



MAR 29 2019

Administrator
Washington, DC 20201

Nathan Checketts
Director
Utah Department of Health
Salt Lake City, UT 84114

Dear Mr. Checketts:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs, including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not “stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115(a)(2) of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Utah’s June 22, 2018 and February 6, 2019 requests to amend its section 1115 demonstration project entitled, “Primary Care Network” (Project Nos. 11-W-00145/8 and 21-W-00054/8), in accordance with section 1115(a)(2) of the Act. As is described in greater detail in other sections of this letter, the amendments we are approving today expand Medicaid to provide additional coverage to beneficiaries already covered pursuant to section 1115(a)(2) under the previously approved demonstration (see p. 4 “Adult Expansion Amendment”) and, in the case of the clinically managed withdrawal services amendment, to all qualifying beneficiaries, including those eligible under the state plan. (see p. 4 “clinically managed withdrawal services amendment”). The amendments we are approving today will allow the state to continue offering expansion coverage to individuals the state is not required to cover, while making the available coverage more robust.

This approval is effective as of the date of the approval letter through June 30, 2022, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire. CMS’s approval is subject to the limitations specified in the attached expenditure authorities and special terms and conditions (STC). The state may deviate from Medicaid state plan requirements only to the extent those requirements have been listed as not applicable to expenditures under the demonstration. Per longstanding policy, CMS considers each state amendment or waiver request independently, and this action does not indicate likely approval or disapproval of any future requests.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title

XIX. The purposes of Medicaid include an authorization of appropriation of funds to “enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. And that is what in fact this proposed demonstration project does, by expanding the scope of Medicaid benefits for certain beneficiaries. But, there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to paying for services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries’ financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may “result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing.” Act § 1115(d)(1). But in the long term, they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better “enabling each [s]tate, as far as practicable under the conditions in such [s]tate” to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.¹ By the same

¹ States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state’s program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to offer Medicaid coverage to populations not specifically included in the statute by using expenditure authority under section 1115(a)(2) of the Act. This authority has been used to allow a number of states, including Utah, to expand Medicaid eligibility beyond the allowable statutory categories. The same authority at

token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115(a)(2) of the Act allows us to offer federal matching funds to states in ways that provide flexibility to experiment with different means of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that give states expenditure authority to provide additional benefits or services, or cover new populations, can advance multiple objectives of Medicaid, including by providing coverage for medical services, improving beneficiary health and financial independence and allowing states to maintain the long-term fiscal sustainability of their Medicaid programs. The two amendments requested by the state advance all of these goals and as such, this demonstration project, as amended, advances the objectives of the Medicaid program.

Background on Medicaid Coverage in Utah

As of December 2018, Utah's Medicaid program provides health coverage to over 312,000 individuals. The Medicaid program includes non-mandatory populations, such as optional adults formerly in foster care, in addition to the mandatory eligibility groups. The state also covers several categories of non-mandatory services, including prescription drugs and clinic services, in addition to mandatory services. Through the state's section 1115 demonstration, Primary Care Network (PCN), individuals eligible under the state plan who are categorically or medically needy parents or other caretaker relatives eligible through section 1925 and 1931 of the Act and are not aged, blind, disabled, or pregnant (referred to as Current Eligibles) currently receive a benefit package that is slightly reduced from the state plan benefit package. Reductions applicable to the Current Eligible Package include annual limits on the number of physical and occupational therapy visits and vision care limits. The demonstration also covers an expansion population consisting of parents and caretaker relatives with incomes from 55 percent of the FPL and childless adults from zero percent of the FPL up to 95 percent of the federal poverty level (FPL) (effectively 100 percent of the FPL with the five percent disregard). This expansion population has a choice of the primary/preventative care program (Demonstration Population I), premium assistance for employer sponsored insurance (ESI) through Utah's Premium Partnership for Health Insurance (UPP) program (Demonstration Population III), or premium assistance for Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) coverage (Demonstration Population V). Individuals who have household incomes up to and including 200 percent of the FPL are eligible to enroll in the ESI or COBRA programs. In addition, the demonstration gives the state authority to provide Medicaid benefits for beneficiaries residing in an Institution for Mental Diseases (IMD) primarily to receive short-term residential treatment for substance use disorder (SUD).

In the June 22, 2018 amendment request, the state requested to provide Medicaid coverage to adults ages 19 through 64 who have household income up to and including 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income) (Adult Expansion Population). The state requested to transfer enrollees with incomes up to and

section 1115(a)(2) of the Act can be used for states to cover benefits beyond what is authorized by statute as well. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

including 95 percent of the FPL from Demonstration Populations I, III, and V to the Adult Expansion Population, and requested the ability to close enrollment in the Adult Expansion Population should projected costs for the group exceed annual state appropriations. In addition, the state requested to mandate enrollment in a qualified employer sponsored insurance (ESI) plan for Adult Expansion Population beneficiaries who have access to such a plan. The state also requested the authority to implement a community engagement requirement as a condition of eligibility for Adult Expansion Population beneficiaries who do not qualify for an exemption from the requirement.

In the February 6, 2019 amendment request, the state requested the authority to provide clinically managed residential withdrawal services to beneficiaries, aged 18 and older, who reside in Salt Lake County, demonstrate moderate withdrawal signs and symptoms, have a primary diagnosis of opioid use disorder (OUD) or another SUD, and require round-the-clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery.

Extent and Scope of the Demonstration

Adult Expansion Amendment

With approval of this demonstration, the state will have the authority to provide Medicaid coverage to adults with incomes up to 95 percent of the FPL who previously were not eligible or who were only eligible for benefits as part of a prior demonstration population (Adult Expansion Population). The adults who are childless or non-custodial parents in the Adult Expansion Population will receive the traditional state plan benefit package (with the exception of the already approved ability of the state to not provide the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit to 19 and 20 year olds); the adults who are custodial parents or caretaker relatives in the Adult Expansion Population will receive the same benefit package as the Current Eligibles. Individuals who are eligible for the Adult Expansion Population and have access to a qualified ESI plan will be required to enroll in that plan and the state will pay the beneficiary's premium. In order to ensure the beneficiary receives the Medicaid benefits the beneficiary is entitled to as a beneficiary in the Adult Expansion Population Medicaid eligibility group (MEG), wrap-around benefits will be provided through a fee-for-service (FFS) delivery system. The state will continue the UPP (Demonstration Population III) and COBRA (Demonstration Population V) programs for individuals with incomes over 95 percent of the FPL up to 200 percent of the FPL.

Should projected costs for the Adult Expansion Population exceed annual state appropriations, the state will be permitted to close enrollment. When enrollment is closed, the state will continue to accept and review applications to determine whether applicants are eligible for Medicaid on any other basis. If the applicant is eligible for the Adult Expansion Population, and no other MEG, that applicant's eligibility will be denied; the state will not have a waitlist to automatically enroll or contact individuals the next time enrollment opens. When the state plans to open enrollment, the state will update its Medicaid website and send information to community partners and state agencies that work with low-income and vulnerable populations, as well as the media about the timeframe for reopening enrollment and how individuals can apply.

Community engagement

With approval of this demonstration, Utah will require, as a condition of eligibility, that non-exempt beneficiaries in the Adult Expansion Population within the first three months of a 12 month benefit year or following notification that the beneficiary is subject to the community engagement requirement, whichever is later, complete the following activities: (1) registering for work through the state's online system that helps Utahans with training and finding work; (2) completing an online assessment of employment training needs; (3) applying for employment, either directly or through the state's automated employment application submission process, with at least 48 potential employers; and (4) completing online job training modules, as determined appropriate for the individual by the online assessment.

The state will exempt various groups: beneficiaries who are pregnant or 60 days or less post-partum; beneficiaries 60 years of age or older; primary caregivers of a family member under six years of age, members of federally recognized tribes; beneficiaries who have applications pending for or are receiving unemployment insurance benefits; beneficiaries participating regularly in SUD treatment; beneficiaries exempt from or in compliance with Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; beneficiaries participating in state refugee employment services; beneficiaries who are physically or mentally unable to meet the requirements as determined by a medical professional or documented through other available data sources; beneficiaries who are responsible for the care of a person with a disability as defined by the Americans with Disabilities Act (ADA), section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act; beneficiaries enrolled at least half time in any school, college, or university or vocational training or apprenticeship program; state Family Employment Program (FEP) recipients who are issued FEP cash assistance diversion payment for that month; or beneficiaries working at least 30 hours a week or working and earning income that is at least equal to earnings for an individual working 30 hours a week at federal minimum wage, as verified through wage data available to the state. Beneficiaries seeking an exemption will be required to report their qualification for an exemption to the state only once during the 12-month eligibility period. Non-exempt beneficiaries will have the opportunity to avoid the consequences of noncompliance by demonstrating a good cause for failure to meet the requirement; a beneficiary experiencing the death of a family member living with the beneficiary is one example of good cause.

After a beneficiary has been accepted into the Adult Expansion Population, the state will notify the beneficiary of his or her need to participate in community engagement activities or qualify for an exemption within three months of the notice as a condition of continued coverage and eligibility. Beneficiaries complete activities through an online system through any internet connected device, such as computers, phones, and tablets. A beneficiary may complete the activities in her home, at a public library, or she may access the online system at Employment Resource Centers operated by the Department of Workforce Services (DWS) across the state, where the beneficiary can receive in-person assistance with completing the activities. Once the system has verified that the beneficiary has met the community engagement requirement by completing the required activities, the beneficiary will remain eligible for the remainder of his or her 12-month eligibility period. The beneficiary must complete the community engagement requirement or qualify for an exemption or good cause exception during the first three months of each 12-month eligibility period to maintain eligibility and coverage.

Non-exempt beneficiaries who fail to complete the community engagement requirement or qualify for a good cause exception within three months of notification that they are subject to the requirement will be disenrolled on the last day of the month in which the beneficiary receives notification of his or her non-compliance, unless an appeal is timely filed or a beneficiary qualifies for a good cause exception.

Following disenrollment, individuals will be able to re-apply for coverage after completing all requirements and would be re-enrolled with eligibility effective the first day of the month in which the beneficiary re-applies. Such an individual would begin a new 12-month eligibility period and would be considered to have met the community engagement requirement for that 12 month period. If an individual is disenrolled and now qualifies for an exemption, that individual must re-apply for coverage and request the exemption. If an individual becomes eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement, the individual can re-enroll immediately and his or her eligibility will have an effective date consistent with the beneficiary's new eligibility category.

Utah's community engagement requirement is a slightly different model than those that CMS has approved in other community engagement section 1115 demonstrations to date. In contrast to other demonstrations, Utah is not counting working 30 hours or more a week or being enrolled at least half-time in an educational/training program as a qualifying activity, but rather as exempting the beneficiary from the otherwise applicable requirement to complete the community engagement activities. Many beneficiaries who qualify for an exemption from the community engagement requirement (e.g. those who are working at least 30 hours per week, enrolled at least half-time in an education or training program, complying with TANF or SNAP employment requirements, or participating in refugee employment services) are already engaging in activities that the community engagement requirement is attempting to promote, and CMS believes that these beneficiaries are already adequately engaged with their community and that requiring them to engage in additional activities specific to this demonstration's community engagement requirement would be unnecessary.

Clinically Managed Residential Withdrawal Services Amendment

Upon approval, the state will have the authority to provide clinically managed residential withdrawal services to beneficiaries, aged 18 and older, who reside in Salt Lake County, demonstrate moderate withdrawal signs and symptoms, have a primary diagnosis of OUD or another SUD, and require round-the-clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery.

Determination that the demonstration is likely to assist in promoting Medicaid's objectives

For reasons discussed below, the Secretary has determined that the amendments to the PCN demonstration, and the amended PCN demonstration as a whole, are likely to assist in promoting the objectives of the Medicaid program.

The demonstration provides coverage beyond what the state plan provides, and the demonstration amendment makes that coverage more robust.

CMS has determined that these amendments, and the amended demonstration, are likely to promote the objective of furnishing medical assistance because the amended demonstration gives

the state the expenditure authority under section 1115(a)(2) of the Act to offer coverage for medical services to adults not eligible under the State plan who are aged 19 through 64 with household income up to and including 95 percent of the FPL. Beneficiaries who will be covered as part of the new Adult Expansion Population previously were eligible only for limited demonstration benefits, consisting of optional premium assistance (employer-sponsored insurance or COBRA coverage) or demonstration coverage that lacked many benefits now available to them, such as inpatient hospital care. Accordingly, the amended demonstration will expand the availability of comprehensive coverage. Members of the Adult Expansion Population, absent the demonstration, would be ineligible for any Medicaid benefits, and absent approval of the amendment, would be eligible only for highly limited benefits. In addition, approval of this amendment allow the state to offer clinically managed residential withdrawal services as a pilot benefit in Salt Lake County. These services will provide beneficiaries, aged 18 and older, with a primary diagnosis of OUD or another SUD with round-the-clock structure and support from licensed providers to complete withdrawal and increase the likelihood of beneficiaries continuing treatment and recovery. Access to these services in Utah’s largest county is an important component of Utah’s plan to address the substance use epidemic.

The demonstration promotes beneficiary health and financial independence.

With approval of these amendments to the PCN demonstration, Utah and CMS will be able to evaluate the effectiveness of a policy that is designed to improve the health of Medicaid beneficiaries and promote their financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects “aimed at promoting healthy behaviors” and “individual ownership in health care decisions” as well as “accountability tied to improvement in health outcomes.”²

The PCN community engagement requirement is designed to encourage beneficiaries to ascertain their employment training needs, undergo appropriate training based on their individual circumstances, and make employer contacts and job applications that may lead first to employment and then to improved health and wellness. Research shows a positive link between community engagement and improved health outcomes.³ Utah also pointed out this connection in its application. However, since none of the existing research definitively shows whether a

² CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 15 (Dec. 10, 2012) (noting also that “states have considerable flexibility under ... [existing] law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level”).

³ Waddell, G. and Burton, AK. *Is Work Good For Your Health And Well-Being?* (2006) EurErg Centre for Health and Social Care Research, University of Huddersfield, UK;

Van der Noordt, M, Jzelenberg, H, Droomers, M, and Proper, K. Health effects of employment: a systemic review of prospective studies. *BMJournals. Occupational and Environmental Medicine*. 2014; 71 (10).

Crabtree, S. In U.S., Depression Rates Higher for Long-Term Unemployed. (2014). Gallup. <http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx>.

United Health Group. *Doing good is good for you*. 2013 Health and Volunteering Study.

Jenkins, C, Dickens, A, Jones, K, Thompson-Coon, J, Taylor, R, and Rogers, M. Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers *BMC Public Health* 2013. 13 (773).

Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. *JAMA*. 2016; 315(16):1750-1766.

community engagement requirement as a condition for continued Medicaid coverage will help beneficiaries improve health outcomes, CMS has determined that it is appropriate to permit states to use section 1115 demonstration projects to determine whether they can achieve this result through a thoughtfully structured community engagement requirement.

Additionally, the amended demonstration incorporating the PCN community engagement requirement is likely to promote the objective of helping beneficiaries attain or retain financial independence. The community engagement program requires demonstration beneficiaries to look for work and engage in modules constructed by the state and tailored to the beneficiary based on an assessment of the beneficiary's particular needs to enhance his or her employability, such as training on job-skills or resume building. These tailored activities, based on a beneficiary's individual needs, as well as the requirement to apply for employment, are specifically designed to increase the likelihood that the beneficiary will succeed in securing paid employment. As the state pointed out in its application, employed individuals are not only more financially stable, but they may in turn have better health.

Finally, clinically managed withdrawal services amendment authorizes Utah to provide clinically managed residential withdrawal management services to all Medicaid eligible adults 18 and older who reside in Salt Lake County. This builds on the state's existing SUD program and adds additional services that are intended to help beneficiaries with SUD safely withdraw from substances in the least restrictive environment followed by placement with SUD treatment services. The state believes providing a more appropriate level of care for withdrawal management services will reduce non-emergent use of the emergency department, and reduce inappropriate inpatient stays. Under the amended demonstration, beneficiaries may be more likely to complete withdrawal and increase the likelihood of continuing treatment and recovery, which may ultimately help beneficiaries achieve better long-term health.

Although, as discussed below, coverage losses may arise at least temporarily as a result of non-compliance with the community engagement requirement, CMS anticipates that the aggregate health benefits from greater employment and community engagement, and the additional SUD withdrawal services, will on balance outweigh any adverse health effects experienced by a subset of the expansion population.

The demonstration will furnish medical assistance in a manner that improves the sustainability of the safety net.

CMS has determined that Utah's community engagement requirement is likely to promote the objective of furnishing medical assistance and, if successful, would also promote the sustainability of Utah's expanded Medicaid program. As a section 1115(a)(2) expenditure authority demonstration, the state is seeking a package that on the one hand offers more generous benefits to the expansion population, while also coupling these benefits with a community engagement requirement applicable to a subset of those individuals who are capable of greater engagement with their communities, but are not currently doing so. Utah seeks to expand coverage and lower the uninsured rate through the amended demonstration, but the state has made clear in its application that it must achieve these goals in a manner that it concludes is fiscally sustainable. The state explained in its application that "under the previous administration, states sought the flexibility to operate an expansion program that would not bust

their budgets but were denied,” and that Utah believes that its proposal is a fiscally sustainable approach to Medicaid expansion. For that reason, Utah “request[ed] to implement enrollment limits to allow the State to stay within its appropriated budget.”

By making the community engagement requirement a condition of eligibility for some members of the expansion population, Utah expects that some beneficiaries will gain financial security and not need public assistance. Those associated savings, in turn, will allow the state to provide medical assistance to beneficiaries and for services that it otherwise would be unable to cover. To the extent the community engagement requirement helps individuals achieve financial independence and transition to commercial coverage, the demonstration would enhance the state’s ability to provide medical services to those who most need the safety net.

By incentivizing community engagement, as described above, the demonstration is also designed to lead to improved outcomes for beneficiaries at a sustainable cost. If participating in community engagement activities improves beneficiaries’ physical and mental health, these beneficiaries may consume fewer health care resources, thus keeping in check state costs on Medicaid. Promoting improved health and wellness ultimately helps to keep health care costs at sustainable levels. To the extent that the demonstration helps individuals achieve improved health, the demonstration may make these individuals less costly for Utah to care for, thus further advancing the objectives of the Medicaid program by helping Utah stretch its limited Medicaid resources responsibly, ensure the long-term fiscal sustainability of the program, and ensure that the health care safety net is available to those Utah residents who need it most.

While CMS and the state are testing the effectiveness of an incentive structure that attaches a penalty for failure to meet the community engagement requirement, the program is designed to make compliance with the requirement achievable. Beneficiaries must complete the activities within three months of notification that they are subject to the community engagement requirement, and once the activities are completed, beneficiaries maintain Medicaid coverage for the rest of the 12-month benefit year. In addition, Utah has taken steps to include adequate beneficiary protections to ensure that the community engagement requirement only applies to those beneficiaries who can reasonably be expected to meet it and for whom the activities are appropriate to put the beneficiary on a pathway to employment. Beneficiaries subject to the community engagement requirement who have good cause for failing to meet it will be able to request an exception from the requirement. Individuals also will have the opportunity to apply for re-enrollment in the Adult Expansion Population after disenrollment for failure to meet the community engagement requirement, if the individual completes the required activities before re-applying and enrollment is not closed. Any individual who is disenrolled for failure to meet the community engagement requirement, or who experiences any other adverse action, will have the right to appeal the state’s decision consistent with all existing appeal and fair hearing protections. Furthermore, the incentives to meet the community engagement requirement, if effective, may result in individuals becoming ineligible because they have attained financial independence – a positive result for the individual.

CMS acknowledges that some beneficiaries could lose coverage, at least temporarily, for failure to comply with the demonstration’s community engagement requirement. However, it furthers the Medicaid program’s objectives to allow states to seek innovative means of deploying their limited state resources in ways that may allow them to provide coverage to individuals beyond the statutory minimum, as Utah does by covering the Adult Expansion Population up to 95

percent of the FPL, as well as optional coverage for benefits, including vision services and clinic services.

The demonstration will help the state and CMS evaluate whether the community engagement requirement helps non-exempt adults in the demonstration transition from Medicaid to financial independence, thus reducing dependency on public assistance. In order to determine whether community engagement requirements adequately incentivize individuals to work as a condition of receiving Medicaid coverage, the state will be required to track effects on employment, including new employment, among Medicaid beneficiaries. As described in the STCs, if monitoring or evaluation data indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. Further, CMS reserves the right to withdraw expenditure authority at any time it determines that its continuance would no longer be in the beneficiaries' interest or promote the objectives of Medicaid.

Consideration of Public Comments

Adult Expansion Amendment

The amendment was posted for a 30-day state public comment period beginning May 1, 2018 through May 31, 2018. The state presented the amendment to the Utah Indian Health Advisory Board (UIHAB) on May 11th, 2018 held a public hearing on May 11th, 2018 and presented to the Medicaid Advisory Committee on May 17th, 2018. During the state public comment period, the state received 29 comments from individuals, advocacy groups, and community partners. CMS posted the amendment request for public comment at the federal level on Medicaid.gov from July 5, 2018 through August 4, 2018 and received 54 comments. Although CMS is not legally required to provide written responses to comments, CMS is addressing some of the central issues raised by the comments and summarizing CMS's analysis of those issues for the benefit of stakeholders. Consistent with federal transparency requirements, CMS reviewed all of the materials submitted by the state, as well as all public comments received during the federal comment period, to determine whether the amended demonstration project as a whole is likely to assist in promoting the objectives of the Medicaid program, and whether the expenditure authorities sought are necessary and appropriate to implement the demonstration.

General comments

Many of the comments were in support of the expansion of coverage for the Adult Expansion Population, but opposed the community engagement requirement and enrollment cap. Some of the comments expressed general concerns that this amendment would result in Utahans losing access to Medicaid. CMS understands these concerns; however, if not for the addition of community engagement requirements and the enrollment cap, this population would not receive the more robust coverage it will be receiving under the demonstration, as amended, but instead would continue to receive very limited benefits or premium assistance only.

Some comments also reflect a misunderstanding of the nature of a demonstration project and appear to reflect the commenters' belief that CMS does not have the authority, under section 1115, to approve this request, particularly the community engagement component, as an amendment. It is not necessary for a state to show in advance that a proposed demonstration will in fact achieve particular outcomes; the purpose of a demonstration is to test hypotheses and

develop data that may inform future decision-making. As HHS previously explained, demonstration projects can “influence policy making at the [s]tate and Federal level, by testing new approaches that can be models for programmatic changes nationwide or in other [s]tates.” 77 Fed. Reg. at 11680. For example, the Temporary Assistance for Needy Families (TANF) work requirements that Congress enacted in 1996 were informed by prior demonstration projects. *See, e.g., Aguayo v. Richardson*, 473 F.2d 1090 (2d Cir. 1973) (upholding a section 1115 demonstration project that imposed employment requirements as conditions of AFDC eligibility). Regardless of the degree to which Utah’s demonstration project succeeds in achieving the desired results, the information it yields will provide policymakers real-world data on the efficacy of such policies. That, in itself, promotes the objectives of the Medicaid statute.

Comments on Community Engagement

Some commenters expressed concern that the requested demonstration will cause some individuals to lose Medicaid coverage, and for that reason, the demonstration cannot be considered to be consistent with the objectives of the Medicaid program. A few commenters used a Kaiser Family Foundation (KFF) study^[1] to extrapolate that anywhere from 6 to 17% of the estimated 95,000 non-SSI, non-dually eligible, and nonelderly Utahans eligible for coverage as part of the Adult Expansion Population will lose coverage due to certain aspects of implementation of the community engagement requirement. First, CMS notes that actual coverage impact will depend greatly on the actions of each individual beneficiary who is subject to the community engagement requirement, and it is therefore challenging to estimate the impact of this new program before it even begins. Second, the focus of the KFF study is on community engagement models in other states that operate differently than Utah’s, so it is not clear that KFF’s methodology can be extrapolated to Utah’s community engagement requirement in a manner that reliably estimates potential coverage loss. For example, in Utah, beneficiaries who work at least 30 hours per week are exempt from the community engagement requirement; these beneficiaries will not have to report routinely that they continue to work. Even if the KFF study accurately predicted the number of individuals who may initially lose coverage as a result of noncompliance, the state offers a ready on-ramp to facilitate renewed coverage, and it is difficult to predict at this point the percentage of those individuals who would permanently lose coverage.

Furthermore, in considering any potential temporary or long-term effect on coverage resulting from the community engagement component of the amended demonstration, it is important to weigh the additional medical services also provided through the amended demonstration. The expansion-eligible population—and not just the individuals not exempt from Utah’s community engagement requirement—will receive a much more robust benefit package than they previously could have received through the demonstration, when available benefits were restricted to a highly limited benefit package or premium assistance for ESI or COBRA coverage. Clinically managed withdrawal services would also be newly available to the state’s Medicaid population. CMS has weighed the potential coverage loss among beneficiaries in the relevant expansion population against the significant coverage gains for the likely much larger pool of beneficiaries who will be eligible for far more robust coverage under the amended demonstration. CMS anticipates that the comprehensive coverage that will be newly available to the Adult Expansion

^[1] Garfield, R, Rudowitz, R, & Musumeci, M (2018). Implications of the Medicaid work requirement: national estimates of potential coverage losses. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses>.

Population will encourage more eligible individuals to apply for and receive comprehensive coverage, and that on balance, weighing potential coverage losses against the demonstrated coverage gains, CMS concludes that the amended demonstration is likely to advance the objectives of Medicaid by providing coverage for net additional services, enhancing the fiscal sustainability of Utah's Medicaid expansion, and improving the health and financial independence of the expansion population.

CMS shares the commenters' concern that everyone who needs Medicaid and meets programmatic eligibility criteria should have access to Medicaid benefits. It is important to CMS that compliance with the community engagement requirement be achievable for every beneficiary subject to it, such that every beneficiary enrolled in the demonstration can continue to receive benefits until he or she obtains another form of coverage, such as commercial coverage, or increases his or her household income to a level too high to be eligible for public assistance. Although CMS recognizes that some coverage loss may occur, CMS believes the features of this demonstration are worth testing to determine whether there is a more effective way to furnish medical assistance to the extent practicable under the conditions in Utah. We recognize that some non-exempt individuals may not comply with the community engagement requirement imposed by the demonstration, and therefore may lose coverage or be unable to take advantage of the coverage expansion, at least temporarily. It should be noted that individuals might also lose coverage if they fail to comply with other requirements, like participating in the redetermination process. But, the goal of the community engagement policy is to incentivize compliance, not to reduce coverage due to lack of compliance.

Furthermore, we anticipate that some beneficiaries' income will increase above the 95 percent of the FPL income eligibility threshold as a result of obtaining a job after completing the community engagement requirement, and that those beneficiaries who already are not enrolled will obtain or continue to be covered by ESI or obtain other commercial coverage, such as subsidized coverage available through the Health Insurance Exchange, once they no longer qualify for the Adult Expansion Population. Through this demonstration, Utah is continuing to provide premium assistance for beneficiaries with incomes above 95 percent of the FPL through 200 percent of the FPL who have access to qualified ESI coverage, which allows beneficiaries with an offer of such coverage to maintain access to affordable health coverage.

The STCs have a number of safeguards that are intended to minimize coverage loss due to noncompliance, and CMS is committed to partnering with Utah to ensure that the new requirement is appropriately incentivizing community engagement, and not acting as an unreasonable barrier to eligibility. These safeguards include providing for a range of exemptions, including, but not limited to a beneficiary being a caretaker to a child under age six or a person with a disability, participating regularly in a SUD treatment program, or being physically or mentally unable to meet the community engagement requirements. Also, CMS is requiring that the following circumstances be included on the list of circumstances that would give rise to good cause for a beneficiary's failure to fail to comply with the community engagement requirement: if the beneficiary experiences severe inclement weather (including a natural disaster); if the beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act (P.L. 111-148) and was unable to meet the requirement for reasons related to that disability, but was not exempted from community engagement requirements; if the beneficiary has an immediate family

member in the home with a disability as defined under the same federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; if the beneficiary has no access to internet or transportation to a place where the requirements can be completed; and if there are fewer than 48 employers in the beneficiary's geographic area that potentially could offer employment to the beneficiary or from whom the beneficiary could reasonably be expected to accept an offer of employment.

CMS has also worked with Utah to include additional guardrails that will protect beneficiaries. These STCs contain a series of assurances, including that the state will screen beneficiaries and determine eligibility for Medicaid in other categories and review for eligibility for insurance affordability programs prior to disenrollment; provide full appeal rights prior to disenrollment; ensure that there are timely and adequate beneficiary notices provided in writing that address the community engagement requirement; assess areas within the state that lack public transportation, internet access, or a sufficient number of employers to permit beneficiaries to send out at least 48 job applications to determine whether there should be further exemptions from the community engagement requirement and/or additional mitigation strategies, so that the community engagement requirement will not be unreasonably burdensome for beneficiaries to meet; and maintain a system that provides reasonable modifications related to meeting the community engagement requirement to beneficiaries with disabilities, among other assurances. The STCs include a provision granting CMS the authority to discontinue the demonstration if the agency determines that it is not promoting Medicaid's objectives. Moreover, CMS will regularly monitor the demonstration and will work with the state to resolve any issues that arise as Utah works to implement the demonstration.

Many commenters expressed concern that the community engagement requirement is not necessary because many beneficiaries are already working, going to school, or engaging in some other employment and training activity. CMS and Utah acknowledge that many beneficiaries are already working or attending school; therefore, those activities are included as activities that exempt beneficiaries from having to meet the community engagement requirement. The community engagement requirement is designed to include activities that will enhance beneficiaries' employability and ultimately connect them with employers and job opportunities. Accordingly, the demonstration's design reflects that CMS and Utah agree that it is not necessary to require beneficiaries who are already engaged in educational, vocational training, or apprenticeship activities that enhance their employability, or are already employed, to take additional steps to meet a community engagement requirement. In order to determine whether the community engagement requirement is effective in enhancing beneficiaries' employability and connecting them to job opportunities, the state will be required to track and evaluate changes in employment, including new employment, among Medicaid beneficiaries, including those subject to the community engagement requirement and those who are exempt from it.

Other commenters expressed concern regarding how the community engagement requirement will impact individuals with disabilities, noting that people with disabilities either may not be able to work or may not be able to find work which can accommodate their needs. Other commenters expressed concern with the potential impact on individuals with a SUD. CMS and Utah share the commenters' concern that the community engagement requirement should not unduly burden individuals with disabilities or individuals with SUD. Participation in the community engagement requirement is limited to adults aged 19 through 60 who are not pregnant or eligible for Medicaid on the basis of a disability. We also note that beneficiaries

who are physically or mentally unable to complete the otherwise required community engagement activities and beneficiaries who are participating regularly in a SUD treatment program are exempt from the requirement. Further, as a condition of approval for this demonstration, the state must provide reasonable modifications related to meeting the community engagement requirement for beneficiaries with disabilities, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the demonstration.

CMS notes that while the activities that meet the community engagement requirement may not immediately cause all beneficiaries to become financially independent through a new job, the activities are nonetheless positive steps for beneficiaries to take on their path to financial independence, which are designed to make it more likely that beneficiaries will gain employment and enjoy the health and economic benefits associated with this form of community engagement. At the very least, CMS believes that it is worth testing and evaluating whether Utah's unique community engagement program design will lead to the anticipated effects. CMS will regularly monitor and evaluate the effects of this demonstration on affected beneficiaries and reserves the right to discontinue specific expenditure authorities if CMS determines that it would no longer be in the public interest or promote Medicaid's objectives to continue them.

Comments on Administrative Burden

Some comments suggested that creating a community engagement requirement in Medicaid would create a burden on the state's administrative functions and perhaps lead to increased cost.

Implementing programs in section 1115 demonstration projects may involve increased administrative costs, particularly during the early stages of the program. To assist in mitigating this concern, Utah will leverage existing state processes, such as the SNAP work requirement system, to minimize confusion and administrative burden and cost for the state and beneficiaries. In addition, due to the state's integrated eligibility system, the same state employees review an individual's applications for and compliance with the requirements of the SNAP and Medicaid programs, for individuals applying for both. The Medicaid community engagement requirement and exemptions are consistent with the SNAP requirements, which the state believes will lead to a lesser administrative burden on state eligibility staff and will increase the likelihood that they will make correct determinations regarding beneficiaries' compliance with or exemption from the demonstration's community engagement requirement.

Moreover, demonstrations designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure ESI or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such demonstrations may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.

Comments on Adult Expansion, Enrollment Cap, and Mandatory ESI

Many commenters approved of the state's request to expand Medicaid coverage up to 95 percent of the FPL with a more robust benefit package than is currently provided for the beneficiaries enrolled for limited demonstration coverage. However, some commenters expressed concerns

about the state's request to close enrollment for the Adult Expansion Population if the state's annual budget requires closure due to the projected costs for the population exceeding appropriated funds, which some commenters argued does not promote the objectives of Medicaid. Commenters were concerned that limiting enrollment will deny Medicaid access to individuals who need coverage. The state has indicated to CMS that, if it were not provided the ability to close enrollment due to budgetary restrictions, the state would have to provide even fewer Utahans with coverage using a slimmer benefit package, to make it less likely that costs for the expansion population would exceed state appropriations. CMS understands the concern with closing enrollment for the Adult Expansion Population when the state determines that projected expenses for the population are likely to exceed the state's a budgetary cap; however, CMS believes that the implementation of this cap will best allow the state to provide robust coverage to the greatest possible number of individuals.

A few commenters were concerned that the requirement for beneficiaries with access to a qualified ESI plan enroll in such plan would be an additional barrier to coverage and care and be more administratively burdensome, particular with regard to the wrap-around benefits. However, the state already has experience in determining which plans qualify for the ESI program and in working with beneficiaries and employers to ensure beneficiaries who are enrolled in ESI coverage receive premium assistance. Since the state already has experience tracking cost-sharing paid by and benefits provided to Medicaid beneficiaries, CMS does not believe that it will be administratively burdensome for the state to determine how to provide a benefit and cost-sharing wrap for which beneficiaries may be eligible.

Clinically managed residential withdrawal services amendment

For the amendment to add clinically managed residential withdrawal services, the state went out for a 30-day public comment period beginning December 1, 2018 through December 31, 2018. The state presented the amendment to the UIHAB on December 14th, held a public hearing on December 10th, and presented to the MAC on December 20th, 2018. During the state public comment period, the state received only one written comment, which was a letter of support from Salt Lake County Behavioral Health. During the presentation to the UIHAB, a concern was raised was the proposal to operate in Salt Lake County only. The state explained that Salt Lake County approached the state with the proposal and agreed to pay the state share of the cost. The state also explained that discussions are taking place with other counties who may be interested in doing the same and if other counties decide to participate, then an amendment can be submitted at that time.

CMS posted the amendment request for public comment at the federal level on Medicaid.gov from February 9, 2019 through March 11, 2018 and received one comment. The American College of Obstetricians and Gynecologists (ACOG) wrote in support of the amendment, but did express concerns that the amendment does not (1) specify that pregnant women receiving services through the waiver will be treated with opioid antagonist pharmacotherapy and will not be forced to participate in medically supervised withdrawal and (2) include a request to extend Medicaid coverage beyond 60 days postpartum to help prevent the discontinuation of pharmacotherapy for SUD. CMS appreciates the ACOG's comments and will share them with the state for consideration.

Other Information

CMS's approval of this demonstration project is conditioned upon compliance with the enclosed list of expenditure authorities and the STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your contact for this demonstration is Ms. Shanna Janu. She is available to answer any questions concerning these amendments. Ms. Janu's contact information:

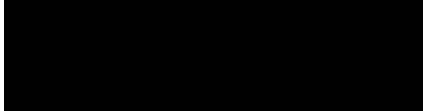
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Shanna.Janu@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Janu and to Ms. Mary Marchioni, Acting Deputy Director for the Denver Regional Operations Group. Ms. Marchioni's contact information is as follows:

Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294
Email: Mary.Marchioni@cms.hhs.gov

If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686.

Sincerely,

A large black rectangular redaction box covers the signature area.

Seema Verma

Enclosures

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBERS: 11-W-00145/8 (Title XIX)
21-W-00054/8 (Title XXI)

TITLE: Primary Care Network (PCN)

AWARDEE: Utah Department of Health

Title XIX Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, as amended, from March 29, 2019 through June 30, 2022, be regarded as matchable expenditures under the state's Medicaid Title XIX state plan. The expenditure authorities listed below promote the objectives of title XIX.

- 1. Current Eligibles.** Expenditures for optional services not covered under Utah's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR 438 *et seq.*
- 2. Demonstration Population I.** Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 95 percent of the federal poverty level (FPL) (effectively 100 percent with the five percent income disregard) who are not otherwise eligible for Medicaid, as described in the special terms and conditions (STC). This expenditure authority will end effective April 1, 2019.
- 3. Demonstration Population III.** Expenditures for premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' employer sponsored insurance (ESI) plan, who are not otherwise eligible for Medicaid, as described in the STCs.
- 4. Demonstration Population V.** Expenditures for premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the

FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs.

- 5. Individuals who are Blind or Disabled.** Expenditures for dental benefits for individuals who are blind or disabled and who are eligible for Medicaid, as described in the STCs.
- 6. Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.
- 7. Targeted Adults.** Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment.
- 8. Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD).
- 9. Adult Expansion Population.** Expenditures to provide coverage to adults, ages 19 through 64, who are not Current Eligibles, and have household income at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of five percent of income), as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents will receive state plan coverage, while members of the Adult Expansion Population who are custodial parents/caretaker relatives will receive the Current Eligibles benefit package, as specified in the STCs. This expenditure authority will end effective January 1, 2021.
- 10. Mandatory Employer Sponsored Insurance.** Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.
- 11. Clinically Managed Residential Withdrawal Pilot.** Expenditures to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries, age 18 and older, who reside in Salt Lake County, have a Physician or Licensed Practitioner of the Healing Arts determine the beneficiary demonstrates moderate withdrawal signs and symptoms, have a primary diagnosis of opioid use disorder (OUD) or another SUD, and require round-the-clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the remaining period of this demonstration.

1. Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group, with the exception of the Former Foster Care Youth from another state to whom state plan services will be provided. To enable the state to vary the amount, duration, and scope of services to individuals in the Targeted Adults expenditure population, to test whether providing dental benefits results in more successful treatment outcomes for certain individuals receiving SUD treatment. To enable the state to include additional benefits, such as case management and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system. To enable the state to vary the amount, duration, and scope of services offered to individuals in the Adult Expansion Population demonstration, based on whether the individual is a custodial parent/caretaker or not a custodial parent/caretaker. To enable the state to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries with a primary diagnosis of OUD or another SUD and living in Salt Lake County which are not available to other beneficiaries under the Medicaid state plan.

2. Federally Qualified Health Centers Payments **Section 1902(a)(15) and Section 1902 (bb)**

To permit the state to pay for Federally Qualified Health Center services provided to Demonstration Population I beneficiaries on a basis other than a prospective payment system.

3. Retroactive Eligibility **Section 1902(a)(34)**

To permit the state not to provide retroactive eligibility for individuals in Demonstration Populations I and III.

4. Statewideness/Uniformity **Section 1902(a)(1)**

To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX populations affected by this demonstration. To enable the state to provide the clinically managed residential withdrawal pilot only in Salt Lake County.

5. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this demonstration.

6. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Section 1902(a)(43)

To enable the state not to cover certain services required to treat a condition identified during an EPSDT screening. This not applicable applies to 19 and 20 year olds for all Title XIX populations affected by this demonstration. This not applicable does not apply to blind and disabled enrollees who receive dental benefits through the demonstration.

**7. Eligibility and Provision of Medical Assistance Section 1902(a)(8) and
Section 1902(a)(10)**

To the extent necessary to enable Utah to require community engagement as a condition of eligibility for beneficiaries in the Adult Expansion Population as described in these STCs.

To the extent necessary to enable Utah to terminate eligibility for, and not make medical assistance available to, beneficiaries in the Adult Expansion Population who fail to comply with the community engagement requirement unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs.

8. Reasonable Promptness Section 1902(a)(8)

To the extent necessary to enable Utah to deny enrollment in the Adult Expansion Population when enrollment is closed, as described in the STCs.

9. Compliance with ABP requirements Section 1903(i)(26)

In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that the conditions for FFP in section 1903(i)(26) are not satisfied.

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, November 1, 2017 through June 30, 2022, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for Demonstration Population VI, described below, except those specified below as not applicable to these expenditure authorities.

- 1. COBRA Children (Demonstration Population VI).** Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such expenditures are authorized without regard to the funding limitation under section 2105(c)(2) of the Act.

Moreover, the Title XXI requirements listed below do not apply to the benefits for this population.

Title XXI Requirements Not Applicable to CHIP Expenditure Authorities for Demonstration Population VI

1. General Requirements, and Eligibility Screening Requirements **Section 2102**

The state child health plan does not have to reflect the demonstration population. Eligibility screening is not required to exclude eligibility for individuals enrolled in continuation coverage pursuant to COBRA.

2. Restrictions on Coverage and Eligibility to Targeted Low-Income Children **Section 2103 and 2110**

Coverage and eligibility is not restricted to targeted low-income children, to the extent that it includes individuals enrolled under continuation coverage pursuant to COBRA.

3. Qualified Employer Sponsored Coverage **Section 2105(c)(10)**

To permit the state to offer a premium assistance subsidy that does not meet the requirements of section 2105(c).

4. Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children **Section 2102**

To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.

5. Benefit Package Requirements **Section 2103**

To permit the state to offer a benefit package for all CHIP populations affected by this demonstration that is limited to premium assistance.

6. Cost Sharing **Section 2103(e)**

To the extent necessary to permit all CHIP populations affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing imposed by employer-sponsored insurance plans.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBERS: 11-W-00145/8 (Title XIX)
21-W-00054/8 (Title XXI)

TITLE: Primary Care Network

AWARDEE: Utah Department of Health

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Utah Primary Care Network
Approval Period: November 1, 2017 through June 30, 2022
Amendment Approved: March 29, 2019

XVII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION EXTENSION

Attachment A: Developing the Evaluation Design

Attachment B: Preparing the Interim and Summative Evaluation Reports

Attachment C: SUD Implementation Protocol

Attachment D: SUD Monitoring Protocol *[reserved]*

Attachment E: Community Engagement Implementation Plan *[reserved]*

Attachment F: Community Engagement Monitoring Protocol *[reserved]*

I. PREFACE

The following are the Special Terms and Conditions (STC) for Utah’s Primary Care Network (PCN) Medicaid section 1115 demonstration program (hereinafter referred to as “demonstration”) under section 1115 of the Social Security Act (the Act). The parties to this agreement are the Utah Department of Health, Division of Health Care Financing (“state”) and the Centers for Medicare & Medicaid Services (“CMS”). All requirements of the Medicaid and CHIP programs expressed in law, regulation and policy statement, not expressly made not applicable in the list of Expenditure Authorities, shall apply to the demonstration project.

The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below. The STCs have been arranged into the following subject areas: program description and objectives, general program requirements, eligibility, benefits, enrollment, cost sharing, delivery systems, general reporting requirements, general financial requirements under Title XIX, general financial requirements, monitoring budget neutrality for the demonstration, evaluation of the demonstration, schedule of state deliverables during the demonstration extension, and substance use disorder.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Utah’s PCN is a statewide section 1115 demonstration to expand Medicaid coverage to certain adults who are not eligible for state plan services and to offer these adults and children on the Children’s Health Insurance Program (CHIP) an alternative to traditional direct coverage public programs. When the demonstration was first approved in 2002, state plan eligibles (referred to as Current Eligibles), who are categorically or medically needy parents or other caretaker relatives, were provided a reduced benefit package and required to pay increased cost-sharing. Savings from this state plan population funded a Medicaid expansion for up to 25,000 uninsured adults age 19 to 65 with family incomes up to 150 percent of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also high-risk pregnant women, whose

resources made them ineligible under the state plan, were covered under the demonstration for the full Medicaid benefits package. Currently, the demonstration covers Current Eligibles and the population above parent and caretaker state plan levels up to 95 percent of the FPL.

The state hypothesizes that the demonstration will improve the health of Utahns by increasing the number of low-income individuals without access to primary care coverage, which will allow more Medicaid beneficiaries to receive regular care instead of relying on the hospitals for emergency care. The state also hypothesizes that by providing Medicaid benefits for beneficiaries residing in IMDs and the full continuum of substance use disorder (SUD) care, the state will be able to provide more extensive care to individuals suffering from SUD and in turn make this population healthier and more likely to remain in recovery.

Upon this approval, Utah will provide full state plan benefits to adults without children who have incomes up to 95 percent of the FPL and the Current Eligible benefit package to adults with children who have incomes up to 95 percent of the FPL (together, these categories are known as the Adult Expansion Population). If the state determines that the state needs to close enrollment in this Medicaid eligibility group (MEG) due to budgetary restrictions, coverage will be closed and no applicants will be able to enroll in this MEG until enrollment re-opens. Beneficiaries in this category who have access to employer sponsored insurance (ESI) coverage will be required to enroll in that coverage to maintain Medicaid eligibility, and will receive wraparound coverage. In addition, non-exempt Adult Expansion Population beneficiaries are required to complete community engagement requirements (or demonstrate good cause for failing to do so) each benefit year to be eligible for continued coverage. Lastly, this approval will allow the state to provide clinically managed residential withdrawal services to adult beneficiaries who reside in Salt Lake County.

Previous Demonstration Waivers and Amendments:

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- **Amendment #1** - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that become pregnant get the full Medicaid state plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform with changes to the benefits available under the state plan. Finally, it increased the co-payment for hospital admissions from \$100 to \$220, again to conform with changes to the state plan. (Approved on August 20, 2002, effective on July 1, 2002)
- **Amendment #2** - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the state subsidizes the employee's portion of the premium for up to 5 years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-sponsored plan. With this amendment, the state was also granted authority to reduce the

enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the \$50 fee was prohibitive as they earn less than \$260 per month. For this population, the state reduced the enrollment fee to \$15. (Approved on May 30, 2003, effective on May 30, 2003).

- **Amendment #3** - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from \$50 to \$25. (Approved on July 6, 2004, effective on July 6, 2004).
- **Amendment #4** - This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the state provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005).
- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005).
- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006).
- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from \$2.00 per prescription to \$3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006).
- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006).
- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspended Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006).

This amendment provides the option of employer sponsored insurance (ESI) premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least five percent of the household's countable income. The state subsidizes premium assistance through a monthly subsidy of up to \$150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with

family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is \$140 per month; otherwise, it is \$120 per month. If dental benefits are not provided by a child's ESI plan, the state offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the Title XXI out-of-pocket cost sharing limit of five percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well child care services, age appropriate immunizations, physician visits, hospital inpatient, and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

- **Amendment #10** – This amendment enables the state to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of employer-based group health coverage at group rates. COBRA coverage becomes available following the loss of ESI due to specified qualifying events, such as an end of employment (voluntary or involuntary); divorce or legal separation; death of employee; entitlement to Medicare; reduction in hours of employment; and loss of dependent-child status. Through this amendment, Utah will provide premium assistance to programmatically-eligible adults and children (as differentiated from individuals who are COBRA-eligible but not otherwise eligible for the Utah COBRA premium assistance program) toward the purchase of COBRA coverage, in a manner similar to the provision of premium assistance for the purchase ESI coverage. (Medicare-eligible individuals who are also COBRA-eligible would be ineligible for the Utah COBRA Premium Assistance Program (CPAP) based on age or the State's standard processes of cross-matching with SSI/SSDI eligibility files).

During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) will work in tandem with the subsidy provided under ARRA for the purchase of COBRA coverage. Specifically, ARRA provides a federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008, through December 31, 2009, and as extended by Congress. As long as the individual receives the ARRA subsidy, the state would provide the family with premium assistance based on the number of programmatically-eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the state under these STCs.

The ARRA COBRA subsidy can last for up to nine months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ends, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP will continue to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to

a family will be based on the number of programmatically-eligible individuals in the household. However, as with the existing ESI program, the state will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualifies for the ARRA COBRA subsidy. Individuals and families who are COBRA-eligible but uninsured may also apply for enrollment in the Utah CPAP. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the state under these STCs. The amendment was approved by CMS on December 18, 2009.

- **Amendment #11** - This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150 percent of the FPL to 200 percent of the FPL. This amendment was approved by CMS on September 28, 2012.
- **Section 1115(e) Extension** - On June 23, 2006, the State of Utah formally requested an extension of their PCN 1115 demonstration waiver under the authority of section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.
- **Section 1115(f) Extension** – On March 1, 2010, the State of Utah formally requested an extension of the PCN demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.
- **Temporary Extension** – The December 24, 2013 amendment and temporary extension, changed the STCs so beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and state plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.
- **Temporary Extension** – The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively 100 percent of the FPL because of the 5 percent income disregard) in order to ensure that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).
- **Temporary Extension** – On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.

- **Temporary Extension** – December 16, 2016, the demonstration was temporarily extended on through December 31, 2017.
- **Amendment #12** – On June 29, 2017, CMS approved an amendment which allows the state to provide state plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.
- **Amendment #13** – On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, Targeted Adults, under which eligible beneficiaries receive state plan services. This new population is made of adults without dependent children, age 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the state has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.
- **Amendment #14** -This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this waiver. The state withdrew this amendment.
- **Amendment #15** - In February 2019, the state received the authority provide comprehensive dental benefits to Targeted Adults who are receiving SUD treatment. In addition, the state received approval to provide state plan Medicaid coverage to Former Foster Care Youth who were ever enrolled in Medicaid in another state.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that

occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to provide the state with additional notice of the changes.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

- a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
- b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the day such legislation was required to be in effect under federal law.

5. State Plan Amendments. The state will not be required to submit Title XIX or Title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In the event of a conflict between the provisions of the Medicaid or CHIP state plan and these STCs with respect to a population eligible through the Medicaid or CHIP state plan, the provisions of the Medicaid or CHIP state plan govern.

As outlined in CMS' November 21, 2016 CMCS Informational Bulletin, *Section 1115 Demonstration Opportunity to Allow Medicaid Coverage to Former Foster Care Youth Who Have Moved to a Different State*, the state shall submit a conforming amendment to the Medicaid state plan for the "out-of-state" former foster care youth affected by the implementation of this demonstration. After the associated Medicaid SPA is effectuated, the state will not be required to submit any additional title XIX SPAs for changes affecting this former foster care youth population made eligible solely through this demonstration.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the

demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

a. Amendment requests must include, but are not limited to, the following:

- i. An explanation of the public process used by the state, consistent with the requirements of STC 14, to reach a decision regarding the requested amendment;
- ii. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- iii. An up-to-date CHIP allotment neutrality worksheet, if necessary;
- iv. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- v. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

b. Changes to benefits described in the state plan shall be made by state plan amendment. Changes to benefits not described in the state plan shall be made by amendment to the demonstration. Changes in benefits shall be implemented in accordance with the process set forth in Section V of these STCs.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets the requirements of 42 Code of Federal Regulations (CFR) §431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR section 431.416(g).
- e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the

project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

12. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and/or XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. Adequacy of Infrastructure. The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

15. Federal Financial Participation (FFP). No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

16. Transformed Medicaid Statistical Information Systems Requirements (T-MSIS). The state must comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems Requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter.

17. Common Rule Exemption. The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

18. Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Eligibility Groups Affected By or Eligible Only Under the Demonstration. Mandatory and optional state plan groups derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard January 1, 2014, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for access to additional benefits not described in the state plan. Expansion groups which are not eligible under the state plan and are eligible only for benefits under this demonstration are subject to all Medicaid requirements except as expressly waived in this demonstration, or expressly listed as not applicable to the specific expansion group. These requirements include determination of income using the same MAGI-based methodologies applicable to populations eligible under the Medicaid state plan.

19. Eligibility Criteria. Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived and as described in these STCs. Current Eligibles, as defined below, are included in the demonstration to generate savings for covering the expansion populations, to mandate enrollment in managed care by waiving the freedom of choice requirement, and to waive other specific programmatic requirements.

Demonstration eligible populations are not otherwise eligible for Medicaid through the state plan, and are only covered under Medicaid through the section 1115 demonstration.

20. Eligibility Groups. The Utah section 1115 demonstration is comprised of the following Eligibility Groups.

- a. Current Eligibles are the following individuals, whose eligibility is derived from the state plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the state plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who

are pregnant are excluded, through the 60th day postpartum. Expenditures on current eligibles are considered demonstration expenditures for purposes of calculation of demonstration budget neutrality. There is no enrollment limit for this group. This population is a part of the original PCN demonstration and is not participating in the ESI program.

- b. Demonstration Population I is comprised of individuals age 19 through 64 with incomes at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income), who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, do not qualify for Medicare or Veterans benefits, and do not have other health insurance. There is no resource limit for Demonstration Population I.

The state may exclude from Demonstration Population I individuals that have access to ESI such that the cost to the employee does not exceed a specified percentage of household countable income; the specified percentage may not exceed 15 percent. Demonstration Population I is subdivided into two groups, which have a combined annual average enrollment limit of 25,000:

- i. Custodial Parents/Caretaker Relatives: A population consisting of adults with children with family income levels that exceed the levels for eligibility under the state plan provisions implementing section 1931 of the Act.
- ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population.

As of April 1, 2019, Demonstration Population I will be suspended and all beneficiaries enrolled in the population will move to the Adult Expansion Population. The state may reopen Demonstration Population I when the state submits and CMS approves an amendment.

- c. Demonstration Population III is comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an Utah's Premium Partnership for Health Insurance (UPP)-approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income. Adults with incomes at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income), who would be eligible to participate in PCN as a member of Demonstration Population I, are only eligible for Demonstration Population III if they elect to receive premium assistance instead of PCN. These individuals are only covered under Medicaid through the section 1115 demonstration. Demonstration Population III is subdivided into three groups:

- i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the state plan provisions implementing section 1931 of the Act. There is no enrollment limit for this group.
- ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population. There is no enrollment limit for this group.
- iii. Adult Children of Custodial Parents/Caretaker Relatives: A demonstration eligible population that meets the eligibility requirements of Demonstration Population III, as well as being age 19 through 26, enrolled in their caretaker's ESI plan, and live in their caretaker's household.

As of April 1, 2019, beneficiaries with incomes up to and including 95 percent of the FPL enrolled in Demonstration Population III will move to the Adult Expansion Population.

- d. Demonstration Population V consists of adults age 19 through 64 with countable gross family income up to and including 200 percent of FPL, are U.S. citizens or qualified non-citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage). Demonstration Population V is subdivided into two groups:
 - i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the state plan provisions implementing section 1931 of the Act.
 - ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population.

As of April 1, 2019, beneficiaries with incomes up to and including 95 percent of the FPL enrolled in Demonstration Population V will move to the Adult Expansion Population.

- e. Current Eligible CHIP Children is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.
- f. Demonstration Population VI is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:

- i. **COBRA-Eligible Children:** A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium assistance for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.
 - ii. **COBRA Continuation Children:** A child that meets the definition of a targeted low-income children except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium assistance.
- g. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:
- i. Be chronically homeless, defined as:
 - (1) An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability; or
 - (2) An individual currently living in supportive housing who has previously met the definition of chronically homeless (1) above.
 - ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
 - i. An individual who has complied with and substantially completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);
 - ii. An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
 - iii. Individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.
 - iii. Needing substance use or mental health treatment, defined as:
 - i. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for 6 months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder;
 - ii. An individual receiving General Assistance from the Department of

Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or

iii. An individual recently discharged from the Utah State Hospital who was civilly committed, to be further specified in the Utah Administrative Code.

h. Former Foster Care Youth from Another State are defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.

i. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of five percent of income). This group may be closed to new enrollment should projected costs exceed state appropriations. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state. The authority to cover this population will end effective January 1, 2021.

Table 1: Eligibility Groups

Note: This Table is presented for information purposes and does not change the state plan requirements or otherwise establish policy.

Medicaid Eligibility Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
Mandatory Medicaid State Plan Groups				
Section 1925 and 1931 TANF related adult family members	Income according to the State Standard of Need	Statewideness, Comparability, Freedom of Choice, EPSDT	<u>Current Eligibles</u>	Current Eligibles
Section 1902(a)(10)(C)/42 CFR 435.322 & 435.330 adults who are blind or disabled	No income standard	Comparability	<u>Blind and Disabled Adults–Dental</u>	1902(a)(10)(C) - <u>Blind and Disabled Adults –Dental</u>
Optional Medicaid State Plan Groups				
Medically Needy adults who are not pregnant/postpartum, aged, blind, or disabled	Individual must "spend down" to a Medically Needy Income Standard set by the state	Statewideness, Comparability, Freedom of Choice, EPSDT	<u>Current Eligibles</u>	Current Eligibles
PCN Demonstration Eligible Groups				

Medicaid Eligibility Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents: Demonstration Population I	Individuals with incomes at or below 95% FPL	Comparability, Freedom of Choice, Statewideness, EPSDT, FQHC, Retroactive Eligibility	<u>PCN Adults w/Children(1)</u> (parents/ caretaker relatives) <u>PCN Childless Adults(1)</u> (childless adults/noncustodial parents)	<u>PCN Adults w/Children (1)</u> <u>PCN Childless Adults(1)</u> (childless adults/non-custodial parents)
Targeted Adults	Individuals with incomes at 0% FPL	Statewideness, Comparability, Freedom of Choice, EPSDT	<u>Targeted Adults</u>	<u>Targeted Adults</u>
Former Foster Care Youth	No income standard	N/A	<u>FCY</u>	<u>FCY</u>
Adult Expansion Population	Individuals with incomes up to and including 95% of the FPL	Statewideness, Comparability, Freedom of Choice, EPSDT, Eligibility and Provision of Medical Assistance, Reasonable Promptness	<u>Adult Expansion Population</u>	<u>Adult Expansion Population</u>
ESI Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents and adult children (19-26) of parents/caretakers Demonstration Population III	Up to and including 200% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, Retroactive Eligibility	<u>ESI Adults w/Children(3)</u> (parents/ caretaker relatives) <u>ESI Childless Adults(3)</u> (childless adults/noncustodial parents) ESI Adult Children (Title XIX)(3)	<u>ESI Adults with Children</u> <u>ESI Childless Adults(3)</u> (childless adults/non-custodial parents) ESI Adult Children
CHIP children of working adults -Current Eligible CHIP Children Population	Up to and including 200% FPL	Cost Sharing Exemption for AI/AN Children, Cost Sharing, Benefit Package Requirement	ESI Children (Title XXI)(4)	ESI Children

Medicaid Eligibility Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
COBRA Premium Assistance Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents eligible for COBRA benefits Demonstration Population V	Up to and including 200% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, Retroactive Eligibility	<u>COBRA Adult w/ Children(5)</u> (parents/caretaker relatives) COBRA Childless Adult (5) (childless adults/non-custodial parents)	<u>COBRA Adults with children</u> COBRA Childless Adult (5) (childless adults)
CHIP children of unemployed adults eligible for COBRA benefits Demonstration Population VI	Up to and including 200% FPL	Cost Sharing Exemption for AI/AN Children, Cost Sharing, Benefit Package Requirements	COBRA-Eligible Children COBRA-Continuation Children (Title XXI)	COBRA-Eligible Children COBRA-Continuation Children

V. BENEFITS

21. Minimum for Current Eligibles. Current Eligible adults enrolled in the demonstration receive most of the services covered under Utah’s state plan according to the limitations specified in the state plan, except as modified below. This benefit package is reduced from that available under the state plan in accord with changes detailed in Table 2a. Any changes that would result in coverage limitations that are more restrictive than those listed in Table 2a, or less restrictive than both table 2a and the corresponding section of the Medicaid state plan, must be submitted as a demonstration amendment. If the state were to amend its Medicaid state plan to provide benefit limitations that are more restrictive than those listed in Table 2a (including elimination of any of the listed services), the revised state plan would determine the benefit. The state must notify the Project Officer of all planned changes to benefits for Current Eligibles, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes. CMS reserves the right to determine whether a change in benefits under the state plan that impacts this demonstration and effects budget neutrality for the demonstration would warrant an amendment. The state may not amend its Medicaid state plan to provide a Benchmark Benefit under section 1937 of the Act to Current Eligibles, or any subset of Current Eligibles, so long as this demonstration is in effect.

Table 2a: Benefits for Current Eligibles and for Members of the Adult Expansion Population who are Custodial Parents/Caretaker Relatives that are Different than State Plan Covered Services and Limitations

*The following table is for illustrative purposes only and does not limit the state’s ability to change the state plan benefits through State Plan Amendments.

Service	Special Limitations for Current Eligibles
Hospital Services	Additional surgical exclusions. Refer to the Administrative Rule UT Admin Code R414-200 Non-Traditional Medicaid Health Plan Services and the Coverage and Reimbursement Code Lookup.
Vision Care	One eye examination every 12 months; No eye glasses
Physical Therapy	Visits to a licensed PT professional (limited to a combination of 16 visits per policy year for PT and OT)
Occupational Therapy	Visits to a licensed OT professional (limited to a combination of 16 visits per policy year for PT and OT)
Speech and Hearing Services	Hearing evaluations or assessments for hearing aids are covered, Hearing aids covered only if hearing loss is congenital
Private Duty Nursing	Not covered
Medical Supplies and Medical Equipment	Same as traditional Medicaid with exclusions. (See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Organ Transplants	The following transplants are covered: kidney, liver, cornea, bone marrow, stem cell, heart and lung (includes organ donor)
Long Term Care	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Dental	Dental services are not covered, with exceptions.

22. Minimum for Demonstration Population I – PCN Eligibles. The benefit package for Demonstration Population I is a limited benefit package of primary and preventative care services through the PCN program. These services include primary care physician, lab, radiology, durable medical equipment, emergency room services, pharmacy, dental, and vision. Covered services are often provided with different limitations than those covered in the state plan. Inpatient hospital, specialty care, and mental health services are among the services that are not covered. The benefits are detailed in Table 2b. The benefit package for Demonstration Population I eligibles must be comprehensive enough to be consistent with the goal of increasing the number of individuals in the state with health insurance, including at least a primary care benefit, which means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. Medicaid state plan services

other than those listed in Table 2b are not covered for Demonstration Population I. Should the state amend its Medicaid state plan to provide benefit limitations that are more restrictive for the services listed in Table 2b (including elimination of any of the listed services), the revised state plan would determine the benefit, and no demonstration amendment would be needed; all other changes to the benefit for Demonstration Population I must be made through a demonstration amendment. The state must notify the Project Officer of all planned changes to benefits for Demonstration Population I, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes. As of April 1, 2019, Demonstration Population I will close and all beneficiaries enrolled in the population will move to the Adult Expansion Population.

Table 2b: Benefits for Demonstration Population I Eligibles that are Different than State Plan Covered Services and Limitations

*The following table is for illustrative purposes only and does not limit the state’s ability to change the state plan benefits through State Plan Amendments.

Service	Special Limitations for Demonstration Population I
Hospital Services	Emergency Services in Emergency Room only
Physician Services	Services by licensed physicians and other health professionals for primary care services only
Vision Care	One eye examination every 12 months, no eyeglasses
Lab and Radiology Services	Lab and Radiology only as part of primary care services or as part of an approved emergency service as identified in the PCN Provider Manual
Occupational Therapy	Not covered
Chiropractic Services	Not covered
Speech and Hearing Services	Hearing evaluations for hearing loss or assessments for hearing aids are covered
Podiatry Services	Not covered
End Stage Renal Disease - Dialysis	Not covered
Home Health Services	Not covered
Hospice Services	Not covered
Private Duty Nursing	Not covered
Medical Supplies and Medical Equipment	Equipment only for recovery (see detail list in the PCN Provider Manual)
Abortions and Sterilizations	Not covered
'Inpatient Treatment for Substance Abuse and Dependency	Not covered
Organ Transplants	Not covered
Long Term Care	Not Covered
Transportation Services	Ambulance (ground and air) for medical emergencies only. Non-emergency transportation is not covered.
Family Planning Services	Consistent with physician and pharmacy scope of services. Not covered: Norplant, Infertility drugs, Invitro fertilization, Genetic counseling, Vasectomy, Tubal ligation.

Service	Special Limitations for Demonstration Population I
High-Risk Prenatal Services	Not covered
Medical and Surgical Services of a Dentist	Not covered
Health Education including Diabetes and Asthma	Not covered
Pharmacy	Pharmacy services limited to 4 prescriptions per month; prior authorization required for non-PDL drugs when a PDL exists for a drug class; some injectables are covered in a pharmacy, and any other injectables identified in the PCN Provider Manual
Dental	Limited scope of services: exams, preventive services, fillings, and limited extractions
Mental Health	Not covered
Outpatient Substance Abuse	Not covered
Targeted Case Management for the Chronically Mentally Ill	Not covered
Targeted Case Management for Substance Abuse	Not covered
Targeted Case Management for Homeless	Not covered
Targeted Case Management for HIV/AIDs	Not covered

23. Benefit Definition

- a. **For Adults and Adult Children in Demonstration Populations III and V – Premium Assistance.** The sole benefit provided to persons eligible for premium assistance (through ESI or COBRA coverage) is assistance in paying the employee’s, individual’s, or family’s share of the monthly premium cost of qualifying insurance plans.
- b. **For Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI) – Premium Assistance.** The primary benefit provided to children eligible for premium assistance (through ESI or COBRA coverage) is assistance in paying the child’s share of the employee’s, individual’s, or family’s share of the monthly premium cost of qualifying insurance plans.

Dental benefits for children will be offered through two paths. If the health benefit package that is available to a child through qualified premium assistance coverage includes dental benefits, the child's premium assistance will be approximately equivalent to the per-child-per-month cost under the Title XXI state plan including dental costs. However, if a child does not receive dental benefits through the qualified premium assistance plan, the state’s minimum dental coverage for children is set by legislation, and is benchmarked to the coverage of the largest private carrier. In this case, the coverage is the same as direct coverage.

- c. Utah will ensure that all participating premium assistance insurance plans cover well-baby/well-child care services, age-appropriate immunizations, and emergency care. The state will also ensure children receive physician visits, hospital inpatient, and pharmacy benefits, at a minimum. Utah may use state rules to establish a set of additional criteria that will be used to determine which insurance plans shall be “qualified plans.”
- d. Benefits furnished by qualified premium assistance insurance plans are not benefits under this demonstration; the only benefit under this demonstration is premium assistance. Qualified plans are not restricted from offering additional benefits, at the option of the plan, which may vary by the plan to which the individual or family has access.

24. Choice of Benefit Plans. An eligible individual or family may enroll in any qualified insurance plan that meets the requirements specified in state rules and is provided by their employer or to which they have access through COBRA.

25. Premium Assistance Subsidy Determination. Demonstration Population III and V beneficiaries will receive premium assistance, under the following conditions:

- a. In accord with the enrollment and implementation procedures as defined in Section VI, the state will provide an eligible and enrolled individual or family with a premium assistance subsidy.
- b. The premium assistance amount for participating plans:
 - i. Must not exceed the maximum amount of the participant’s share of the premium.
 - ii. The maximum subsidy limit, which the state may adjust in accord with STC 25(c), is:
 - **For ESI plans –**
 - Adults and Adult Children = \$150 per enrollee per month
 - Children = \$120 per enrollee per month with state wrap around dental benefits
 - Children = \$140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage
 - **For COBRA plans –**
 - Adults = \$150 per enrollee per month
 - Children = \$120 per enrollee per month with state wrap around dental benefits
 - Children = \$140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage.
- c. **Adjustments for Health Care Inflation.** For adults enrolled in the premium assistance programs, the state may increase the maximum amount per month as long as it does not exceed the without waiver ceiling amount established in the budget neutrality calculation of estimated service expenditures.

For children enrolled in the premium assistance programs, the per child monthly premium assistance payment will be approximately equivalent to the per-child-per-month

cost under the Title XXI state plan (excluding dental costs – currently \$120 per month; or including dental costs – currently \$140 per month).

- d. The premium assistance subsidy will be paid directly to the individual/family up to the maximum amount specified in STC 25(b).
- e. The COBRA subsidy -
 - i. For a qualified individual, who is determined to be an assistance-eligible individual under section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA) and can receive the nine-month ARRA COBRA subsidy, the UPP-Like COBRA program will provide additional premium assistance to subsidize the payment of the former employee's 35 percent share of the monthly premium for COBRA continuation coverage (up to the limits set below).
 - ii. After the expiration of the ARRA COBRA subsidy, the Utah COBRA premium assistance program will subsidize the former employee's share in accord with STC 25.

26. Dental Benefit for Enrollees who are Blind or Disabled. All individuals who are blind or disabled, 18 and older, who are enrolled in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.322, 435.324 and 435.330, will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services.

27. Targeted Adults. Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits. Beneficiaries that are enrolled in this eligibility category and receiving SUD treatment will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services.

28. Former Foster Care Youth from Another State. Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

29. Adult Expansion Population. Beneficiaries in this category will receive benefits as follows:

- a. Custodial Parents/Caretaker Relatives enrolled in this eligibility category will receive the same benefits as Current Eligibles, which are outlined in Table 2a.
- b. Childless Adults/Non-custodial Parents enrolled in this eligibility category will receive full Medicaid state plan benefits.
- c. Mandatory ESI Enrollees. As of January 1, 2020, beneficiaries in this eligibility group that are eligible to enroll in a qualified ESI plan (as described in STC 20(i)), are required enroll in that plan, and will be reimbursed for the full amount of the beneficiary's share of the monthly premium cost of the qualified ESI plan. In order to ensure the beneficiary receives Medicaid benefits, wrap-around benefits will be provided through a FFS delivery system.

VI. ENROLLMENT AND IMPLEMENTATION

30. General Requirements

- a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.
- b. Any individual who is denied eligibility in any health coverage program authorized under this demonstration must receive a notice from the state that gives the reason for denial, and includes information about the individual's right to appeal.
- c. The state will adhere to the demonstration population enrollment limits presented in Section IV.

31. Enrollment in the PCN Program (Demonstration Population I).

- a. Individuals applying for the PCN program must be screened for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.
- b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and the applicant meets all of the eligibility criteria for PCN, and if PCN is open to new enrollment at the time of the determination, the applicant may be enrolled in PCN.
- c. PCN may be closed to new enrollment either at the state's election, or because the enrollment limit specified in these STCs has been reached. If PCN is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period.
- d. The state will provide for a redetermination of eligibility at least once every 12 months.
- e. As of April 1, 2019, this program is closed to enrollment.

32. Enrollment in UPP for ESI Premium Assistance (Demonstration Populations III and Current Eligible CHIP Children).

- a. Adults with incomes at or below 95 percent of the FPL who have been determined eligible for the PCN (Demonstration Population I) may be given an opportunity to receive premium assistance for ESI through UPP, instead of the PCN benefit.
- b. Adults with incomes up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population III will be given the option to receive premium assistance for ESI through UPP.
- c. Families with dependent children that are eligible for CHIP may elect to have their children receive premium assistance for ESI through UPP, instead of receiving CHIP coverage. However, children may opt back into direct coverage at any time.

- d. The state must establish and maintain procedures (which may be done through rulemaking) that will:
 - i. Ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium assistance subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving UPP subsidies from the state;
 - ii. Provide written information prior to enrollment in UPP explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and ESI coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);
 - iii. Ensure the consent of the responsible adult family member to receiving premium assistance under UPP instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);
 - iv. Allow children to opt out of ESI and begin receiving CHIP coverage at any time, with an immediate effective date upon request;
 - v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage and the individual's/family's share of the premium;
 - vi. Require clients to notify the Utah Department of Health within ten days if they change their ESI plan, there is a change in the amount of their premium, or their ESI coverage is terminated;
 - vii. Ensure that the total amount of UPP subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation toward their ESI coverage;
 - viii. Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage. The federal share must be returned within the timeframes established in statute and regulations; and
 - ix. Provide for a redetermination of eligibility at least once every 12 months.

33. Enrollment in Utah COBRA Premium Assistance Program

- a. Adults with incomes at or below 95 percent of the FPL who have been determined eligible for the PCN (Demonstration Population I) may be given an opportunity to receive premium assistance for COBRA Coverage through UPP, instead of the PCN benefit.

- b. Adults with incomes up to and including of 200 percent of the FPL who meet all other requirements for Demonstration Population V will be given the option to receive premium assistance for COBRA through UPP.
- c. Families with dependent children that are eligible for CHIP, and whose children have lost COBRA-eligible ESI coverage, may elect to have their children receive premium assistance for COBRA coverage through UPP, instead of receiving CHIP coverage.
- d. The state may offer premium assistance for COBRA coverage to all adults and children who are receiving COBRA coverage and who are receiving a subsidy of 65 percent of its cost under ARRA. COBRA premium assistance may be offered to adults and children who would be eligible for PCN or CHIP, respectively, if uninsured. Families must submit applications within the 60-day period referenced above to qualify for this assistance.
- e. The state must establish and maintain procedures (which may be done through rulemaking) that will:
 - i. Ensure that at least one adult family member is eligible for COBRA continuation coverage, that the COBRA benefit qualifies for the COBRA premium assistance subsidy, and that the eligible individual elects to participate and maintains participation in the COBRA plan for all individuals receiving UPP COBRA subsidies from the state;
 - ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and COBRA coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);
 - iii. Ensure the consent of the responsible adult family member to receiving COBRA premium assistance instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);
 - iv. Allow children to opt out of the Utah COBRA Premium Assistance Program and begin receiving CHIP coverage at any time; with an immediate effective date upon request.
 - v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in COBRA coverage and the individual's/family's share of the premium. Verification may include the use of the Coverage Election Notice, forms developed by the state, and use of inter-agency administrative databases such as eFILE;
 - vi. Require clients to notify the Utah Department of Health within 10 days if there is a change in the amount of their premium or their COBRA coverage is terminated;

- vii. Ensure that the total amount of the Utah COBRA Premium Assistance Program subsidy(ies) provided to an individual or family does not exceed the amount of the former employee's financial obligation toward their COBRA coverage, which must be net of any ARRA subsidy amount received;
- viii. Provide for recovery of payments made for months in which the individual or family did not receive COBRA coverage. The federal share must be returned within the timeframes established in statute and regulations; and
- ix. Provide for a review of benefits on a timeframe consistent with anticipated changes in COBRA coverage or premiums and a redetermination of eligibility at least once every 12 months.

34. Disenrollment from the Premium Assistance Programs. If an individual/family is involuntarily disenrolled from a demonstration premium assistance program, such as when a participating plan no longer meets the established state criteria or the individual meets the eligibility criteria for direct Medicaid coverage:

- a. There is no sanction period before a child, who has been involuntarily disenrolled from a premium assistance program, could be enrolled in CHIP.
- b. Children involuntarily disenrolled from premium assistance will be seamlessly enrolled in the CHIP program. Utah CHIP will ensure that there is no break in coverage.

35. Interaction with Medicaid. For individuals eligible for Demonstration Populations III (ESI adults) and V (COBRA adults) who are not eligible for Demonstration Population I (PCN), the state will offer opportunities for these individuals to enroll in Demonstration Population I or other direct Medicaid coverage if they are later determined to be eligible for such coverage.

- a. Individuals may at any time apply for Medicaid, and if determined eligible, be enrolled in direct coverage.
- b. At least every 12 months, the state must remind each individual by mail, an eligibility redetermination, or other comparable means that he or she is entitled to apply for Medicaid and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

36. Enrollment in Dental Benefits. There is no separate enrollment process required for individuals who are blind or disabled and otherwise enrolled in the state plan, or Targeted Adults who are receiving SUD treatment, to receive dental services through this demonstration.

37. Targeted Adults Enrollment. As of November 1, 2017, individuals who are currently eligible for Demonstration Population I and can be identified as eligible for this demonstration population, may be moved to the Targeted Adults eligibility group. Current

Demonstration Population I eligible individuals who cannot be identified as eligible for the Targeted Adults population will be sent notification informing them of the availability of this program.

- a. Individuals applying for Medicaid will be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults eligibility group.
- b. The state will provide for a redetermination of eligibility at least once every 12 months.
- c. The Targeted Adults group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period.
- d. The state will provide continuous eligibility for a period of 12 months to the Targeted Adults. Income and other changes during the continuous eligibility period will not affect a beneficiary's eligibility with the exception of the following reasons:
 - Moving out of state;
 - Death;
 - Determined eligible for another Medicaid eligibility category;
 - Fraud; or
 - Client request.
- e. All eligibility criteria, including income, will be considered at the time of the individual's annual eligibility redetermination to determine if the individual continues to meet eligibility for Medicaid.

38. Adult Expansion Population. This group may be closed to new enrollment should projected costs exceed state appropriations. If this eligibility group is closed to new enrollment, the state will still accept and review applications and determine applicants' eligibility for all Medicaid eligibility groups. If the applicant only qualifies for coverage in the Adult Expansion Population, the application will be denied; applications will not be held over for a new enrollment period and the individual will have to re-apply when enrollment re-opens to obtain coverage as a member of this population. The authority to cover this population will end effective January 1, 2021.

39. Mandatory ESI Enrollment. For beneficiaries in the Adult Expansion Population who are required to enroll in a qualified ESI plan as specified in STC 20(i), access to and enrollment in a qualified ESI plan and the beneficiary's premium amount will be verified at initial application, every three months, and at annual recertification.

VII. COST SHARING

40. Cost Sharing. Cost sharing must comply with Medicaid requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR §447.56(a), and be reflected in the state plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447.52(b) applies to the demonstration.

- 41. Demonstration Populations III and Current Eligible CHIP Children in ESI and Demonstration Populations V and VI in COBRA.** Adults and children of families that choose premium assistance will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium assistance will be charged cost sharing amounts set by their ESI or COBRA coverage and will not be limited to the Title XXI five percent out-of-pocket family income maximum. All other cost sharing, including co-payments, and co-insurance, are set by the qualified plan and the responsibility of the participant.
- 42. Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** American Indian/Alaskan Native individuals enrolled in the demonstration are subject to cost sharing exemptions of section 5006 of the American Recovery Reinvestment Act of 2009 (and are not required to pay premiums or cost sharing for services received through the Indian health care system).
- 43. Enrollment Fee.** The state must not impose an enrollment fee on any demonstration populations.

VIII. DELIVERY SYSTEMS

- 44. Enrollment in Managed Care.** The state may require Current Eligibles, Adult Expansion Population, and Targeted Adults to receive the health care benefits to which they are entitled through managed care delivery systems, consistent with regulations at 42 CFR 438 *et seq.*
- 45. Compliance with Managed Care Reporting Requirements** A status update on managed care delivery systems, including a discussion of recent developments, problems encountered and steps taken to resolve them, must be included in each annual report.
- 46. ESI and COBRA Delivery Systems.** Demonstration Populations III through VI will receive services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium assistance.
- 47. Dental Services.** As of July 1, 2017, dental services provided through the demonstration will be delivered fee-for-service (FFS). Effective September 1, 2018, the state began delivery of these services through managed care under 1915(b) authority.

The state will contract with entities to provide dental services to the Targeted Adults who are receiving SUD treatment. The state must ensure that contracted entities:

- Have demonstrated experience working with beneficiaries who are being treated for both a SUD and a major oral health disease;
- Operate a program, targeted at the individuals described above, that has demonstrated effectiveness in providing dental services to such individuals who are receiving SUD treatment, as reflected in a peer-reviewed evaluation or study; and
- Enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described above through an intergovernmental transfer (IGT) consistent with section

1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

48. Targeted Adults Delivery System. As of November 1, 2017, health care benefits will be delivered FFS. At a future date, the state may transition delivery of these services to managed care under 1915(b) authority or by amendment to this demonstration.

49. Adult Expansion Population Delivery System. As of April 1, 2019, health care benefits will be delivered through FFS. At a future date, the state may transition delivery of these services to managed care under 1915(b) authority or by amendment to this demonstration.

IX. COMMUNITY ENGAGEMENT

50. Overview. Beginning no sooner than January 1, 2020, Utah will implement a community engagement requirement as a condition of continued eligibility for the Adult Expansion Population demonstration beneficiaries described in STC 20(i) who are not otherwise subject to an exemption described in STC 51. To maintain program coverage, non-exempt beneficiaries will be required to participate in activities specified in STC 52 or show good cause as specified in STC 54(c). Beneficiaries who are subject to the community engagement requirement will have three months from the first of the month following approval/recertification into the Adult Expansion Population to meet the community engagement requirement. Once the requirement is met, the beneficiary will remain eligible for the remainder of the 12-month eligibility period. Beneficiaries who fail to meet the community engagement requirement within the three month period will be notified in the immediately following month that the beneficiary will be disenrolled at the end of that month and will not be eligible for coverage in the Adult Expansion Population for the rest of the 12-month eligibility period until the beneficiary completes the requirement. If an individual reports having met the requirement within this notice month the individual will not be disenrolled and will remain eligible without having to reapply.

51. Exempt Populations. Beneficiaries who report, in accordance with 42 CFR 435.945(a), meeting one or more of the following exemptions (or if the state has systems data that show a beneficiary meets the exemption) will not be required to complete community engagement related activities to maintain eligibility for as the 12-month benefit period during which they continue to qualify for one or more of the following exemptions while otherwise subject to the community engagement requirement. A beneficiary is exempt from the community engagement requirement if the beneficiary is:

- Age 60 or older;
- Pregnant or up to 60 days postpartum;
- Physically or mentally unable to meet the requirements as determined by a medical professional or documented through other data sources;
- A parent or other member of household with the responsibility to care for a dependent child under age six;

- Responsible for the care of a person with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act;
- A member of a federally recognized tribe;
- Has applied for and is awaiting an eligibility determination, or is currently receiving unemployment insurance benefits, and has registered for work at Department of Workforce Services (DWS);
- Participating regularly in a SUD treatment program, including intensive outpatient treatment;
- Enrolled at least half time in any school (including, but not limited to, college or university) or vocational training or apprenticeship program;
- Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;
- State Family Employment Program (FEP) recipients who are working with an employment counselor;
- Beneficiaries in compliance with or who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (TANF) employment requirements; or
- Working at least 30 hours a week or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.

Beneficiaries meeting one or more of the above listed exemptions will not be required to complete community engagement related activities within the 12 month benefit year in which the exemption is claimed in order to maintain continued coverage.

52. Qualifying Activities. Beneficiaries who are not exempt under STC 51 and who are not eligible for good cause under STC 54(c) must satisfy their community engagement requirement by completing all of the following activities through DWS:

- Registering for work through the state system;
- Completing an assessment of employment training needs;
- Applying for employment, either directly or through the state's automated employment application submission process, with at least 48 potential employers; and
- Completing the job training modules as determined to be relevant to the individual through the assessment of employment training needs.

53. Requirements and Reporting. Beneficiaries who are not exempt under STC 51 and who do not qualify for a good cause exception under STC 54(c) must participate in the qualifying activities listed in STC 52 within the three-month period starting on the first of the first month after notification that the beneficiary must meet the community engagement requirement. Beneficiaries complete activities through an online program at any location with internet access and also may access the program at Employment Resource Centers across the state. Once the system has verified that beneficiary has met the community engagement requirement by completing the required activities, the beneficiary will remain eligible for the remainder of the 12-month eligibility period. The beneficiary must complete the community engagement requirement or qualify for an exemption or demonstrate good

cause during the applicable three-month period for each 12-month eligibility period to continue to be eligible for Medicaid and receive benefits.

54. Non-Compliance. Beneficiaries who fail to comply with STC 52 and STC 53, within the three-month compliance period will be disenrolled, unless the beneficiary requests and demonstrates good cause as described in STC 53(c) within the three months that the beneficiary is otherwise required to complete the community engagement activities or if the beneficiary appeals the termination prior to its effective date.

- a. Disenrollment effective date. Beneficiaries who fail to comply with the community engagement requirement as described in STC 52 and STC 53, and who do not have an exemption from meeting the community engagement requirement as described in STC 51 or do not qualify for a good cause exception as described in STC 54(c), will have eligibility terminated on the last day of the month in which the beneficiary receives notification of his or her non-compliance, unless an appeal is timely filed or a beneficiary qualifies for a good cause exception as specified in STC 54(c) of this STC.
- b. Re-enrollment Following Non-Compliance. Following disenrollment, individuals will be able to re-apply for coverage after completing all required activities and would be re-enrolled with eligibility effective the first day of the month in which the beneficiary re-applies. However, if the individual reports having met the requirements within one month of disenrollment, the individual will not have to submit a new application. If the individual meets the qualifications for an exemption listed in STC 51, demonstrates good cause for the earlier non-compliance in STC 54(c) or becomes eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement, the individual can re-enroll immediately and their eligibility will have an effective date of the first of the month of application or, if eligible in a group other than the Adult Expansion Population, consistent with the beneficiary's new eligibility category. An individual who has been disenrolled for non-compliance and is subsequently re-enrolled after completing all the required activities or qualifying for an exemption, will begin a new 12-month eligibility period, with an effective date to the first of the month of application, and will be considered to have met the community engagement requirement or to be exempt for that 12 month period.
- c. Good Cause. The state will consider a beneficiary to be compliant with the community engagement requirement if the beneficiary demonstrates good cause for failing to meet the required community engagement activities within the three month period. Beneficiaries may report a good cause circumstance for the state's approval up to 10 days prior to termination. The recognized circumstances that give rise to good cause include, but are not limited to, at a minimum, the following verified circumstances:
 - i. The beneficiary has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the beneficiary or

- an immediate family member who was living in the home with the beneficiary experiences a hospitalization or serious illness;
- ii. The beneficiary experiences the birth, or death, of a family member living with the beneficiary;
 - iii. The beneficiary experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
 - iv. The beneficiary has a family emergency or other life-changing event (e.g. divorce or domestic violence);
 - v. Beneficiary has no access to internet or transportation to a place where the requirements can be completed, such as a job center or library, to complete the requirements;
 - vi. There are fewer than 48 employers in the beneficiary's geographic area that potentially could offer employment to the beneficiary or from whom the beneficiary reasonably could be expected to accept an offer of employment (including considerations related to, for example, the beneficiary's ability to obtain transportation to the employment site); in this case, the number of required employer contacts shall be reduced to an appropriate level so that the beneficiary is not required to make applications for employment that the beneficiary demonstrates are likely to be futile; or
 - vii. The beneficiary is the primary caretaker of a child age 6 or older and was unable to meet the requirement due to childcare responsibilities.

55. Reasonable modifications: The state must provide reasonable modifications related to meeting the community engagement requirement for beneficiaries with disabilities protected by the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The state must also provide reasonable modifications for program requirements and procedures, including but not limited to, assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; demonstrating good cause; appealing disenrollment; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications.

Reasonable modifications must include exemptions from participation where a beneficiary is unable to participate for disability-related reasons and provision of support services necessary to participate, where participation is possible with supports. In addition, the state should evaluate each beneficiary's ability to participate and the types of reasonable modifications and supports needed.

56. Community Engagement: State Assurances. Prior to implementation of the community engagement requirements as a condition of continued coverage, the state shall:

- a. Ensure that there are processes and procedures in place to stop or recoup payments to a Managed Care Organization (MCO) when a beneficiary is terminated for failure to

- comply with program requirements and to trigger payment when eligibility is reinstated.
- b. Ensure that there are processes and procedures in place to seek data from other sources including SNAP and TANF, and systems to permit beneficiaries to efficiently report community engagement activities or obtain an exemption or good cause exception, in accordance with 42 CFR 435.907(a), and 435.945, and to permit the state to monitor compliance.
 - c. If a beneficiary has requested a good cause, that the good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial.
 - d. Assure that termination, disenrollment, or denial of eligibility will only occur after an individual has been screened and determined ineligible for all other bases of Medicaid eligibility and reviewed for eligibility for insurance affordability programs in accordance with 435.916(f).
 - e. Ensure that specific activities that may be used to satisfy community engagement requirements are available during a range of times at no cost to the beneficiary.
 - f. Ensure that there are timely and adequate beneficiary notices provided in writing, including but not limited to:
 - i. When community engagement requirements will commence for that specific beneficiary;
 - ii. Whether a beneficiary is exempt, how to request an exemption, and under what conditions the exemption would end;
 - iii. A list of the specific activities that must, be used to satisfy the community engagement requirements and a list of the specific activities that beneficiaries can engage in;
 - iv. When and how the beneficiary must report participation or request an exemption or good cause exception;
 - v. Information about resources that help connect beneficiaries to opportunities for activities that would meet the community engagement requirement, and information about the community supports that are available to assist beneficiaries in meeting the community engagement requirement;
 - vi. Information about how community engagement activities will be counted and documented;
 - vii. What gives rise to a termination of eligibility, what a termination would mean for the beneficiary, and how to avoid a termination, including how and when to apply for a good cause exception, and what kinds of circumstances might give rise to good cause;
 - viii. If beneficiary has sought to demonstrate good cause, that the good cause has been approved or denied, with an explanation of the basis for the decision and how to appeal a denial;
 - ix. Any differences in the program requirements that beneficiaries will need to meet in the event they transition off of SNAP or TANF but remain subject to the community engagement requirement of this demonstration;
 - x. If a beneficiary is not in compliance, that the beneficiary is out of compliance, and, if applicable, how the beneficiary can resume compliance in order to avoid termination of eligibility;

- xi. How beneficiaries are expected to report the activities and exemptions or good cause exceptions;
 - xii. If a beneficiary's eligibility is terminated, how to appeal the termination, information on how to appeal that decision and/or how to reapply for Medicaid benefits; and
 - xiii. The right of individuals with disabilities to reasonable modifications in community engagement requirement, with examples of the reasonable modifications in those requirements to which individuals may be entitled, including, assistance with documenting participation, exemptions or good cause exceptions from requirements if an individual is unable to participate for a disability-related reason, and reductions in number of employer contacts required if an individual is unable to contact the required number of employers.
- g. Provide full appeal rights as required under 42 CFR, Part 431, subpart E prior to termination or dis-enrollment, and observe all requirements for due process for beneficiaries whose eligibility will be denied or terminated for failing to meet the community engagement requirement, including allowing beneficiaries the opportunity to raise additional issues in a hearing, including whether the beneficiary should be subject to the termination, and provide additional documentation through the appeals process.
 - h. Maintain an annual redetermination process, including systems to complete ex parte redeterminations and use of notices that contain prepopulated information known to the state, consistent with all applicable Medicaid requirements.
 - i. Develop and implement an outreach strategy to inform beneficiaries how to report compliance with or exemption from the community engagement requirement, changes in circumstances, and how to request a good cause exception, including how notices provided at enrollment will provide information on resources available to beneficiaries who may require assistance reporting compliance with or exemption from the community engagement requirement, changes in circumstances, and/or requesting a good cause exception.
 - j. Establish beneficiary protections, including assuring that beneficiaries do not have to duplicate requirements to maintain access to all public assistance programs that require employment or another form of community engagement.
 - k. Make good faith efforts to connect beneficiaries to existing community supports that are available to assist beneficiaries in meeting community engagement requirement, including available non-Medicaid assistance with transportation, child care, language access services and other supports.
 - l. Ensure the state will assess areas within the state that experience high rates of unemployment, areas with limited economies and/or educational opportunities, and areas with lack of public transportation to determine whether there should be further exemptions from the community engagement requirement and/or additional mitigation strategies, so that the community engagement requirement will not be unreasonably burdensome for beneficiaries to meet.
 - m. Develop and maintain an ongoing partnership with the DOH and DWS to assist recipients with identifying and accessing opportunities for workforce training,

complying with community engagement requirement, and moving toward independence and self-sufficiency.

- n. Provide each beneficiary who has been terminated from Medicaid with information on how to access primary care and preventative care services at low or no cost to the beneficiary. This material will include information about free health clinics and community health centers including clinics that provide behavioral health and substance use disorder services. The state shall also maintain such information on its public-facing website and employ other broad outreach activities that are specifically targeted to beneficiaries who have lost coverage.
- o. Make the general assurance that the state is in compliance with protections for beneficiaries with disabilities under the ADA, Section 504, or Section 1557 of the Patient Protection and Affordable Care Act and:
 - i. Make good faith efforts to connect beneficiaries with disabilities as defined above with services and supports necessary to enable them to meet the community engagement requirement;
 - ii. Maintain a system that provides reasonable modifications related to meeting the community engagement requirement to beneficiaries with disabilities as defined above;
 - iii. Ensure the state will assess whether people with disabilities have limited job or other opportunities for reasons related to their disabilities. If these barriers exist for people with disabilities, the state must address those barriers; and
 - iv. Provide beneficiaries with written notice of the rights of people with disabilities to receive reasonable modifications related to meeting the community engagement requirement.
- p. Ensure that the state will monitor the application of exemptions to ensure that there is not a disparate impact based on race.

X. SUBSTANCE USE DISORDER

57. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Effective upon CMS' approval of the SUD Implementation Protocol, the demonstration benefit package for Medicaid recipients will include OUD/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Disease (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance and OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD once CMS approves the state's Implementation Protocol. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD residential treatment and withdrawal management in IMDs will expand Utah's current SUD benefit package available to all Medicaid recipients as outlined

in Table 3. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 3: Utah OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy (Individual; Group; Family; Collateral)	State plan (Individual services covered)	
Intensive Outpatient Program	State plan (Individual services covered)	
Partial Hospitalization Treatment (including Day Treatment for children/youth under the age of 21)	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs
Crisis Intervention (including Mobile Crisis)	State plan (Individual services covered)	
Residential Crisis Stabilization	State plan (Individual services covered)	Services provided to individuals in IMDs

58. SUD Implementation Protocol. The state must submit an SUD Implementation Protocol within 90 calendar days after approval of this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment C, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol or failure to obtain CMS approval will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Protocol will describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration project:

- a. **Access to Critical Levels of Care for SUDs:** Service delivery for new benefits, including residential treatment, crisis stabilization and withdrawal management within 12-24 months of OUD/SUD program demonstration approval;
- b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;
- c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;
- d. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Utah Administrative Code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
- e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
- f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;
- g. **Sufficient Provider Capacity at Critical Levels of Care including MAT:** An assessment of the availability of providers in the key levels of care throughout the

state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

- h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;
- i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in this STC; and
- j. **Improved Care Coordination and Transitions:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

59. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment D. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 58. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements.

60. Mid-Point Assessment. The state must conduct an independent mid-point assessment between DYs 17 and 18 of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to

high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state will submit to CMS modifications to the SUD Implementation Plan and SUD Monitoring Protocols for ameliorating these risks subject to CMS approval.

61. Deferral for Insufficient Progress Toward Milestones and Failure to Report

Measurement Data. If the state does not demonstrate sufficient progress on milestones in the SUD Implementation Protocol, as determined by CMS, or fails to report data as approved in the SUD Monitoring Protocol, CMS will defer funds in the amounts specified in STC 71 for each incident of insufficient progress and failure to report in each reporting quarter.

62. SUD Evaluation. The SUD Evaluation will be subject to the same terms as the overall demonstration evaluation, as listed in Sections IX (General Reporting Requirements) and XIV (Evaluation of the Demonstration) of the STCs.

63. SUD Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Failure to submit an acceptable and timely evaluation design along with any required monitoring, expenditure, or other evaluation reporting will subject the state to a \$5 million deferral. The state must use an independent evaluator to design the evaluation.

- a. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.
- b. **Evaluation Questions and Hypotheses.** The state must follow the general evaluation questions and hypotheses requirements as specified in **STC 111**. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include (but is not limited to): initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose.

64. SUD Health Information Technology (Health IT). The state will provide CMS with an

assurance that it has a sufficient health IT infrastructure/”ecosystem” at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This “SUD Health IT Plan,” or assurance, will be included as a section of the state’s Implementation Protocol (see STC 58) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

- a. The SUD Health IT section of the Implementation Protocol will include implementation milestones and dates for achieving them (see Attachment D).
- b. The SUD Health IT Plan must be aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) “Health IT” Plan.
- c. The SUD Health IT Plan will describe the state’s goals, each DY, to enhance the state’s prescription drug monitoring program’s (PDMP).¹
- d. The SUD Health IT Plan will address how the state’s PDMP will enhance ease of use for prescribers and other state and federal stakeholders.² This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- e. The SUD Health IT Plan will, as applicable, describe the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will: (a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns³ and (b) ensure

¹ Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the “opioid” epidemic and facilitate a nimble and targeted response.

² *Ibid.*

³ Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

that Medicaid does not inappropriately pay for opioids—and that states implement effective controls to minimize the risk.

- g. In developing the Health IT Plan, states shall use the following resources.
 - i. States may use resources at Health IT.Gov (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/>) in “Section 4: Opioid Epidemic and Health IT.”
 - ii. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicare.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
 - iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.
- h. The state will include in its Monitoring Protocol (see **STC 59**) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.
 - i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Reports (see **STC 78**).
 - j. The state shall advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
 - i. Wherever it is appropriate, the state must require that contractors providing services paid for by funds authorized under this demonstration shall adopt the standards, referenced in 45 CFR Part 170.
 - ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170 but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standards.

65. SUD Interim Evaluation Report. The state must submit an Interim Evaluation Report for

the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
- b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
- c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design will be adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B of these STCs.

66. SUD Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

XI. CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL PILOT

67. Overview. Under this pilot, the state will provide clinically managed residential withdrawal services to adult Medicaid beneficiaries, age 18 and older, who reside in Salt Lake County. These pilot services are appropriate for a beneficiary when a Physician or Licensed Practitioner of the Healing Arts determines the beneficiary demonstrates moderate

withdrawal signs and symptoms, has a primary diagnosis of OUD or another SUD, and requires round-the-clock structure and support to complete withdrawal management and increase the likelihood of continuing treatment and recovery. There is no cost-sharing charged for these services.

68. Plan of Care. Clinically managed residential withdrawal services must be delivered in accordance with an individualized plan of care and may include the following specific services, as provided by physicians or other practitioners lawfully authorized to provide such services within the scope of their practice or license:

- a. **Assessment:** The evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Assessment may include a physical examination and laboratory testing necessary for substance use disorder treatment.
- b. **Observation:** The process of monitoring the beneficiary's course of withdrawal. To be conducted as frequently as determined to be medically appropriate for the beneficiary and the level of care the beneficiary is receiving. This includes, but is not necessarily limited, to observation of the beneficiary's health status, withdrawal symptoms and severity, and evaluation of whether a more intense level of care may be needed (e.g., to determine whether it would be medically appropriate for the beneficiary to receive medication intervention or emergency room services).
- c. **Medication Services:** The prescription and/or administration of medications related to substance use disorder treatment services, and/or the assessment of the side effects or results of that medication.
- d. **Psychoeducation:** Services that are designed to educate and inform the beneficiary about substance use disorder and to help the beneficiary develop an understanding of the process of recovery.
- e. **Discharge Services:** The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to treatment resources in the community.

69. Provider Qualifications. Clinically managed residential withdrawal services are provided by the following practitioners in a residential facility that is licensed by the Utah Office of Licensing to provide withdrawal management services:

- a. Licensed Clinical Social Workers (LCSW);
- b. Registered Nurses;
- c. Certified Recovery Assistants;
- d. Masters Degree-level Mental Health Clinicians;
- e. Certified Case Managers; and
- f. Certified Peer Support Specialists.

Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

XII. GENERAL REPORTING REQUIREMENTS

70. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 (\$5M) per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) Thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state’s anticipated date of submission. Should CMS agree to the state’s request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state’s failure to submit all required reports, evaluations, and other deliverables

will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

- 71. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in implementation protocol and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.
- 72. Submission of Post-Approval Deliverables.** The state must submit all deliverables using the process stipulated by CMS and within the timeframes outlined within these STCs.
- 73. General Financial Requirements.** The state must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section X. The state must submit any corrected budget and/or allotment neutrality data upon request.
- 74. Reporting Requirements Related to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.
- 75. Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 reporting and analytics functions, the state will work with CMS to:
- a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
 - b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
 - c. Submit deliverables to the appropriate system as directed by CMS.
- 76. Implementation Plan.** The state must submit an Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, as amended, including community engagement. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment E. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals; renewals; coordination with other state agencies; beneficiary protections; and outreach.

77. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as Attachment F.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 78 below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration, including but not limited to community engagement. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 78 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

78. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The fourth-quarter information that would ordinarily be provided in a separate quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 days) following the end of each demonstration quarter. The Annual Report (including the fourth-quarter information) is due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis..

- a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

- b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS’ framework for monitoring community engagement. The performance metrics will also reflect all other components of the state’s demonstration. For example, these metrics will cover enrollment, disenrollment or termination by specific demographics and reason, participation in community engagement qualifying activities, access to care, and health outcomes.

Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals.

The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

- c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality, including baseline cost and member months, set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.
- d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

79. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

80. Close out Report. Within 120 days prior to the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

- a. The draft final report must comply with the most current Guidance from CMS.
- b. The state will present to and participate in a discussion with CMS on the Close-Out

- report.
- c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.
 - d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.
 - e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 70.

81. Monitoring Calls. CMS will convene periodic conference calls with the state.

- a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
- b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
- c. The state and CMS will jointly develop the agenda for the calls.

82. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

83. Reporting Expenditures under the Demonstration. The state will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, enrollment fees, or third party liability.

- a. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance

Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality limit will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 84. DY1 is the year beginning July 1, 2002 and ending June 30, 2003, and subsequent DYs are defined accordingly.

- b. Premium offsets and enrollment fees that are collected by the state for enrollees under this demonstration shall be reported to CMS on the CMS-64 summary sheet. Enrollment fees shall be reported as an administrative offset on Line 9.d., columns c and d. Premium offsets shall be reported as a services offset on Line 9.d., columns a. and b. In order to assure that the demonstration is properly credited with these collections, please provide the appropriate information on the CMS-64 narrative.
- c. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit found in section XII. Utah must complete separate waiver forms for the following eligibility groups/waiver names:
 - i. Current Eligibles
 - ii. PCN Adults w/Children (1)
 - iii. PCN Childless Adults (1)
 - iv. ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)
 - v. ESI Childless Adults (3)/ COBRA Childless Adults (5)
 - vi. Current Eligible CHIP Children (4) and COBRA Children (6) are reported on the applicable CMS-21 form.
 - vii. Dental Services for Section 1902(a)(1)(C)/42 CFR 435.322 & 435.330 Blind and Disabled Adults ("BD Dental")
 - viii. Targeted Adults
 - ix. Former Foster Care Youth From Another State ("FFCY")
 - x. SUD
 - xi. Targeted Adults Dental ("TAD")
 - xii. Adult Expansion Population
 - xiii. Employer Sponsored Insurance
 - xiv. Withdrawal Management
- d. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal

government provides a federal medical assistance percentage (FMAP) of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent.

84. Expenditures Subject to the Budget Agreement. For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include all Medicaid expenditures on behalf of all demonstration participants (i.e., Current Eligibles, Demonstration Population I, Demonstration Population III, Demonstration Population V, Dental Services – Blind/Disabled, Targeted Adults, Former Foster Care Youth from Another State, SUD, Dental Services – Targeted Adults as defined in STC 83(c)(i-xxiv) of the STCs).

85. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name "ADM".

86. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

87. Reporting Member Months. For the purpose of calculating the budget neutrality expenditure limit and other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member/months for the eligibility groups (EG) as defined in STC 20. Enrollment information should be provided to CMS in conjunction with the quarterly reports referred to in section X. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

- a. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member/months.
- b. There will be eight demonstration populations that will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following waiver names. The groups used for calculating the budget neutrality expenditure limit are described below:
 - i. "PCN Current Eligibles," as defined in section IV of these STCs.

- ii. "PCN Adults with Children(1)" is a hypothetical group under "PCN Adults with Children" and members of the Demonstration Population I, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. PCN Adults w/Children(1)" does not include members of Demonstration Population I who are childless adults/noncustodial parents, or members of Demonstration Population III.
- iii. "ESI Adults with Children(3)" is a hypothetical group under "ESI Adults with Children" and are members of the Demonstration Population III, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. "ESI Adults w/Children(3)" does not include members of Demonstration Population III who are childless adults/noncustodial parents, or members of Demonstration Populations I.
- iv. "COBRA Adults with children(5)" is a hypothetical group under "COBRA Adults with Children" and are members of the Demonstration Population V, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. "COBRA Adults w/Children(X)" does not include members of Demonstration Population III, or members of Demonstration Populations I.
- v. Current Eligible CHIP Children of Title XXI CHIP ESI Children (reported as "ESI Children") and Demonstration Population VI of Title XXI (CHIP COBRA Children reported as "COBRA Children") reported as Non-Group Children will be reported separately. Expenditures for Title XXI ESI Children and COBRA Children are reported on the CMS-21.
- vi. "Blind and Disabled Adults" is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.
- vii. "Former Foster Care Youth from Another State" ("FFCY") is a hypothetical budget neutrality coverage group as defined in section IV of these STCs.
- viii. "SUD" is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.
- ix. "Adult Expansion Population" is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.
- x. "Employer Sponsored Insurance" is a group from the Adult Expansion Population that is mandatorily enrolled into ESI as defined in section IV of these STCs whose beneficiaries receive hypothetical services.
- xi. "Withdrawal Management" is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

88. Standard Medicaid Funding Process. The standard Medicaid funding process will be used during the demonstration. The state must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the state will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

89. Extent of FFP for the Demonstration. The CMS will provide FFP at the applicable federal matching rate for the following, subject to the limits described in the Budget Neutrality Monitoring For the Demonstration, Section XIII:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

90. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

91. State Certification of Funding Conditions. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—

fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

92. State Assurances.

- a. The acceptance of these STCs is Utah's confirmation that its information technology systems and administrative processes (including internal controls) are able to report reliably and accurately expenditures related to the 1115 demonstration to the CMS-64 system.
- b. **Implementing Changes Based on the Independent Audit.** The state assures to CMS and the federal review team (FRT) that the budget neutrality of contemporary DYs is measurable and verifiable. This assurance will be verified in part through the Phase II audit findings. Should the Phase II audit find that the state's current information technology systems and administrative processes (including internal controls) are not sufficient to report expenditures related to the 1115 demonstration to the CMS-64 report reliably and accurately, CMS will require further corrective action until such assurances can be made.
- c. The state must assure CMS at all times of the integrity and accuracy of its claims processing systems and for the administrative processes associated with claiming FFP. In order to support the continuation of this demonstration, future amendments, or extension requests, Utah must maintain the state's information technology systems and administrative processes (including internal controls) so that expenditures related to the 1115 demonstration are reliably and accurately reported on the CMS-64.

XII. GENERAL FINANCIAL REQUIREMENTS

93. Expenditures Subject to the Allotment Neutrality Limit. The state shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the Utah HIFA-ESI demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP only for allowable Utah demonstration expenditures that do not exceed the state's available Title XXI allotment. Expenditures for Current Eligible CHIP Children and Demonstration Population VI are subject to the allotment neutrality limit.

94. Quarterly Expenditure Reporting through the MBES/CBES. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the MBES/CBES, as part of the routine quarterly CMS-21 reporting process. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver/CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).

- 95. Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
- 96. Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. Utah must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the demonstration populations. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 97. State Certification of Funding Conditions.** The state will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.
- 98. Limitation Title XXI Funding.** Utah will be subject to a limit on the amount of federal Title XXI funding that the state may receive on Current Eligible CHIP Children and Demonstration Population VI expenditures during the waiver period. Federal Title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available Title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available. Total federal title XXI funds for the state's CHIP program (i.e., the approved Title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.
- 99. Administrative Costs.** Total expenditures for outreach and other reasonable costs to administer the Title XXI state plan and the demonstration that are applied against the state's Title XXI allotment may not exceed 10 percent of total Title XXI net expenditures.
- 100. Exhaustion of Title XXI Funds.** If the state exhausts the available Title XXI federal funds in a federal fiscal year during the period of the demonstration, the state may continue to provide coverage to the approved Title XXI state plan separate child health program population, the Current Eligible CHIP Children, and Demonstration Population VI with state funds.

101. Exhaustion of Title XXI Funds Notification. All federal rules shall continue to apply during the period of the demonstration that Title XXI federal funds are not available. The state is not precluded from closing enrollment or instituting a waiting list with respect to the Current Eligible CHIP Children and Demonstration Population VI. Before closing enrollment or instituting a waiting list, the state will provide prior notice to CMS.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

102. Limit on Title XIX Funding. The state will be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

103. Risk. The state will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of Medicaid eligibles. By providing FFP for all eligibles, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

104. Calculation of the Budget Neutrality Limit: General. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 81. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of Medicaid expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 109.

105. Impermissible DSH, Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

106. "Hypothetical" Eligibility Groups. Budget neutrality agreements may include optional

Medicaid populations that could be added under the state plan but were not included in current expenditures. For this demonstration, these are the “PCN Adults with Children,” “ESI Adults with Children,” “COBRA Adults with Children,” groups, and “Former Foster Care Youth from Another State.” However, the agreement will not permit access to budget neutrality "savings" from the addition of the group. A prospective per capita cap on federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

107. Supplemental Budget Neutrality Test: Substance Use Disorder Expenditures. As part of the SUD initiative, the state may receive FFP (once the Implementation Protocol is approved) for the continuum of services to treat opioid use disorders (OUD) and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the SUD services listed in Table 3 in STC 57 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality “savings” from these services. Therefore, a separate expenditure cap is established for SUD services. The SUD MEG listed in the table in STC 108 is included in the SUD Supplemental Budget Neutrality Test.

- a. The SUD expenditures cap is calculated by multiplying the projected PMPM for the SUD MEG, each DY, by the number of actual eligible SUD member months for the same MEG/DY—and summing the products together across all DYs. The federal share of the SUD expenditure cap(s) is/are obtained by multiplying those caps by the Composite Federal Share (see STC 109).
- b. SUD Supplemental Budget Neutrality Test is a comparison between the federal share of SUD expenditure cap(s) and total FFP reported by the state for the SUD MEG.

108. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in section X. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The base year per capita amounts for “PCN,” “ESI,” and “COBRA” are designated by the initials “BY.” The trend rate of 5.3 percent for DY 16 is based on the FY2017 President’s Budget for the adult category. The per capita amounts shown below reflect rounding to the nearest cent at each step of the calculation.

Eligibility Group	Trend Rate	DY 16 PMPM	DY 17 PMPM	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM

Current Eligibles	5.3%	\$999.33	\$1,052.29	\$1,108.07	\$1,166.79	\$1,228.63
Demo Pop I – Adults with Children	5.3%	\$48.63	\$51.21	\$53.92	\$56.78	\$59.79
Demo Pops III & IV – Adults with Children	5.3%	\$158.03	\$166.41	\$175.23	\$184.51	\$194.29
Dental Services – Blind and Disabled	3.0%	\$18.42	\$18.97	\$19.54	\$20.13	\$20.73
Former Foster Care Youth	4.8%	\$990.87	\$1,038.43	\$1,088.28	\$1,140.51	\$1,195.26
SUD Services	5.0%	\$3,321.96	\$3,488.06	\$3,662.46	\$3,845.58	\$4,037.86
Dental Services – Targeted Adults	5.3%	n/a	\$33.33	\$35.10	\$36.96	\$38.92
Adult Expansion Population	4.7%	n/a	\$542.08	\$567.56	\$594.23	\$622.16
Employer Sponsored Insurance	4.7%	n/a	n/a	\$230.63	\$241.47	\$252.82
Withdrawal Management	4.5%	n/a	\$700.00	\$731.50	\$764.42	\$798.82

109. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used

through the same process or through an alternative mutually agreed upon method.

110. Exceeding Budget Neutrality. The budget neutrality limit calculated in STC 77 will apply to actual expenditures for demonstration services as reported by the state under Section X. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

111. New Funding. If the state seeks to reallocate Title XXI or Disproportionate Share Hospital funds to fund this demonstration, the state must request a demonstration amendment. These funds are only available on a prospective basis. In order to provide for a seamless continuation of 1115 waiver authority for the eligibles under Title XIX, the state should provide CMS with adequate notification of the state's intent.

112. Enforcement of Budget Neutrality. CMS shall enforce the budget neutrality agreement over the life of the demonstration extension, which for this purpose will be from July 1, 2017 – June 30, 2022. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration periods of July 1, 2013 through June 30, 2017, but not from any earlier approval period.

Year	Cumulative target definition	Percentage
DY 16	DYs 1 through 16 combined budget neutrality limit	0 percent
DY 17	DYs 1 through 17 combined budget neutrality limit	0 percent
DY 18	DYs 1 through 18 combined budget neutrality limit	0 percent
DY 19	DYs 1 through 19 combined budget neutrality limit	0 percent
DY 20	DYs 1 through 20 combined budget neutrality limit	0 percent

113. Budget Neutrality Savings Phase-Down. Beginning with the demonstration period that begins on July 1, 2017, the net variance between the without-waiver and actual with-waiver costs will be reduced. The reduced variance, calculated as a percentage of the total variance, is used in place of the total variance to determine overall budget neutrality of the demonstration. The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages are determined based on how long Medicaid populations have been subject to the demonstration. In the case of Utah, the program will retain 25 percent of the total variance as future savings for the demonstration. Should the state request an extension of its demonstration beyond June 30, 2022, budget neutrality will be adjusted again to reflect revised PMPMs based on the data from the current extension.

XIV. EVALUATION OF THE DEMONSTRATION

114. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and

analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 43.

115. Independent Evaluator. Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

116. Evaluation Budget. A budget for the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

117. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 calendar days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

- a. All applicable Evaluation Design guidance, including guidance about community engagement. Community engagement hypotheses will include (but not be limited to): effects on enrollment and continuity of enrollment; and effects on employment levels, income, transition to commercial health insurance, health outcomes, and Medicaid program sustainability.
- b. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD Evaluation Designs (as applicable, and as

provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

- 118. Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.
- 119. Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
- 120. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.
- a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
 - b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
 - c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

- d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
- e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

121. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

- a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.
- b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

122. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

123. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

124. Additional Publications and Presentations. For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

Attachment A: Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

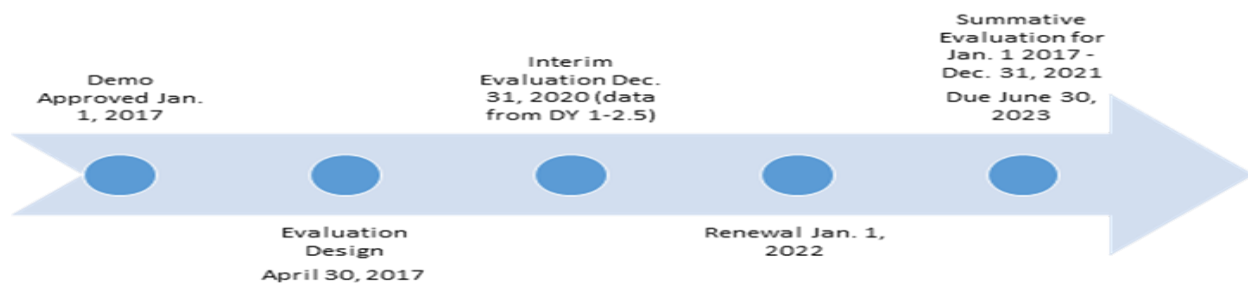
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- A. General Background Information;
- B. Evaluation Questions and Hypotheses;
- C. Methodology;
- D. Methodological Limitations;
- E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state’s Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

- 1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
- 2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- 3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
- 4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
- 5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

- 1) Describe how the state’s demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
- 2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram

includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: <https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf>

- 3) Identify the state’s hypotheses about the outcomes of the demonstration:
 - a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
 - b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

- 1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?
- 2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
- 3) *Evaluation Period* – Describe the time periods for which data will be included.
- 4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by “owning”, defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
 - a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
 - b. Qualitative analysis methods may be used, and must be described in detail.
 - c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
 - d. Proposed health measures could include CMS’s Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care

Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

- e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
- f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

- a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
- b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
- c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
- d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries	-Medicaid fee-for-service and	-Interrupted time series

		-Beneficiaries with diabetes diagnosis	encounter claims records	
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

- 1) When the state demonstration is:
 - a. Long-standing, non-complex, unchanged, or
 - b. Has previously been rigorously evaluated and found to be successful, or
 - c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)
- 2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
 - a. Operating smoothly without administrative changes; and
 - b. No or minimal appeals and grievances; and
 - c. No state issues with CMS 64 reporting or budget neutrality; and
 - d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

A. Independent Evaluator. This includes a discussion of the state’s process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial

evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes “No Conflict of Interest” signed conformation statements.

- B. Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.
- C. Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments could benefit from improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

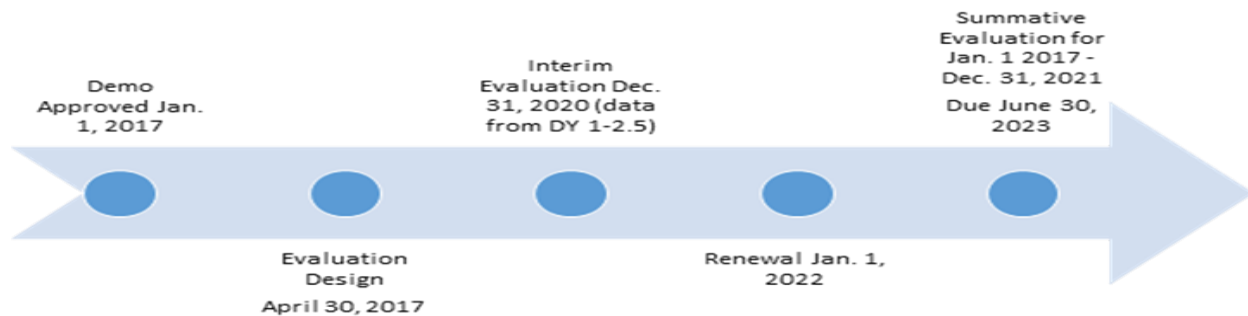
The format for the Interim and Summative Evaluation reports are as follows:

- A. Executive Summary;
- B. General Background Information;
- C. Evaluation Questions and Hypotheses;

- D. Methodology;
- E. Methodological Limitations;
- F. Results;
- G. Conclusions;
- H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
- I. Lessons Learned and Recommendations; and
- J. Attachment(s).

Submission Timelines

There is a specified timeline for the state’s submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state’s website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state’s Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state’s submission must include:

- d. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.
- B. General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:

- i. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
- ii. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
- iii. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
- iv. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
- v. Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state’s demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2. Identify the state’s hypotheses about the outcomes of the demonstration;
 - a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
 - b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
 - c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to

explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2. *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3. *Evaluation Period*—Describe the time periods for which data will be collected
4. *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5. *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6. *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

- F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

- G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results.

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
 - a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

- H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state’s Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

- I. **Lessons Learned and Recommendations** – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the “opportunities” for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1. Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: SUD Implementation Protocol

State of Utah
SUD 1115 Waiver
Implementation Plan

Division of Medicaid and Health Financing
Utah Department of Health



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Overview

The Utah Department of Health (DOH) was created in 1981 to protect the public’s health by preventing avoidable illness, injury, disability and premature death; assuring access to affordable, quality health care; promoting healthy lifestyles; and monitoring health trends and events. The Utah Department of Health is the designated Medicaid single state agency pursuant to Title 26, Chapter 1 of the Utah Code Annotated. The Division of Medicaid and Health Financing (DMHF) is the agency authorized to administer Utah’s Medicaid program.

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah Code Annotated (UCA) §62A-15-103 as the single state authority in Utah. It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services are available throughout the state. In addition, DSAMH is tasked with ensuring that public funds are spent appropriately.

According to the annual report from the Division of Substance Abuse and Mental Health, Department of Human Services, State of Utah, 134,764 adults in the state were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015. For youth in grades 6 through 12, 11,804 are in need of treatment for drug and/or alcohol dependence or abuse. Seventy four percent (74%) of all adults treated by the public system are

Medicaid eligible. If amendment # 15 (Attachment 9) is approved by CMS the percentage of adults needing SUD services who are Medicaid eligible will increase. At the same time 46% of all youth receiving treatment in the public system are Medicaid eligible.

Utah, like other states, is trying to address a significant increase in opioid use. According to a report recently published by the Utah Department of Health, from 2012-2014 Utah ranked 4th in the U.S. for drug poisoning deaths. Every month, 49 Utahns die as a result of a drug overdose.

In 2014, 32.3% of Utah adults reported using at least one prescribed opioid pain medication during the preceding 12 months, an increase of 55.3% since 2008. Furthermore, the prevalence of Utah adults who reported using prescription opioids that had not been prescribed to them increased 77.8% from 2008 (1.8%) to 2014 (3.2%). In 2012, Utah ranked 15th highest in the nation for high-dose opioid prescribing. A number of factors have contributed to the increase and widespread availability of prescription opioids. In the early 1990s, physicians were urged to be more attentive in identifying and aggressively treating pain. In addition, the pharmaceutical industry aggressively marketed the use of prescription opioids to providers. Consequently, opioid pain relievers, such as oxycodone and hydrocodone, gained widespread acceptance. Health care professionals prescribed opioid pain relievers more frequently as part of patient care. The increase in prescription pain medication prescribing resulted in these medicines being kept in home medicine cabinets, providing in an increased opportunity for theft or misuse. Utah needs to use all available options in a continuum of care to treat this health care crisis in our state.

MILESTONE 1: Access to Critical Levels of Care for SUD

Substance Use Disorder Delivery System

The Utah public mental health and substance abuse system provides an array of services that assure an effective continuum of care. Under the administrative direction of DSAMH, the counties and their local mental health authority (LMHA) are given the responsibility to provide mental health and substance use disorder services to its citizens. Counties set the priorities to meet local needs and submit an annual local area plan to DSAMH describing what services they will provide with State, Federal, and County money. State and Federal funds are allocated to a county or group of counties based on a formula established by DSAMH.

In Utah, a continuum of services has been designed to address the full spectrum of substance use problems. Treatment services are based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Comprehensive Benefit Design

Utah administers a comprehensive evidence-based MH/SUD benefit that offers a full continuum of care. Treatment services are based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Effective July 1, 2017, Utah added coverage for SBIRT (Screening, Brief Intervention and Referral to Treatment) as a state plan covered service.

The following table provides an overview of each ASAM level of care with current Utah Medicaid coverage along with proposed changes:

ASAM Level of Care	Title	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N
0.5	Early Intervention	Screening, Brief Intervention and Referral for Treatment (SBIRT)	Managed care or Fee for Services provider	Y as of July 1, 2017	
1	Outpatient Services	Less than 9 hours of services /week (adults); Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.5	Day Treatment/ Psychosocial Rehabilitation Services	20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour care, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
3.1	Clinically Managed Low-Intensity Residential Services	24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	

3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.7	Medically Monitored Intensive Inpatient Services	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
4	Medically Managed Intensive Inpatient	24 hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those	DHS/OL Licensed OTP Maintenance Providers, Licensed Prescribers	Y	

		with severe opioid use. MAT includes methadone, Suboxone, Naltrexone			
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Table Two- ASAM Criteria for Withdrawal Services

Level of Withdrawal Management	Level	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N
Ambulatory Withdrawal Management Without Extended on-Site Monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision	DHS/OL Certified Outpatient Facility w/ Detox Certification; Physician, licensed prescriber; or OTP for opioids	N	Y
Ambulatory Withdrawal Management with Extended On-site Monitoring	2-WM	Moderate withdrawal management and support and supervision; at night has supportive family or living situation	DHS/OL Certified Outpatient Facility w/ Detox Certification; Licensed Prescriber; or OTP for Opioids	Y	
Clinically Managed Residential Withdrawal Management	3.2-WM	Moderate withdrawal, but needs 24 hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	DHS/OL Licensed Residential Facility w/ Detox Certification; Physician, Licensed Prescriber; Ability to Promptly Receive Step-downs	N	Y

Utah currently covers the discrete individual services if an individual is eligible for Medicaid and is in residential treatment for ASAM level 3.1, 3.3, 3.5 and 3.7 levels of

care. Utah's waiver allows Medicaid to cover services provided for ASAM level 3.1, 3.3, 3.5 and 3.7 on a per diem basis for all Medicaid eligible populations in facilities with 17 or more beds. Each of the ASAM levels of care will be addressed in more detail to describe current coverage, future coverage, and a timeline for implementation of any proposed changes. In addition, the Utah Medicaid Provider Manual, Rehabilitative Mental Health and Substance Abuse Disorder Services will be updated to reflect each ASAM level of care covered by Utah Medicaid. This update will be completed by July 1, 2018.

Residential treatment

Services for Adolescents and Youth with an SUD

Access to substance abuse treatment is especially important for the millions of children who live with at least one parent who is dependent on alcohol or an illicit drug. Utah provides coverage to all children under the age of 21 for screening, vision, dental, hearing, and other medically necessary health care services to treat, correct, or ameliorate illnesses and conditions discovered, regardless of whether the service is covered in the Utah Medicaid State Plan, as required by Early and Periodic screening, Diagnostic, and Treatment (EPSDT). This benefit extends to all substance abuse treatment identified through the ASAM continuum of care, including residential and inpatient treatment.

Level of Care: 0.5 (Early Intervention)

Current State:

Utah Medicaid provides coverage for several individual services around early intervention, including smoking cessation counseling and screening, brief intervention, and referral to treatment (SBIRT). These services are available to all Utah Medicaid members without prior authorization.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Level of Care: 1.0 (Outpatient Services)

Current State:

Utah Medicaid reimburses for outpatient treatment (OT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

<https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf>

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.1 (Intensive Outpatient Services)

Current State:

Utah Medicaid reimburses for intensive outpatient treatment (IOT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

<https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf>

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.5 (Day Treatment/Psychosocial Rehabilitation Services/ Partial Hospitalization)

Current State:

Utah Medicaid covers Day Treatment/Psychosocial Rehabilitation Services for all members as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

<https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf>

Future State:

No immediate changes are expected.

Summary of Actions Needed:

None

Level of Care: 3.1 / 3.5 (Clinically Managed Low-Intensity Residential / Clinically Managed High-Intensity Residential)

Current State:

Residential treatment for substance abuse disorders can be provided within institutions for mental disease (IMDs). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64. One of the primary goals of the 1115 SUD waiver is to waive this restriction and allow IMDs to provide treatment to all Utah Medicaid members, including inpatient and residential treatment.

Utah Medicaid currently covers the discrete individuals services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.1 or 3.5 with no more than 16 beds.

Future State:

Utah Medicaid determined a per diem rate to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver and Utah's SUD Implementation Plan, Level 3.1 (clinically managed low-intensity residential) and Level 3.5 (clinically managed high-intensity residential) will be reimbursable in a facility with 17 or more beds (IMD) for all Utah Medicaid populations (fee-for-service and managed care).

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for both Level 3.1 and 3.5 residential services will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting.

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

- MMIS system modifications (including finalizing coding)
- Update the Utah provider manual, “Rehabilitative Mental Health and Substance Abuse Disorder Services” to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7.
- Provider notification and training

Action Implementation Timeline

- Develop rate methodology for residential treatment- COMPLETE
- MMIS system modifications (including finalizing coding)- November 1, 2017
- Provider notification and training- Beginning November 2, 2017
- Coverage and Reimbursement for ASAM levels of care 3.1/3.5 on a per diem basis in a facility with 17 or more beds (IMD) will be available immediately upon approval the Utah’s SUD Implementation Plan.
- Update the Utah provider manual, “Rehabilitative Mental Health and Substance Abuse Disorder Services” to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Level of Care: 3.7 (Medically Monitored Intensive Inpatient / Medically Managed Intensive Inpatient) Withdrawal Management Services (Inpatient Detoxification)

Current State

Utah Medicaid currently covers the discrete individual services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.7 with no more than 16 beds.

Utah Medicaid has established a methodology to pay for residential treatment for substance use disorder. Therefore upon approval of Utah’s amendment to its 1115 waiver Level 3.7 (Medically Monitored Intensive Inpatient) will be reimbursable for all populations (fee-for-service and managed care).

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for Level 3.7 will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting.

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.7 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM

designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

- MMIS system modifications (including finalizing coding)
- Update provider manuals
- Provider notification and training

Action Implementation Timeline

- Develop rate methodology for residential treatment- COMPLETE
- MMIS system modifications (including finalizing coding)- November 1, 2017
- Provider notification and training- Beginning November 2, 2017
- Coverage and Reimbursement for ASAM levels of care 3.7 on a per diem basis will be available immediately upon approval the Utah’s SUD Implementation Plan.
- Update the Utah provider manual, “Rehabilitative Mental Health and Substance Abuse Disorder Services” to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

Future State:

No changes are expected

Summary of Actions Needed:

None

Sub Support Service – Addiction Recovery Management Services

Current State:

Utah currently covers addiction recovery management services. Please see the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

<https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf>

Future State:

No changes are expected

Summary of Actions Needed:

None

MILESTONE 2. Use of Evidence –based SUD Specific Patient Placement Criteria

Patient Assessments

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following (1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division

Directives: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY_17_Final.pdf.

In addition, Utah Administrative Rule R523-4 requires: “Assessments shall identify the individual's level of motivation for treatment and implement strategies to increase engagement and need for clinically appropriate Mental Health Disorder services and/or Substance Use Disorder services in the following modified ASAM Patient Placement Criteria dimensions:

- (a) Risk of acute psychosis, intoxication/withdrawal;
 - (b) Biomedical conditions or complications;
 - (c) Emotional, behavioral, or cognitive conditions;
 - (d) Readiness to change;
 - (e) Relapse, continued use or continued problem potential; and
 - (f) Recovery environment.
- (3) The assessment shall include relevant information on:
- (a) The individual's psychosocial function, substance use including tobacco/nicotine, mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;
 - (b) Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;
 - (c) Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;

(d) Cognitive, social, and affective development; family, peer, and intimate relationships; trauma; current or past emotional, physical or sexual abuse; suicidality; and safety;

(e) Collateral information from other sources that are relevant to the individual's situation and provides insight into the issues in Subsection R523-4-6(2)(a) through (2)(d).

(4) The assessment shall include a diagnosis when clinically indicated.

(5) Based on the screening and the assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs.

(6) The levels of care and array of services shall be based on the ASAM.”

DSAMH conducts annual monitoring site visits to all county local authority treatment programs in which clinical records and client placement is reviewed. Our monitoring tools and reports are online at: <https://dsamh.utah.gov/provider-information/contracts-monitoring/>.

Retention in treatment is the factor most consistently associated with positive client outcomes. The appropriate length of a treatment varies based on the needs of the individual. However, the National Institute of Drug Addiction (NIDA) states: “Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some individuals with opioid use disorders continue to benefit from methadone maintenance for many years.” Just like treatment for any other chronic disease, addiction treatment must be of sufficient duration to succeed. Client progress over a short period of time should not be seen as a “cure.” Likewise, relapse should not be a reason to discontinue care. Programs should employ multiple strategies to engage and retain clients. Successful programs offer continuing care, and use techniques that have been proven to enhance client motivation. It is also important to recognize that multiple episodes of treatment may be necessary.

Future State:

All providers will be trained on ASAM criteria

Summary of Actions Needed:

Ongoing provider training on ASAM criteria

Action Implementation Timeline

- Provider education will continue to be provided on ASAM Criteria by the Division of Substance Abuse and Mental Health throughout 2017 and 2018

Independent Third Party

Once an eligible licensed professional completes a psychosocial assessment for individuals needing substance abuse treatment, those findings must be reviewed by an independent third party that has the necessary competencies to use the ASAM Patient Placement Criteria to assure the findings were correct.

The Division of Substance Abuse and Mental Health is responsible for monitoring and oversight of the public behavioral health system. DSAMH conducts annual, on-site monitoring of each Local Authority in the public behavioral health system. The monitoring visits are required by Utah Code and are intended to measure contract compliance, use of evidence-based practices, as well as ensure a cohesive, strategic direction for the state and to assure individuals are receiving services at the appropriate level of care.

In addition, if a Medicaid member is enrolled in a PMHP for their SUD services, the PMHP is responsible to assure the findings from a psychosocial assessment is correct for their enrollee. PMHPs may also implement utilization review in the form of prior authorization of services.

Future State:

Utah Medicaid does not currently require prior authorization for residential treatment based on ASAM Levels of Care for fee for service members. Utah Medicaid will need to establish a utilization review process based on ASAM criteria to assure that all residential placement for fee for service members are appropriate. In addition, Utah Medicaid needs to review PMHP contract language to assure this requirement is clear. Each entity will be allowed to utilize any evidence-based system for clinical guidelines that incorporates the medical criteria required for an individual to meet an ASAM level of care.

Summary of Actions Needed:

This requirement will be formalized in Medicaid policy and Managed Care contracts. Procedures need to be established and implemented for fee for service members.

Action Implementation Timeline:

- Medicaid policy will be clarified by July, 1, 2018
- PMHP contracts clarified no later than July 1, 2018.
- Utah Medicaid will establish and implement procedures to review placements for appropriate ASAM level of care for fee for service members by July 1, 2018

Milestone 3: Use of Nationally Recognized SUD-specific Program Standard to Set Provider Qualifications for Residential Treatment Facilities

Certification of Residential Facilities

Utah through the Division of Substance Abuse and Mental Health established provider qualification requirements for residential treatment providers in their licensure standards, or other guidance that mirror the description of good quality residential treatment services in the ASAM Criteria or other nationally recognized SUD-specific program standards, <https://rules.utah.gov/publicat/code/r501/r501-19.htm>. In addition, counties that contract for residential services have detailed contracts with providers based on ASAM Criteria.

The Office of Licensing audits to these guidelines. DSAMH conducts annual monitoring site visits to Local Authorities reviewing Policy and Procedures, licensures, schedules, clinical documents. Copies of DSAMH monitoring tools and reports can be found at: <https://dsamh.utah.gov/provider-information/contracts-monitoring/>.

Future State:

Utah Medicaid will have a process established to certify private residential treatment facilities based on ASAM criteria who may provide services to Medicaid fee for service members.

Summary of Actions Needed:

Utah Medicaid will need to establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members. In addition, PMHP contracts language regarding this requirement should be reviewed to determine if changes to the contract to support this milestone are necessary.

Action Implementation Timeline

- Utah Medicaid will establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than July 1, 2018.
- The Utah Division of Substance Abuse and Mental Health and the Office of Licensing will implement a process to certify public and private non-profit residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than December 31, 2018.

- PMHP contracts language regarding this requirement will be reviewed and modified if appropriate by July 1, 2018.
- Administrative rule making will be promulgated to support this milestone with an effective date of July 1, 2018.
- An addendum to the Utah Medicaid Provider Agreement will be implemented to gather information on ASAM levels of care provided by private residential treatment providers by March 31, 2018.

MILESTONE 4- Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment

Network Development Plan

Overall Strategy- Addiction Treatment Services Providers

Network adequacy is a critical concern for the success of the 1115 SUD waiver. DSAMH certifies all mental health and addiction providers in Utah. In addition, SUD professionals are licensed by the Utah Division of Occupational and Professional Licensing. Finally residential treatment programs are licensed by the Division of Licensing, Utah Department of Human Services.

Local Substance Abuse authorities are responsible to provide SUD treatment to the residents of their county. Community mental health centers and their contracted providers are the core of public SUD services in Utah. The DSAMH monitors the Local authorities to assure appropriate access to care for county residents. In addition, the DMHF and DSMH are working with several private non-profit residential treatment providers to expand their capacity to provide treatment to Medicaid members in need of residential treatment. The state anticipates there will be at least 240 residential treatment beds available by July 1, 2018. DSAMH also prepared an inventory of additional residential treatment providers across the state who can provide treatment if the need arises.

The DSAMH works closely with the Local Mental Health and Substance Abuse Authorities to ensure there are a sufficient number of providers in the community to provide access to outpatient services. In addition, HSAG, Utah Medicaid contracted external quality review organization (EQRO) also conducts an assessment of the adequacy of provider networks for Medicaid contracted managed care entities. The Local MH/SA Authorities contract with Utah Medicaid as PIHPs or PAHPs pursuant to Utah's 1915(b) Prepaid Mental Health Waiver.

Future State:

The inventory of providers prepared by DSAMH does not identify providers by ASAM level of care nor identify if the provider is accepting new patients. The State may have a total of 240 residential treatment beds from private non-profit providers by July 1, 2018.

Summary of Actions Needed:

The DSAMH provider inventory needs to be updated to identify providers by ASAM level of care and whether or not providers are accepting new patients. DMHF and DSAMH will continue to work together to assure Medicaid members in need of SUD treatment services have access to care.

Action Implementation Timeline:

- DSAMH will update their provider inventory referred to above to include information on the providers at each ASAM level of care and whether or not the provider is accepting new patients by September 2018.
- DMHF and DSAMH will meet on an annual basis to evaluate the adequacy of access to SUD providers for the entire continuum of care on an annual basis beginning May 2018.

Program Integrity Safeguards

Utah Medicaid complies with all required provider screening and enrollment requirements as outlined in *42 CFR 455, Subpart E*.

Risk-Based Screening

Each provider is subject to pre-enrollment screening. Providers are categorized by risk level - limited, moderate, or high - using the Centers for Medicare & Medicaid Services (CMS) guidelines for risk determination. The risk level assignment of an individual provider may be increased at any time as a result of a payment suspension, an overpayment, Office of Inspector General (OIG) exclusion within the past 10 years, or at the discretion of the State pursuant to Utah Administrative Code R. In these instances, the provider is notified by the State, and the new risk level will apply to processing enrollment-related transactions. Providers who are enrolling (including changes of ownership) or revalidating are screened according to their assigned risk levels. Providers assigned to the high-risk category are required to pass a national fingerprint-based criminal background check in order to enroll or remain enrolled with the Utah Medicaid. All individuals who have at least 5% ownership or controlling interest in the enrolling business entity are required to have criminal background checks. The requirement also applies to individual practitioners who have been assigned to the high-risk category.

The criminal background check requires affected individuals to submit to fingerprinting.

When fingerprints are taken, a confirmation number is provided. Individuals being fingerprinted should be sure to record the confirmation number, as they will need this information when completing the IHCP provider enrollment application. Individuals who have had fingerprint-based federal criminal background checks for the IHCP within the last six months do not need to repeat the process for a new enrollment; the confirmation number of the prior fingerprinting is acceptable, as long as it was conducted within six months of submission. Individuals are responsible for the cost of the fingerprinting. It is important to follow instructions carefully, or it may be necessary to be fingerprinted.

Utah Medicaid may deny or terminate an individual's or entity's eligibility to participate as a Medicaid provider in the state of Utah if the agency finds that the provider or a person owning, directly or indirectly, at least 5% of the enrolling/enrolled entity has been convicted of any offense (including guilty pleas and adjudicated pretrial diversions) that the agency determines is inconsistent with the best interest of Utah Medicaid members or the Medicaid program. The following list includes examples of offenses that may demonstrate that a provider is not eligible for participation. This list is not exhaustive. Felony crimes against persons, such as murder, rape, assault, and other similar violent crimes.

- Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other crimes of criminal neglect, misconduct, or fraud
- A criminal offense that may subject members to an undue risk of harm
- Sexual misconduct that may subject members to an undue risk of harm
- A crime involving a controlled substance
- Abuse or neglect of a child or adult
- A crime involving the use of a firearm or other deadly weapon
- Crimes directly related to the provider's ability to provide services under the Medicaid Program

In addition, Utah Medicaid may implement administrative sanction against a provider who abuse or improperly apply the program pursuant to Utah Administrative Code R414-22.

Provider Revalidation

The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to revalidate provider enrollments at intervals not to exceed every five years. The CMS revalidation requirement for durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments, is more frequent, at intervals not to exceed every three years.

Utah Medicaid providers receive notification letters when it is time to recredential their enrollments. Notification with instructions for revalidating are sent 90 and 60 days in advance of the revalidation deadline. Notices are mailed to the Service Location address indicated on the provider's service location profile. Providers with multiple service locations must revalidate the enrollment of each service location. Providers that fail to

submit revalidation paperwork in a timely manner will be disenrolled from participation in Utah Medicaid.

After disenrollment, the provider will need to submit a new Utah Medicaid Provider Enrollment Application and all Documents to reenroll with Utah Medicaid. Disenrollment with subsequent re-enrollment may result in a gap in the provider's eligibility.

Provider Agreements

Before participating with Utah Medicaid, all substance abuse providers must have a signed Provider Agreement with Utah Medicaid pursuant to *42 CFR 431.107*. All providers on a PMHPs provider panel must also be enrolled directly with the Utah Medicaid program. In addition the provider is credentialed by the plan and enter into a contract with the PMHP.

Billing and Compliance Issues

As part of the Provider Agreement, providers agree to disclose information on ownership and control, information related to business transactions, information on changes in ownership, and information on persons convicted of crimes. In addition to DMHF, the Utah Office of Inspector General for Medicaid Services has responsibility for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of all Medicaid-eligible beneficiaries as well as referring cases of suspected fraud to the Utah Office of the Attorney General, Medicaid Fraud Control Unit. Additionally, each of Utah Medicaid MCEs are contractually obligated to have administrative procedures that detail the manner in which each will detect fraud and abuse, including the operation of special investigation units (SIUs). The MCE SIUs meet regularly with the OIG and MFCU address program integrity issues. The MCEs are also contractually obligated to provide reports to Utah Medicaid on their activities.

Providers can find out how to enroll with Utah Medicaid at <https://medicaid.utah.gov/become-medicaid-provider>

Benefit Management

All Utah ACOs and PMHPs are required by contract to provide the same benefits as Utah's fee for service Medicaid program in accordance with Article 4 of the contract.

Future State:

No changes are expected.

Summary of Actions Needed:

None

MILESTONE 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

Level of Care: OTS (Opioid Treatment Services)

Current State:

Utah Medicaid currently provides coverage for opioid treatment program (OTP) services, including the daily administration of methadone. Methadone programs are licensed by the Department of Human Services. Methadone is only administered by licensed clinics, which bill Utah Medicaid directly on a fee for service basis for any Medicaid member, even those enrolled in managed care. Methadone is a carved out service for managed care.

Methadone providers are enrolled as Utah Medicaid Providers or as an ordering, prescribing, or referring provider in accordance with Section 6401 of the Patient Protection and Affordable Care Act.

Utah Administrative Rule R523-4 requires that “All individuals with alcohol and/or opioid disorders shall be educated and screened for the potential use of medication-assisted treatment.” In addition, the DSAMH Directives require that, “Local Substance Abuse Authority treatment programs . . .

- ii. Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. Educate the client about MAT options; when clinically indicated and the client is amenable:
 - a. Include the use of MAT in the treatment plan, and
 - b. Either provide MAT as part of the treatment, or
 - c. Refer the individual for MAT.

Some Local Authority Residential Providers have a physician in their program that can provide MAT (Buprenorphine) to contracted residential treatment providers. In addition, they coordinate closely with the Utah State Opioid Treatment Providers who provide MAT to residential programs on or off site.

In Utah, the illegal use of prescription drugs has reached epidemic proportions.

- An average of 21 Utahns die as a result of prescription opioids (pain killers) each month
- Opioids contribute to approximately three out of four drug overdose deaths
- The number of prescription opioid deaths decreased from 301 in 2014 to 278 in 2015

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by 7.6% in one year <https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf>. DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevention abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence-based prevention programs. DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

- Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.
- The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.
- Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

- Detoxification (the process by which the body rids itself of a drug)
- Behavioral counseling, medication (for opioid, tobacco, or alcohol addiction)
- Evaluation and treatment for co-occurring mental health issues such as depression and anxiety with long-term follow-up to prevent relapse.

In 2016 Utah published a comprehensive report, “Opioid Prescribing Practices in Utah.” This report was a partner publication of the Utah Department of Health and Utah Department of Commerce, Division of Occupational and Professional Licensing. The following Utah Department of Health programs contributed to this report: Center for Health Data and Informatics, Department of Technology Services, Executive Director’s Office, Health Informatics Program, Office of Health Care Statistics, and Violence and Injury Prevention Program. The report outlines Utah’s efforts to establish prescribing guidelines consistent with the CDC Guidelines. The report can be found at:

<https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf>

A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed. Follow-up care may include community- or family-based recovery support systems. Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid

use and the risk of overdose. Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a “whole-patient” approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities. There are 14 OTP providers in the State of Utah. Utah’s OTP’s provide safe and effective treatment that includes regular counseling sessions, drug testing, and medication assisted treatment and recovery support. In 2015, 3,495 individuals sought assistance at the OTP clinics in Utah.

Buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Like methadone, buprenorphine suppresses and reduces cravings for the abused drug. Buprenorphine is prescribed as part of a comprehensive treatment plan that includes counseling and participation in social support programs. SAMHSA has developed an online prescriber locator: samhsa.gov/medication-assistedtreatment/physician-program-data/treatmentphysician-locator.

Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

DSAMH assisted in passing Legislation related to Naloxone education and distribution. DSAMH also works closely with the Utah Department of Health (UDOH), Utah Naloxone and other stakeholders to increase access to Naloxone. DSAMH has provided funding to the Department of Public Safety, the Utah Department of Corrections and the Utah Department of Health for projects related to naloxone training, purchase and distribution.

DSAMH will also provide funding to the University of Utah’s Utah Naloxone Project. Information about this project can be found at: <http://www.utahnaloxone.org/>. In addition, DSAMH will provide funds to support 13 local Naloxone training and distribution entities contracted with UDOH. In addition, the 2018 DSAMH Directives includes the following requirement: “Local Substance Abuse Authority treatment programs shall provide Naloxone education, training and assistance to individuals with opioid use disorders and when possible to their families, friends, and significant others.” DSAMH will monitor to ensure this requirement is met during annual site visits.

Prior Authorization Criteria

Utah Medicaid's prior authorization criteria for pharmacy can be found on the Utah Medicaid website at <https://medicaid.utah.gov/pharmacy/prior-authorization>

Prescribing Guidelines

DSAMH participated with the UDOH and the Utah Medical Association (UMA) in the development of the Utah Clinical Guidelines on Prescribing Opioids published in 2008. DSAMH worked again with UDOH and the UMA to update these guidelines in 2016.

ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence from prescription drugs that may have also led to current heroin use. Since its beginning, 120 clients have been served in the Opioid Community Collaborative. Currently, in Salt Lake County, a pilot project was legislatively funded in FY15 offering clients coming out of jail or prison with the option of using Vivitrol in coordination with treatment. Salt Lake County Behavioral Health Services launched this project in September 2015 and has served 205 clients to date. The average length of stay in the program is 3-4 months. Salt Lake County anticipates ongoing growth and increased participation and length of stay in the program. Syringe Exchange Programs (SEP) also known as syringe services programs (SSPs), needle exchange programs (NEPs), and needle-syringe programs (NSPs), are community-based programs that provide access to sterile needles and syringes free of charge. The programs also facilitate safe disposal of used needles and syringes. SEPs are an effective component of a comprehensive, integrated approach to HIV and hepatitis C prevention among people who inject drugs. Most SEPs offer other prevention materials and services, such as HIV/HCV education; overdose prevention, including Naloxone distribution; referral to substance abuse treatment programs; and counseling and testing for HIV and hepatitis C.

Syringe exchange programs became legal in Utah in 2016, the day Utah Governor Gary Herbert signed House Bill 308 into law. The bill went into effect May 2016, and states that agencies in Utah "may operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs and those individuals' contacts." HB 308 does not fund syringe exchange programs in Utah, it only provides guidelines and reporting requirements and follows the restrictions of federal funding.

Naloxone (Narcan®) is a life-saving prescription medication used as an antidote to opioid overdose. Naloxone has mainly been used in the past in the hospital or by emergency medical personnel. However, Naloxone kits are now available for patients to use for emergency treatment of overdoses at home. In 2016, the executive director of the Utah Department of Health signed a statewide standing order allowing to dispense Naloxone,

without a prior prescription, to anyone at increased risk of experiencing or witnessing an overdose. Through this standing order, anyone can purchase Naloxone without a prescription. DSAMH has worked to provide Naloxone kits and training to first responders, as well as all Adult Probation & Parole agents, and individuals in the community.

Drug Courts

Individuals with a substance use disorder are disproportionately represented in our criminal justice system. Evidence indicates that approximately 80% of individuals in the criminal justice system meet the definition of substance use involvement and between one-half to two-thirds meet diagnostic criteria for substance abuse or dependence.

Drug courts are special court dockets designed to treat individuals with substance use disorders and provide them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, and treatment representatives.

Drug Courts provide an alternative to incarceration. Eligible participants for these programs have a moderate-to-severe substance use disorder, are charged with non-violent, drug-related offenses, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction, and who are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with this population, Drug Courts provide intensive supervision and treatment services in a community environment. Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation.

DSAMH funds 45 drug courts throughout the state of Utah; 25 adult felony drug courts, 15 family dependency drug courts, and 5 juvenile drug courts. In fiscal year 2016, Utah's drug court program served 2084 individuals, the majority of whom participated in the adult felony drug court program.

DSAMH and partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of the courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, once completed new performance measurements will be developed and implemented throughout the state to help insure best practice standards are followed.

Future State:

Utah Medicaid will implement a coverage policy to limit opioid prescriptions for dental procedures to 3 days without prior authorization

Summary of Actions Needed:

Draft policy and administrative rule
Submit rule for public comment
Publish policy and notify providers and pharmacies

Action Implementation Timeline

- Draft policy and rule by March 1, 2018
- Notify providers and pharmacies in June and July 2018 Medicaid Information Bulletin
- Implement coverage policy that limits opioid prescriptions for dental procedures to three (3) days by July 1, 2018.

Milestone 6 Improved Care Coordination and Transitions between Levels of Care

Transitions of Care

Current State

Appropriate management of transition of care is critical to the success of the individual in overcoming their SUD. Several of Utah’s residential treatment providers also provide a full continuum of outpatient SUD services.

Future State:

Utah will add an addendum to the Utah Provider agreement for enrolled residential treatment providers that outlines a specific requirement that the provider is responsible to assure appropriate transitions of care either by providing this service directly or coordinating the provision of this service with another provider.

Utah plans to amend the Utah Provider Manuals for, Targeted Case Management for Individuals with Serious Mental Illness, to include Substance Use Disorder. In addition, Utah will amend the Utah Provider Manual for Hospital services. Both manuals will clearly state the requirement for residential and inpatient treatment facilities to coordinate and facilitate transition of Medicaid member to community based services and supports following a stay at a facility.

In addition, Utah will modify the language in its Prepaid Mental Health Plan (PMHP) contracts in section 10.3 Coordination and Continuity of Care to specify the same requirements as stated in revised policy.

Summary of Actions Needed:

Utah will amend provider manuals and managed care contracts. Providers and Managed Care Contractors will need to be notified and trained regarding the state's transitions of care requirement.

Action Implementation Timeline

- Utah will amend provider manuals and the PMHP contracts by July 1, 2018
- Providers will be notified of this change in the May, June and July 2018 Medicaid information Bulletin.

ADDITIONAL INFORMATION

Case Management

Case management is a central highlight of community mental health work, both in teams and individually working with people with mental illness and/or substance use disorders to help achieve their goals. Case Management is a mandated service in Utah, and the Local Mental Health and Substance Use Authorities are responsible to provide case management in their local areas. Case management provides four critical functions often referred to using the acronym CALM (Connecting, Advocating, Linking and Monitoring): connecting with the individual, advocating for the individual, linking and planning for services, and monitoring service provision.

Providers of case management services also provide skill development services, personal services, as well as psychosocial rehab groups. DSAMH has improved the quality of case managers through a certification process that has proven to be successful. DSAMH is also working with the local homeless service providers to develop a certification program with basic standards for all providers serving individuals that are homeless.

DSAMH developed preferred practices for case management, including a training manual, and an exam with standards to promote, train, and support the practice of case management and service coordination in behavioral healthcare. In SFY 2016, DSAMH has certified 184 case managers compared to 176 in SFY 15, for a total of 650 certified case managers.

Crisis Intervention Team (CIT)

The Crisis Intervention Team (CIT) Program is an innovative model of community policing that involves partnerships between law enforcement, the mental health system, and advocacy groups.

CIT provides law enforcement personnel with specialized crisis intervention training to assist a person experiencing a mental health or SUD crisis, which improves officer and consumer safety, and redirects individuals with mental illness from the judicial system to the health care system. This training includes a 40-hour course that is completed in a one-week session. DSAMH has partnered with CIT Utah Inc. and its board of directors to provide statewide law enforcement training and support. In this partnership, law enforcement personnel who take the 40 hour training and pass a state test will achieve the CIT certification. A total of 127 law enforcement agencies have sent representatives to the CIT Academies. For more information, visit the CIT website: CIT-Utah.com.

[Certified Peer Support Specialists \(CPSS\)](#)

Peer Support Specialists are adults in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making.

CPSS also provide essential expertise and consultation to the entire treatment team to promote a culture in which each client's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities. Since the program's inception, 488 individuals have been certified by DSAMH as CPSS. DSAMH currently contracts with Utah State University, Optum Health and the Salt Lake City Veteran Affairs Medical Center to provide standardized training across the state. Utah State University has developed or is developing additional special population peer support training modules for Youth- In-Transition (age 16-25), Refugee, Native American and Hispanic populations. To date, 122 CPSS have received Youth-In-Transition Training.

[Trauma-informed Approach](#)

Most individuals with substance use disorders and mental illness are also dealing with trauma. Between 34% and 53% of people with a severe mental illness report childhood physical/sexual abuse. A Center for Substance Abuse Treatment publication states that as many as two-thirds of women and men in treatment for substance abuse report experiencing childhood abuse or neglect. Child abuse, sexual assault, military combat, domestic violence, and a host of other violent incidents help shape the response of the people we serve. Adverse childhood experiences are strongly related to development and prevalence of a wide range of health problems, including substance abuse and mental illness. Over time people exposed to trauma adopt unhealthy coping strategies that lead to substance use, disease, disability and social problems, and premature mortality.

Since 2012, DSAMH embarked on several statewide efforts to implement the Trauma-Informed Approach in public and private programs, by providing training; organizational evaluation and consultation; policy implementation and partnering with local and national organizations. Some of these initiatives and training events are listed below:

1. Ongoing Organizational Evaluation, Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.
2. Utah Trauma Academy: October 31, November 4, 2016 for 110 public and private providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.
3. Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in their practices.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Grievances and Appeals

Utah Medicaid members and providers receive notice of any adverse action pursuant to 42 CFR 341 Part E. In addition, all managed care entities contracted with the Utah Medicaid program must comply with the grievance and appeals provisions of 42 CFR 438 Part F. Finally all state Medicaid fair hearings are conducted in accordance with Title 63G Chapter 4 Utah Code Annotated, Utah Administrative Procedures Act and Utah Administrative Code R414-4, Administrative Hearing Procedure.

https://le.utah.gov/xcode/Title63G/Chapter4/63G-4.html?v=C63G-4_1800010118000101.

<https://rules.utah.gov/publicat/code/r410/r410-014.htm>.

Future State:

Utah Administrative Code and internal procedures are consistent with recent changes to federal regulations.

Summary of Actions Needed:

Utah Medicaid will review 42 CFR 431 Part E and 42 CFR 438 Part F once again to assure Utah Code reflects the requirements of current federal regulation.

Action Implementation Timeline

- Utah Medicaid will conduct a review of current administrative code and federal regulations to determine any needed updates by November 30, 2017.
- Utah Medicaid will implement any necessary changes to administrative code and internal procedures by March 31, 2018

Attachment D: SUD Monitoring Protocol

[To be incorporated after CMS approval]

Attachment E: Implementation Plan

[To be incorporated after CMS approval]

Attachment F: Monitoring Protocol
[To be incorporated after CMS approval]