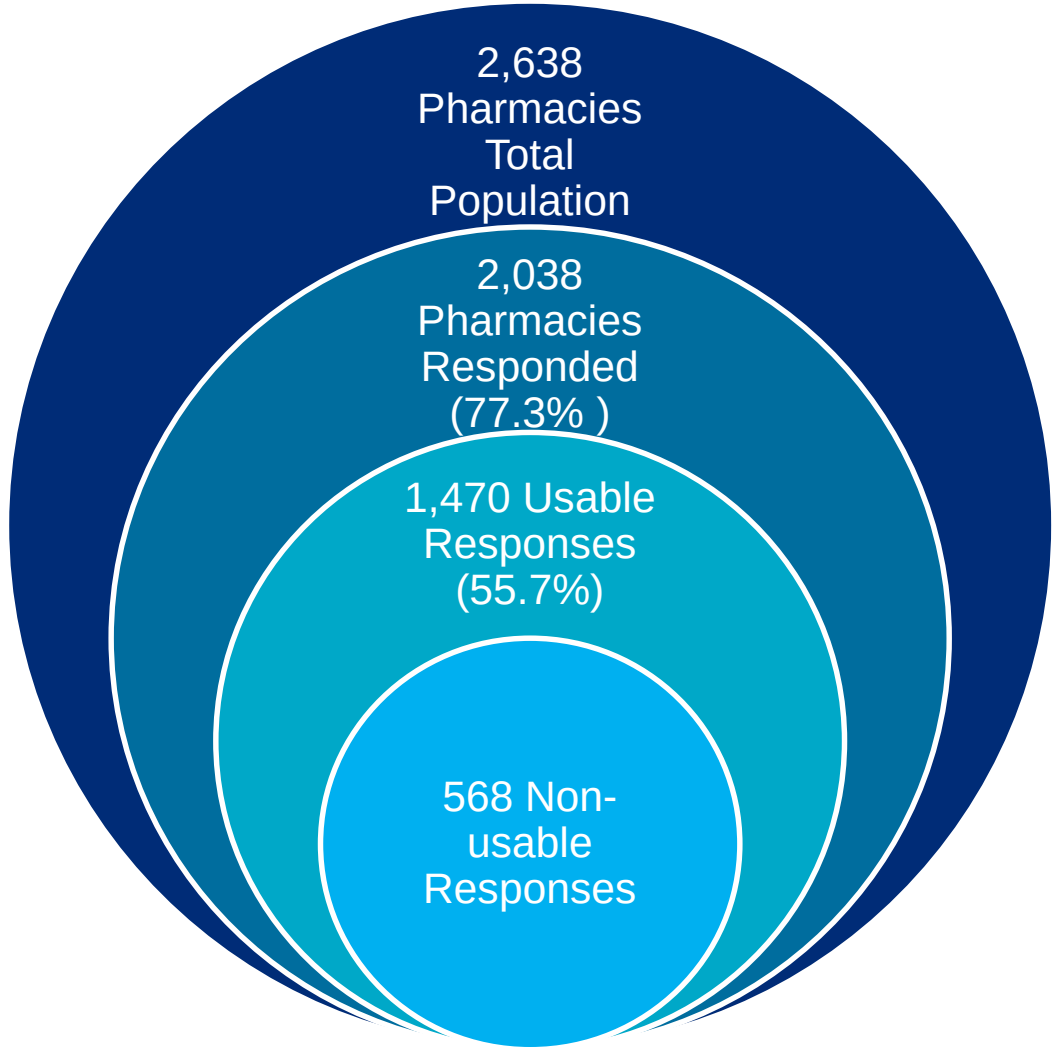
PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY METHODOLOGY



PROFESSIONAL DISPENSING FEE ANALYSIS
TOTAL CALCULATION



PROFESSIONAL DISPENSING FEE ANALYSIS
PDF SURVEY RESPONSE



PROFESSIONAL DISPENSING FEE ANALYSIS
SURVEY RESULTS

Pharmacy Type	*Annual Prescription Volume*	*Winsorized Mean Weighted by Response Probability*
Retail Community	0–49,999	$13.64
	50,000–74,999	$10.80
	75,000–99,999	$9.51
	100,000+	$8.30
	All Volumes	$10.49
Long Term Care		$15.58
Clinic/Outpatient		$12.18
FQHC/RHC		$8.86
Compounding		$113.06
Home Infusion		$122.80
Specialty		$175.31

PROFESSIONAL DISPENSING FEE ANALYSIS
REGRESSION ANALYSIS

Regression analysis simultaneously performed to identify attributes with statistical significance

Pharmacy attributes included:

- Type of pharmacy*
- Years open*
- Whether the business owns the building
- Pharmacist(s) also an owner*
- Total prescription volume*
- Percentage of prescriptions accounted for by Medicaid
- Percentage prescriptions compounded
- Whether delivery of Medicaid prescriptions are offered*

**Indicates statistical significance in the regression*

PROFESSIONAL DISPENSING FEE ANALYSIS

FISCAL IMPACT-COMMUNITY RETAIL PHARMACIES INCLUDING 340B

Method	Overall average dispensing fee	Estimated Annual Fiscal Impact
Current dispensing fee	$1.80	$10,090,000
Proposed single professional dispensing fee	$10.49	$58,804,000
Proposed tiered professional dispensing fee		
0-49,999	$13.64	$11,329,000
50,000-74,999	$10.80	$11,299,000
75,000-99,999	$9.51	$10,423,000
100,000 or more	$8.30	$21,852,000
Combined	$9.79	$54,903,000

PROFESSIONAL DISPENSING FEE ANALYSIS

DISPENSING FEE OPTION COMPARISON

Reimbursement Method	Pros	Cons
Single professional dispensing fee	• Minimal administrative burden • No need for additional verification or annual claim volume validation procedures • Rewards efficiency	• 53.6% of independent retail pharmacies reimbursed less than reported cost • Creates potential access concerns • Reimburses high volume pharmacies above reported cost to dispense
Tiered professional dispensing fee	• Distributes Medicaid funds at reimbursement levels closely reflecting costs • Increases the likelihood of Medicaid member access in underserved or rural areas	• Need for annual claims volume review and claim system update • Does not reward efficiency achieved through growth or volume • For all tiers, efficiency is rewarded by managing costs below the mean for each tier

ACTUAL ACQUISITION COST REIMBURSEMENT ANALYSIS

AAC REIMBURSEMENT ANALYSIS
FINAL RULE REQUIREMENTS

Effective April 1, 2017, ODM will be changing the covered outpatient drug reimbursement methodology to comply with the federal rule

- ✓ Ingredient cost reimbursement will move from EAC to AAC
- ✓ Applies to drugs dispensed by a retail community pharmacy and 340B Covered Entities

Payment for the following drugs do not need to meet the AAC reimbursement definition:

- ✓ Specialty drugs not typically dispensed by a retail community pharmacy
- ✓ Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers and Centers of Excellence

ODM must demonstrate a process that meets compliance with federal upper limits

AAC REIMBURSEMENT ANALYSIS
ANALYSIS METHODOLOGY

FFS pharmacy claims utilization data from CY 2015 was repriced for comparison

Current ingredient cost reimbursement

- Lower of:
  - FUL, if available
  - SMAC, if available
  - WAC + 7% or AWP - 14.4% if WAC is not available
- 340B claims were not re-priced, CY 2015 reported ingredient cost was used

AAC-based ingredient cost reimbursement

- States acquire AAC data through one, or combination of, the following:
  - National survey of retail pharmacy providers (e.g. CMS' NADAC rate process)
  - State survey of retail pharmacy providers
  - Published compendia prices (e.g., WAC)
  - AMP

AAC REIMBURSEMENT ANALYSIS METHODOLOGY

CY 2015 FFS Pharmacy Claims Data

Compound claims excluded

Dual eligible claims flagged in data and included in analysis

All pricing files used (e.g., FUL, SMAC, WAC, AWP, NADAC and state AAC rate) have rates effective August 1, 2016

- If WAC was missing in any scenario, AWP equivalents were used

Drug type (Brand, Generic) determined using ODM's claim adjudication logic

Assumed SMAC and FUL pricing only applied to Generic or blank drug types as Brand necessary override data were not available

AAC REIMBURSEMENT ANALYSIS

AAC OPTIONS MODELED

Ingredient Cost

Move to AAC

NADAC

- NADAC with WAC + 0% for all non-NADAC drugs
- NADAC with CMS reported WAC equivalents for all non-NADAC drugs (WAC - 3.4% brands, WAC - 40.9% generics)

Representative State AAC

- Lower of FUL, Representative State AAC or WAC + 0% for all non-State AAC drugs
- Lower of FUL, Representative State AAC or CMS Reported WAC equivalents for all non-State AAC drugs (WAC - 3.4% brands, WAC - 40.9% generics)

WAC-Based

- Lower of FUL and State Utilization-based WAC Rates (WAC - 3.1% brands, WAC - 44.5% generics)
- Lower of FUL and CMS reported WAC Rates (WAC - 3.4% brands, WAC - 40.9% generics)

- Hemophilia drugs repriced with ASP+6% as directed by ODM (minus the furnishing fee)
- Under AAC reimbursement, specialty drugs repriced at WAC + 0% or other WAC equivalents to NADAC

AAC REIMBURSEMENT ANALYSIS
COMPARISON OF AAC OPTIONS

	Total	No NADAC, No WAC	Percent of Total	No NADAC, No WAC, No AWP	Percentage of Total	No State AAC, No WAC	Percentage of Total	No State AAC, No WAC, No AWP	Percentage of Total
NDC Count	19,200	1,050	5.5%	380	2.0%	1,240	6.5%	300	1.6%
Claim Count	5,523,400	95,700	1.7%	12,900	0.2%	107,000	1.9%	9,800	0.2%
Estimated Ingredient Cost (Current EAC Methodology)	$467,619,000	$1,172,000	0.3%	$23,800	0.0%	$1,836,000	0.4%	$1,900	0.0%

- Observations:
  - All scenarios will require an alternative pricing benchmark for claims payment
  - Utilizing AWP rate, from Medispan, decreased the gap to 0.2% of claims without a pricing benchmark
  - Mercer observed a number of specialty drugs in ODM's CY 2015 FFS pharmacy data that do not have a NADAC price that are included in the table above

AAC REIMBURSEMENT ANALYSIS
AAC OPTIONS – ESTIMATED FISCAL IMPACT

Scenario	Estimated Annual Ingredient Cost	Estimated Annual Ingredient Cost Difference From Current EAC Methodology	Percentage Difference Compared to Current EAC Methodology
Current EAC Reimbursement Methodology	$467,619,000	N/A	N/A
NADAC Scenarios			
NADAC with WAC+0% for all non-NADAC drugs	$410,903,000	($56,716,000)	-12.1%
NADAC with WAC-3.4% for non-NADAC brand drugs and WAC-40.9% for non-NADAC generic drugs	$406,246,000	($61,373,000)	-13.1%
Representative State AAC Scenarios			
Lower of FUL and Representative State AAC or WAC + 0% if State AAC not available	$410,264,000	($57,355,000)	-12.3%
Lower of FUL and Representative State AAC or WAC - 3.4% for no State AAC brand drugs and WAC - 40.9% for no State AAC generic drugs	$401,783,000	($65,836,000)	-14.1%
WAC Scenarios			
Lower of FUL and State utilization-based NADAC WAC Equivalent Rate of WAC - 3.1% for brands and WAC - 44.5% for generics	$399,881,000	($67,738,000)	-14.5%
Lower of FUL and CMS-based NADAC WAC Equivalent Rate of WAC - 3.4% for brands and WAC - 40.9% for generics	$401,405,000	($66,214,000)	-14.2%

AAC REIMBURSEMENT ANALYSIS
340B AAC ANALYSIS

Per the final rule:

- 340B drug claims are subject to AAC reimbursement
- States must reimburse 340B drugs, but should not reimburse at an amount higher than the 340B ceiling price
- Applies to both 340B Covered Entities (CEs) and 340B contract pharmacies

340B ceiling price is calculated as the difference between Average Manufacturer Price (AMP) and Unit Rebate Amount (URA)

ODM currently specifies that 340B contract pharmacies may not use 340B drugs for Medicaid members

AAC REIMBURSEMENT ANALYSIS
340B AAC OPTIONS MODELED

340B AAC

- 340B AAC, if 340B AAC is unavailable, use WAC - 50% (or AWP - 58.33%)

340B Ceiling Price

- Ceiling Price, if 340B Ceiling Price is unavailable use WAC - 50% (or AWP - 58.33%)

Lower of 340B AAC and Celling Price

- Lower of 340B AAC and Ceiling Price, if unavailable use WAC - 50% (or AWP - 58.33%)

AAC REIMBURSEMENT ANALYSIS
340B AAC CLAIM COMPARISON

340B AAC	Total 340B	No 340B AAC	Percent of Total	No 340B AAC, No NADAC	Percent of Total	No 340B AAC, NADAC, or WAC	Percent of Total	No 340B AAC, NADAC, WAC, or AWP	Percent of Total
NDC Count	5,220	400	7.7%	290	5.6%	90	1.7%	10	0.2%
Claim Count	82,200	4,700	5.7%	3,600	4.4%	1,600	1.9%	100	0.1%
CY 2015 Ingredient Cost	$3,885,000	$300,000	7.7%	$287,300	7.4%	$15,300	0.4%	$200	0.0%

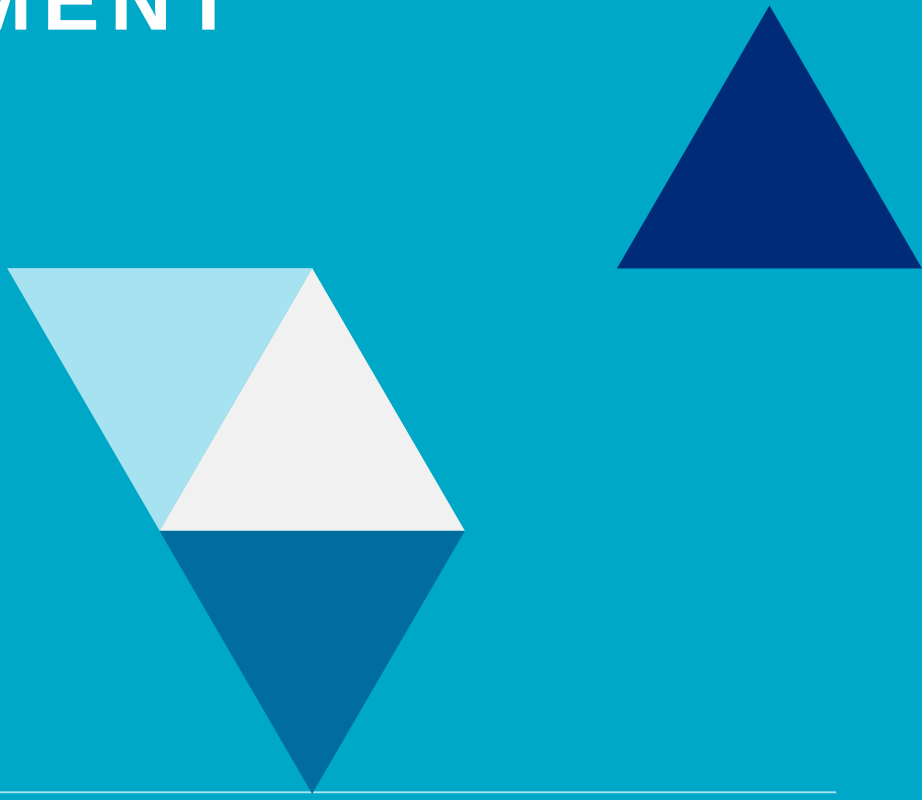
340B Ceiling Prices	Total 340B	No Ceiling Price	Percent of Total	No Ceiling Price, No 340B AAC	Percent of Total	No Ceiling Price, No 340B AAC, No WAC	Percent of Total	No Ceiling Price, No 340B AAC, No WAC, No AWP	Percent of Total
NDC Count	5,220	430	8.2%	230	4.4%	90	1.7%	10	0.2%
Claim Count	82,200	8,800	10.7%	3,400	4.1%	1,600	1.9%	100	0.1%
CY 2015 Ingredient Cost	$3,885,000	$150,000	3.9%	$84,100	2.2%	$15,100	0.4%	$100	0.0%

- Observations
  - 7.7% of NDCs and 5.7% of 340B claims did not have a 340B AAC price for this analysis
  - 8.2% of NDCs and 10.7% of 340B claims did not have a 340B Ceiling Price for this analysis
  - Approximately 4% of NDCs and claims and 2% of 340B ingredient costs did not have a 340B AAC or Ceiling price

AAC REIMBURSEMENT ANALYSIS
340B AAC – ESTIMATED FISCAL IMPACT

Scenario	CY 2015 Ingredient Cost/Estimated Annual Ingredient Cost	Estimated Difference From CY 2015 Ingredient Cost	Percentage Difference Compared to CY 2015 Ingredient Cost
CY 2015 Ingredient Cost	$3,885,000	N/A	N/A
340B AAC Scenario			
340B AAC, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$3,080,000	($805,000)	-20.7%
Ceiling Price Scenario			
Ceiling Price, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,998,000	($1,887,000)	-48.6%
Lower of 340B AAC and Ceiling Price Scenario			
Lower of 340B and Ceiling Price, if one of two are available use the one, if both are unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,962,000	($1,923,000)	-49.5%

TOTAL REIMBURSEMENT ANALYSIS



TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – TRADITIONAL OUTPATIENT DRUG SPEND (NON-340B, NON-COMPOUND)

	Ingredient Cost	Current Dispensing Fee	Single Dispensing Fee	Tiered Dispensing Fee
Dispensing Fee Amounts	-	$10,090,000	$57,941,000	$54,065,000
Current EAC	$467,619,000	$477,709,000		
NADAC with WAC + 0% for all non-NADAC drugs	$410,903,000	-	$468,844,000	$464,968,000
NADAC with WAC - 3.4% for non-NADAC brand drugs and WAC - 40.9% for non-NADAC generic drugs	$406,246,000	-	$464,187,000	$460,311,000
Lower of FUL and Representative State AAC or WAC + 0% if State AAC not available	$410,264,000	-	$468,205,000	$464,329,000
Lower of FUL and Representative State AAC or WAC - 3.4% for no State AAC brand drugs and WAC - 40.9% for no State AAC generic drugs	$401,783,000	-	$459,724,000	$455,848,000
Lower of FUL and State utilization-based NADAC WAC Equivalent Rate of WAC - 3.1% for brands and WAC - 44.5% for generics	$399,881,000	-	$457,822,000	$453,946,000
Lower of FUL and CMS-based NADAC WAC Equivalent Rate of WAC - 3.4% for brands and WAC - 40.9% for generics	$401,405,000	-	$459,346,000	$455,470,000

TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – 340B DRUG SPEND

	Ingredient Cost	Current Dispensing Fee	Single Dispensing Fee	Tiered Dispensing Fee
Dispensing Fee Amounts	-	$148,000	$863,000	$838,000
CY 2015 Ingredient Cost	$3,885,000	$4,033,000		
340B AAC, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$3,080,000	-	$3,943,000	$3,918,000
Ceiling Price, if unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,998,000	-	$2,861,000	$2,836,000
Lower of 340B and Ceiling Price, if one of two are available use the one, if both are unavailable use WAC - 50%, if unavailable use AWP - 58.33%	$1,962,000	-	$2,825,000	$2,800,000

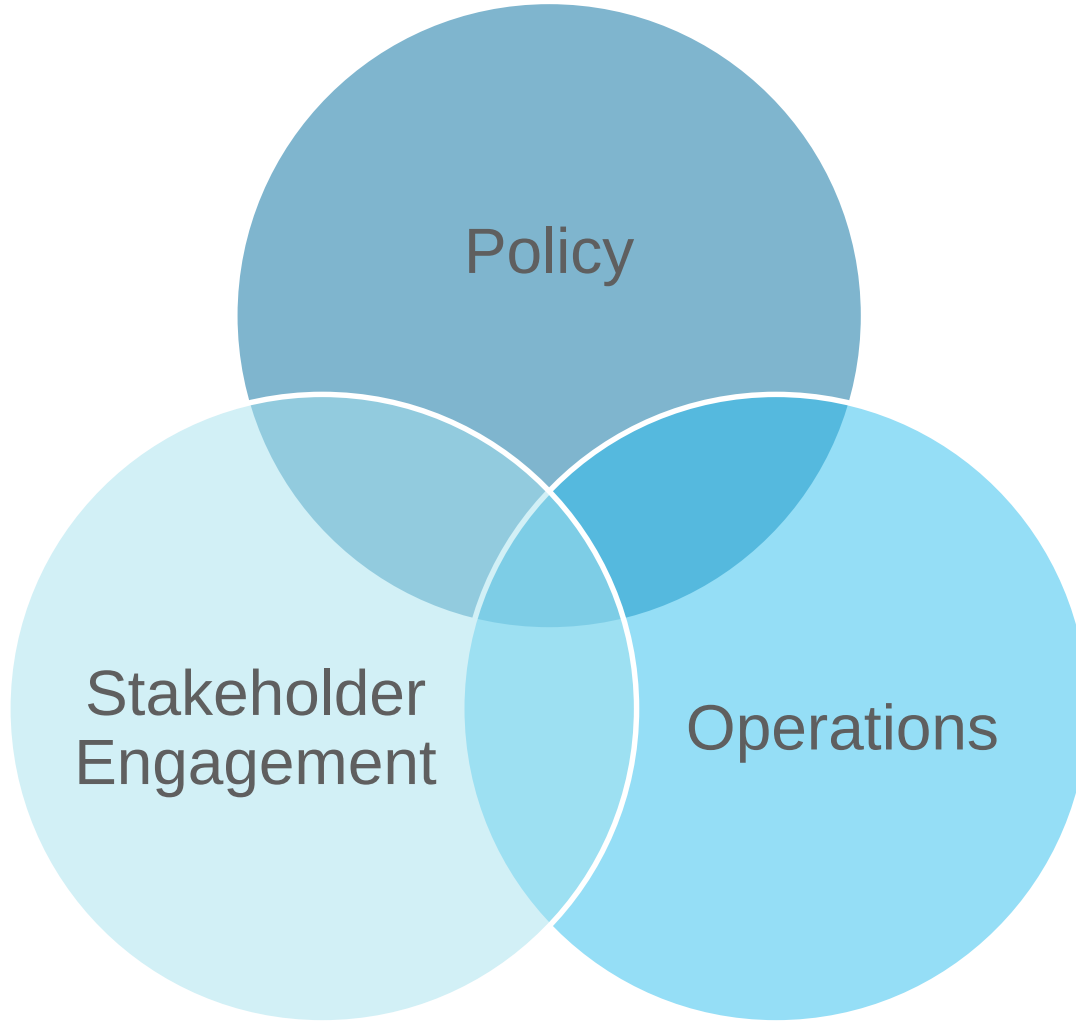
- Observations
  - The Ceiling Price scenario reflects CMS guidance that states pay no more than the Ceiling Price for 340B drugs

TOTAL REIMBURSEMENT ANALYSIS
ESTIMATED FISCAL IMPACT – TOTAL DRUG SPEND

Single Dispensing Fee			
	Estimated Annual Ingredient Cost	Dispensing Fee	Total Reimbursement
Current EAC Reimbursement Methodology	$471,504,000	$10,090,000	$481,594,000
Final Proposed Reimbursement with Single Dispensing Fee			
NADAC with WAC+0% for all non-NADAC drugs (Hemophilia ASP+6%)	$410,903,000	$57,941,000	$468,844,000
Ceiling Price, if unavailable use WAC-50%, if unavailable use AWP-58.33%	$1,998,000	$863,000	$2,861,000
Total	$412,901,000	$58,804,000	$471,705,000
Difference	-$58,603,000	$48,714,000	-$9,889,000
% Difference			-2.1%
Tiered Dispensing Fee			
	Estimated Annual Ingredient Cost	Dispensing Fee	Total Reimbursement
Current EAC Reimbursement Methodology	$471,504,000	$10,090,000	$481,594,000
Final Proposed Reimbursement with Tiered Dispensing Fee			
NADAC with WAC+0% for all non-NADAC drugs (Hemophilia ASP+6%)	$410,903,000	$54,065,000	$464,968,000
Ceiling Price, if unavailable use WAC-50%, if unavailable use AWP-58.33%	$1,998,000	$838,000	$2,836,000
Total	$412,901,000	$54,903,000	$467,804,000
Difference	-$58,603,000	$44,813,000	-$13,790,000
% Difference			-2.9%

IMPLEMENTATION ROADMAP

IMPLEMENTATION ROADMAP
KEY AREAS OF CONSIDERATION AND DECISION MAKING



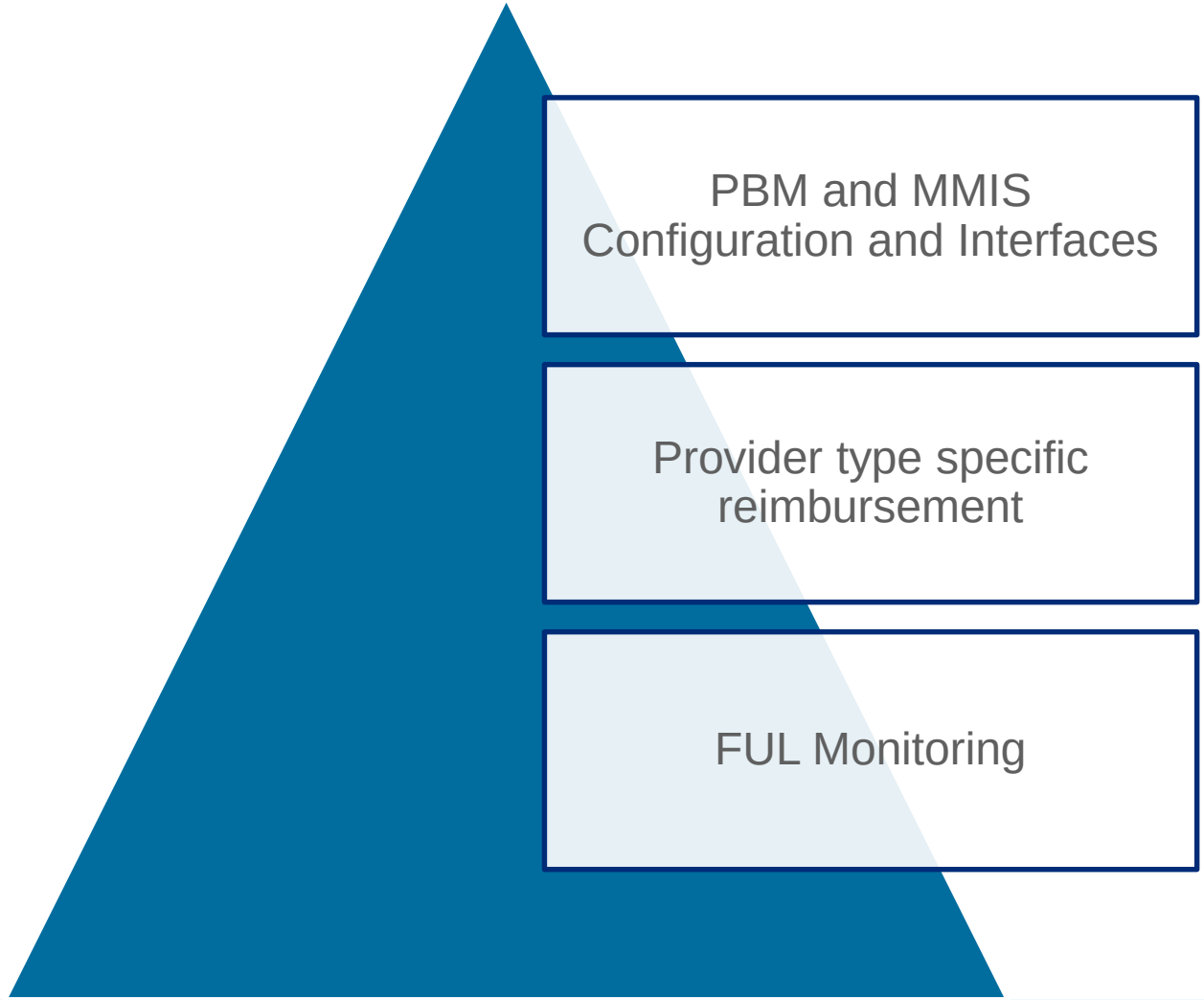
IMPLEMENTATION ROADMAP
POLICY CONSIDERATIONS

State Plan Modifications	• Evaluate all areas impacted • Determine affected provider types • Evaluate opportunity to align reimbursement among providers • Develop and submit State Plan Amendment

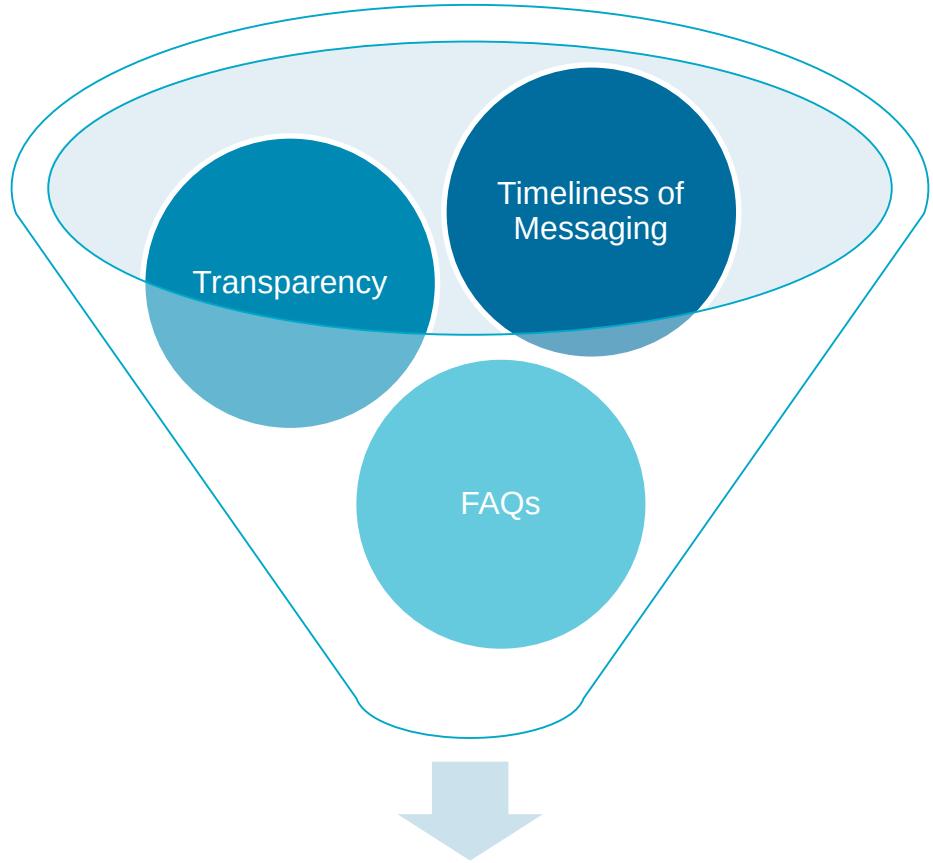
Access Monitoring Review Plan	• Develop Monitoring Review Plan
	  • Availability of Medicaid pharmacy providers
	  • Utilization of Medicaid prescription drugs
	  • Monitor extent to which Medicaid beneficiaries needs are fully met
	• Respond to CMS Standard Access Questions

Policy and Program Updates	• Review and update all program materials, rules and billing guidelines
	• Develop and implement communication plan
	  • Direct outreach to providers
	  • Transition web page and FAQ

IMPLEMENTATION ROADMAP
OPERATIONAL CONSIDERATIONS



IMPLEMENTATION ROADMAP
STAKEHOLDER ENGAGEMENT



AAC-based Reimbursement Implementation

IMPLEMENTATION ROADMAP
IMPLEMENTATION TIMELINE

Activity	Dates
Conduct stakeholder outreach and engagement	Ongoing
Develop Access Monitoring Review Plan (AMRP)	October – November 2016
Finalize overall reimbursement methodologies	November – December 2016
Develop State Plan Amendment (SPA)	November – December 2016
Solicit Public Comment on SPA and AMRP	December 2016
Submit SPA and AMRP to CMS	January 2017
Conduct Claims Volume Review (tiered approach only)	January – February 2017
Develop and configure PBM and MMIS systems	January – February 2017
Review and update all policy and program materials	January – March 2017
Provider messaging and website launch	February – March 2017
Test PBM systems and MMIS	March 2017
Go Live with AAC based reimbursement	April 2017

MAKE TOMORROW, TODAY

MERCER