



# STATE OF UTAH

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November 1, 2019

Honorable Alex Azar, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Azar:

My State has worked over many years to develop a Medicaid expansion proposal that would cover adults in the Affordable Care Act (ACA) coverage gap while providing financial protections for the State so that Medicaid expenditures are not allowed to monopolize and cannibalize other important social service spending. I appreciated your suggestions and guidance when we met in Washington earlier this year. Therefore, I am pleased to submit the State of Utah's request for an amendment to its 1115 demonstration waiver. This waiver amendment is a result of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 General Session of the Utah State Legislature.

This waiver request seeks to provide increased coverage to Utahns in a fiscally sustainable manner. Section 1901 of the Social Security Act states that the purpose of the Medicaid program is to enable "each State, as far as practicable under the conditions in such State," to provide medical assistance to certain populations. In Utah, the State Constitution requires that the State have a balanced budget and that income taxes be spent on education. As a result, the sales tax is the primary source of funding for the State's General Fund. Medicaid, transportation and other infrastructure, public health and other social services, law enforcement and public safety, along with general government operations all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent.

These growing costs occurred while Utah served the original populations targeted by Title XIX - families with dependent children and individuals that are aged, blind, or disabled. With the waiver approved in March 2019 and with this waiver request, the State included additional adults with dependent children and adults without dependent children historically not served by Medicaid.

While the State of Utah has been able to allocate existing resources to accommodate current Medicaid needs and has authorized an increase in sales tax to fund this waiver request, it may not be practicable in the State of Utah for Medicaid expenditures to continue to grow as a share of available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a reliable long term funding source for the program absent additional budgetary flexibilities. Therefore, due to the current and potential budget conditions that may arise in the State of Utah, this waiver proposal includes a request that the State have the ability to cap enrollment based on available state appropriations.

With Medicaid continuing to consume a growing share of Utah's General Fund, the State's ongoing fiscal sustainability is dependent on finding fiscal sustainability for Medicaid. Rising health care costs and increasing enrollment in the Medicaid program drive the State to find efficiencies in operating the program. Several provisions of this waiver request (i.e., housing supports, community engagement requirement, and enrollment in employer sponsored insurance) are specifically designed to help individuals gain employment, increase their income, and join the majority of Utahns in receiving their health care through employer sponsored insurance. By helping these individuals move off of Medicaid and on to other coverage, these program features help Utah ensure the overall fiscal sustainability of its Medicaid program.

On July 27, 2019, the Centers for Medicare and Medicaid Services (CMS) released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare.

Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely that you will use your authority at this time to allow enhanced funding for an expansion that includes an enrollment cap, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

First, the landscape regarding Medicaid expansion may change. Most notably, the U.S. Court of Appeals for the 5th Circuit will be issuing a decision in the *Texas v. U.S.*, litigation challenging the ACA. Comments attributed to administration officials in news articles regarding CMS's

position on partial expansion and enrollment caps seem to tie this administration's position to a hope that *Texas v. U.S.* will overturn the ACA. However, as shown by the Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012), court decisions are not entirely predictable. Therefore, in light of the possibility that the legal situation regarding the ACA may change (or may not) in the near future, the State is submitting its entire request for your review.

Second, the State's waiver request contains many other program features beyond the request for enhanced match for expansion with an enrollment cap. The State believes the other components of its waiver request can be approved and are important to operating an efficient and effective Medicaid Expansion program.

This waiver request includes the following proposals for Utah's Medicaid Expansion:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including Adult Expansion and Targeted Adult Populations
- Lock-out from the Medicaid Expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports for groups within Medicaid Expansion
- Not allowing hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a \$10 surcharge for each non-emergent use of the emergency department after having received a warning for inappropriate use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP).

The State is also requesting to continue the following components for the Adult Expansion demonstration group, which are currently authorized under the State's 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

The State of Utah appreciates your consideration of this waiver request. The State has worked with CMS for over a year on specific expansion proposals seeking to find areas where the federal government and the State are aligned in their visions for Medicaid Expansion. Earlier this year, Utah invested a significant amount of time and energy in pursuit of a Per Capita Cap waiver. CMS ultimately rejected that request which pushed the State to this "Fallback" waiver request. We are now again in the position of submitting another waiver request seeking your approval to operate Medicaid Expansion in an efficient and effective manner. It is time for CMS to approve the State's requests and allow the State to begin receiving enhanced match for this coverage; therefore, we are seeking approval of this request by December 31, 2019. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Expansion program.

Respectfully,



Gary R. Herbert  
Governor



Utah 1115 Demonstration Waiver  
Amendment

November 1, 2019

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# Utah Section 1115 Demonstration Waiver

## Amendment

### Medicaid Expansion

#### Section I. Program Description and Objectives

During the 2019 General Session, the Utah State Legislature passed, and Governor Herbert signed into law, Senate Bill 96 “Medicaid Expansion Adjustments”. This legislation directed the Utah Department of Health (UDOH), Division of Medicaid and Health Financing to seek 1115 waiver approval from the Centers for Medicare and Medicaid Services (CMS) to implement specific proposals. Some of these proposals were approved by CMS on March 29, 2019, as part of the State’s “Bridge Plan” for Medicaid expansion.

With this amendment, the State is seeking approval to implement the following proposals for its Medicaid expansion as directed by Senate Bill 96:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL), to 133 percent FPL, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including the Adult Expansion demonstration group and the Targeted Adult demonstration group
- Lock-out from the Medicaid expansion for committing an intentional program violation
- Federal expenditure authority to provide housing related services and supports (HRSS) for groups within Medicaid Expansion
- Not allow hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a \$10 surcharge for each non-emergent use of the emergency department after having received a warning for inappropriate use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid.
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah’s Premium Partnership for Health Insurance (UPP)

The State is also requesting to continue the following components for the Adult Expansion demonstration group which are currently authorized under the State’s 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance (ESI) to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

The proposals included in this request will apply to the Medicaid Expansion population described in Section II. “Program Overview and Demonstration Eligibility” below, unless otherwise noted. With this application, the State is requesting the authority to operate a Medicaid Expansion program consisting of both the Targeted Adult demonstration group and the Adult Expansion demonstration group.

#### A. Goals and Objectives

Under Section 1115 of the Social Security Act, States may implement “experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]”. The State believes the provisions requested in this proposal are likely to promote the following goals and objectives:

- Providing health care coverage for low-income Utahns that would not otherwise have access to, or be able to afford, health care coverage
- Improving participant health outcomes and quality of life
- Lowering the uninsured rate of low income Utahns
- Supporting the use of ESI by encouraging community engagement and providing premium reimbursement for ESI plans
- Providing continuity of coverage for individuals

This demonstration will allow the State to test the effectiveness of policy that is designed to improve health outcomes of demonstration individuals, as well as promote their financial independence. The Demonstration will provide the needed support of housing supports and services, while encouraging individuals to obtain or sustain employment.

#### B. Operation and Proposed Timeframe

The Demonstration will operate statewide. The State intends to implement the Demonstration effective January 1, 2020.

### Section II. Program Overview and Demonstration Eligibility

#### A. Approved Demonstration Populations and Components

As stated above, the State is requesting approval to continue the following components and programs with this amendment for the expanded Adult Expansion demonstration group, which are currently authorized under the State’s 1115 Demonstration Waiver.



## 1. Community Engagement through a Self Sufficiency Requirement

With this waiver amendment, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion demonstration group. The community engagement requirement was originally approved for this population, as part of the expansion authorized in the March 29, 2019 amendment to the State’s 1115 Demonstration Waiver. The community engagement requirement applies to Adult Expansion beneficiaries who do not meet an exemption and do not show good cause, as outlined in the sections below. Participation requirements and activities are outlined in the “Community Engagement Participation” section below.

Many studies have concluded that employed individuals have better physical and mental health, and are more financially stable than unemployed individuals.<sup>1</sup> Recognizing the connection between employment and health, the State proposes that the community engagement requirement will; increase an individual’s health and well-being through incentivizing work and community engagement, increase their sense of purpose, help to build a healthy lifestyle, and increase employment and wage earnings of able-bodied adults, while focusing funding on the State’s neediest individuals. The State will align closely with the work requirements and activities of the Supplemental Nutrition Assistance Program (SNAP) program as well as Temporary Assistance for Needy Families (TANF) work activities to ensure consistency and reduce complexity for those individuals required to participate.

### *Community Engagement Exemptions*

The State recognizes that not all individuals may be able to participate in the community engagement requirement, or they may already be participating in other work or training activities that meet the goals of the Demonstration. Therefore, the State will exempt certain individuals from the requirement, as approved under the State’s 1115 Waiver. The exemptions are largely aligned with federal SNAP exemptions. The exemptions are:

1. Age 60 or older;
2. Pregnant or up to 60 days postpartum;
3. Physically or mentally unable to meet the requirements as determined by a medical professional or documented through other data sources;
4. A parent or other member of the household with the responsibility to care for a dependent child under age six;
5. 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 ;

<sup>1</sup> Karsten I. Paul, Klaus Moser, (2009), Unemployment Impairs Mental Health: Meta-Analyses, *Journal of Vocational Behavior*, 74 (3), 264-282. McKee-Ryan, Z.Song, C.R. Wanbert, and A.J. Kinicki. (2005). Psychological and physical well-being during employment: a meta-analytic study. *Journal of Applied Technology*, 90 (1), 53-75.

6. A member of a federally recognized tribe;
7. Has applied for and is awaiting an eligibility determination for unemployment insurance benefits, or is currently receiving unemployment insurance benefits, and has registered for work at the Department of Workforce Services (DWS);
8. Participating regularly in a substance use disorder treatment program, including intensive outpatient treatment;
9. Enrolled at least half time in any school (including, but not limited to, college or university) or vocational or apprenticeship program;
10. Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;
11. State Family Employment Program (FEP) recipients who are working with an employment counselor;
12. Beneficiaries in compliance with or who are exempt from SNAP and/or TANF employment requirements; or
13. 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.

An individual can claim an exemption at any time. Individuals meeting one or more of the above listed exemptions will not be required to complete the community engagement participation requirement within the 12-month certification period in which the exemption is claimed in order to maintain continued coverage.

#### *Community Engagement Participation*

Individuals who do not meet an exemption or do not show good cause will be referred for participation on the first of the month following approval for the Adult Expansion program. This will be month one of the three-month participation period. This is the same participation period used for the SNAP program. Individuals will be required to complete participation requirements within the three-month period. Once they have met the requirement, they will be eligible for the remainder of their eligibility period. Eligibility periods are 12 months. The individual must complete participation requirements every 12 months to continue to receive Medicaid.

Individuals who do not meet an exemption, or who are not eligible for good cause must complete the following participation activities:

- Register for work through the state system
- Complete an evaluation of employment training needs
- Complete the job training modules as determined to be relevant to the individual through the assessment of employment training needs
- Applying for employment with at least 48 potential employers

Activities will be completed through the DWS, using the same online evaluation, training, and search resources offered to Utah SNAP recipients.

### *Closure Due to Non-Participation*

Failure to comply with the community engagement requirement will result in a loss of Medicaid eligibility, unless good cause is demonstrated, or the individual meets an exemption. If an individual fails to participate by the end of the third month, a notice will be sent in the following month stating they will no longer be eligible for Medicaid at the end of that month.

The following will apply:

- Only those individuals who fail to participate will lose eligibility.
- If an individual completes all activities within the notice month, the individual will not lose eligibility, and will remain eligible without having to reapply.

### *Regaining Eligibility*

- Individuals who lose eligibility may become eligible again by completing all required activities or by meeting an exemption.
- After completing all required participation activities, the individual must reapply for Medicaid. Benefits will be effective the first day of the month in which they reapply.
- As long as the individual applies for benefits in the month following the month they complete all required activities, open enrollment requirements will not apply if enrollment limits are approved under this Demonstration.
- If the individual meets the qualifications for an exemption or demonstrates good cause for the earlier non-compliance, 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.

### *Good Cause Exemptions*

The State will waive loss of eligibility if an individual claims good cause for failure to participate in the community engagement requirement. The good cause exemption will exempt the individual as long as the good cause reason exists. Good cause exemptions include, but are not limited to:

1. The individual 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 individual or an immediate family member who was living in the home with the individual experiences a hospitalization or serious illness;
2. The individual experiences the birth, or death of a family member living with the individual;
3. The individual experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
4. The individual has a family emergency or other life-changing event (e.g. divorce or domestic violence);
5. The individual is not able to participate due to a lack of internet access or transportation;
6. There are fewer than 48 employers in the individual's geographic area that potentially could offer employment to the individual or from whom the individual reasonably could be expected to accept an offer of employment; in this case the number of required employer contacts shall be reduced to an appropriate level so that the individual is not required to make applications for employment that would likely be futile;
7. The individual is the primary caretaker of a child age 6 or older and is unable to meet the requirement due to childcare responsibilities.

### *Reasonable Modifications*

The State will 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 will 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 the provision of support services necessary to participate is unavailable, where participation is otherwise possible with supports.

### *Beneficiary Supports*

The State will work with DWS and other community partners to make a good faith effort to connect participating individuals to existing community supports that are available to assist individuals in meeting the community engagement requirement. This may include non-Medicaid assistance with transportation, childcare, language access services, and other supports; and connect individuals with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services to enable them to participate.

### *Impact to Beneficiaries*

Based on the State's experience with SNAP work requirements, the State estimates approximately 70 percent of Adult Expansion beneficiaries will meet an exemption to community engagement participation. Among individuals who do not meet an exemption or good cause reason, the State projects that approximately 75-80 percent will comply with the community engagement requirements.

## **2. Enrollment Limits**

As directed by Senate Bill 96, the State requests to continue to apply enrollment limits to the Adult Expansion and Targeted Adult Populations under this amendment. Enrollment limits for these populations are currently approved under the State's 1115 Demonstration Waiver that was amended on March 29, 2019. The State proposes to apply enrollment limits when projected costs exceed annual state appropriations. There will not be a set enrollment cap, but rather it will be based on available funding. When enrollment is suspended, the State will continue to accept and review applications to determine if individuals are eligible for other Medicaid programs. If the individual is not eligible for any other Medicaid program, other than Medicaid Expansion, eligibility will be denied. The State will not maintain a waitlist to automatically enroll individuals when enrollment is re-opened. Individuals will need to apply during the next open enrollment period. All eligible individuals that apply before an enrollment limit is in place will be enrolled in the program. Individuals already enrolled in the program at the time enrollment is suspended will remain enrolled.

The State will post information on its website, and distribute information to community partners, state agencies, and the media when the State has determined an open enrollment period will occur.

The State is requesting to continue to apply enrollment limits for these populations to allow the State to be able to continue to furnish medical assistance to approved populations in a fiscally sustainable manner, and within the budget conditions that the State faces now and may face in the future.

#### *Enrollment Limit Exception*

The State proposes to exempt individuals with verified membership in a federally recognized tribe from the enrollment limit for the Adult Expansion and Targeted Adult Populations. Enrollment for these populations will continually remain open for individuals who meet this exception.

#### *Impact to Enrollment*

Although the State is requesting an enrollment limit, the projected enrollment and associated expenditures for this waiver are not expected to exceed budgeted State funds within the time period of the waiver demonstration, and therefore the State does not estimate any impact on enrollment from this provision within the waiver period.

Individuals already enrolled in the Medicaid Expansion at the time enrollment is suspended will remain enrolled.

### **3. ESI Reimbursement**

As approved on March 29, 2019, under the State's 1115 Demonstration waiver, the State proposes to require individuals who are eligible for the Adult Expansion demonstration group, and have access to ESI, to purchase their ESI plan. The State will reimburse the eligible individual for the health insurance premium amount for that individual. Failure to enroll in, and purchase, the insurance plan will result in ineligibility for Medicaid. The State requests flexibility to exempt certain groups from disenrollment if they fail to enroll. Under the authority granted to the State through this waiver, the State will implement this closure policy through its administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to exempt certain income groups from the ESI requirement.

#### *ESI Benefit Package*

Eligible individuals will be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified plan. In addition, the individual will receive wrap-around benefits through the State's fee for service (FFS) Medicaid program.

#### *Qualified Plan*

In order to be eligible for reimbursement, the health insurance plan must meet the criteria for a qualified health plan, as defined by the State. Under the authority granted to the State through this waiver, the State is proposing to establish the criteria for a qualified health plan through state administrative rule. The state administrative rule for the Adult Expansion Population qualified plan would likely follow similar criteria to that already established through state administrative rule for the 1115 Demonstration Waiver - Demonstration Group III – UPP Adults (see R414-320-2 (12)). The state administrative rule would likely define a qualified health plan for the Adult Expansion Population as a health plan offered by an employer to employees or their dependents that meets the following criteria:

1. The plan covers physician visits, hospital inpatient services, pharmacy, well child exams and child immunizations.

2. The network deductible is less than \$4,000 per person.
3. The plan pays at least 70% of an in network inpatient stay (after deductible).
4. The plan does not cover abortion services; OR the plan only covers abortion services in the case where the life of the mother would be endangered if the fetus were carried to term, or in the case of incest or rape.
5. The employer pays at least 50 percent of the premium for the primary insured individual.

#### *Verification of Coverage*

Verification of ESI coverage and the individual's premium amount will be verified at initial application, routinely between recertifications, and at recertification.

#### *Exemption*

Members of federally recognized tribes will be exempt from the requirement to purchase ESI coverage. However, if they choose to enroll in a qualified ESI health plan, they may be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified plan

#### *Impact to Beneficiaries*

The State estimates that approximately 14,000-19,000 individuals under this demonstration will be eligible for an ESI plan and will enroll in that plan. The State estimates 100-200 members per year will lose Medicaid eligibility due to failure to enroll in ESI coverage.

#### **4. Early and Periodic Screening, Diagnostic, and Treatment**

Through the State's 1115 Waiver Demonstration, the State currently has authority to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for adults age 19 and 20 years old in the Adult Expansion and Targeted Adult Populations. The State requests to continue this authority for these populations.

### **B. New Demonstration Waiver Requests**

As stated previously, with this amendment the State is seeking approval to implement the following proposals as directed by Senate Bill 96.

#### **1. Income Limit Increase for Adult Expansion Population**

The State proposes to increase the income limit from 95 percent FPL, to 133 percent FPL for the Adult Expansion Population, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion, which includes both the Adult Expansion and the Targeted Adult demonstration groups. If the allowable enhanced FMAP is ever reduced to below 90 percent, the State will sunset the Adult Expansion demonstration group no later than July 1 after the date on which the FMAP is reduced.

The Adult Expansion Population is defined as individuals who meet the following criteria:

- Adults ages 19 through 64
- A U.S. Citizen or qualified alien
  - Non-qualified non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
- A resident of Utah
- Not pregnant

- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 133 percent of FPL using the MAGI methodology which includes a five percent FPL disregard
- Ineligible for other Medicaid programs that do not require a spenddown to qualify
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Not enrolled in the Targeted Adult demonstration group
- Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.

As a result of expanding the Adult Expansion demonstration group to individuals with household income up to 133 percent FPL, the State will change the income range for demonstration populations III, V and Current Eligible CHIP Children (referred to as Utah's Premium Partnership for Health Insurance or UPP). The income range criteria for the UPP program will change to; household income above 133 percent through 200 percent FPL.

## 2. Lock-Out due to Intentional Program Violation

The State proposes to apply a six-month period of ineligibility if an individual commits an intentional program violation (IPV) to become, or remain eligible for Medicaid. Only the individual who commits the IPV will be disqualified. This request applies to the entire Medicaid Expansion, including both the Adult Expansion and Targeted Adults populations.

An IPV is defined as:

- Knowingly making false or misleading statements;
- Misrepresenting, concealing or withholding facts;
- Violating program regulations on the use, presentation, acquisition, receipt or possession of medical assistance or the medical card; or
- Not reporting the receipt of a medical card or medical service that the individual knows the individual was not eligible to receive;
- Posing as someone else;
- Not reporting a required change within 10 days after the change occurs, and the individual knew the reporting requirements, and the intent was to obtain benefits they were not entitled to receive;
- Intentionally submitting a signed application or eligibility review containing false or misleading statements in an attempt to obtain medical assistance, even if the individual received no assistance.

The State will inform individuals of the reporting requirements at application, upon Medicaid approval, and at recertification.

The determination of an IPV is different from a determination of fraud. Fraud is determined by a district court as a result of a criminal prosecution. For the purposes of medical assistance eligibility and public assistance, the definition of fraud is found in Title 76 Chapter 8 Section 1205 of the Utah Code Annotated. The agency makes fraud referrals when evidence clearly shows an intent to fraud and the situation meets one of the following additional criteria:

1. The combined overpayment amount exceeds \$5,000 and the duration of the overpayment is at least twelve months, or
2. In addition to any application and review forms, the defendant must have knowingly provided false or forged documents, worked or received government benefits using a false ID or social security number, or overtly taken an action for the purpose of perpetrating the fraud, or
3. It is the second occurrence of a fraud situation for that defendant, or
4. It is a Check Fraud case that includes multiple checks/warrants or collusion.

If the evidence supports pursuing adjudication through the criminal process, the agency refers the case to a criminal specialist for review. If the specialist agrees with the referral, the specialist prepares the case for review by the assigned attorney in the Attorney General's (AG) Office. The AG's Office will either accept or reject the case. If the AG's Office accepts the case, they will file the case in court. If rejected, it is classified as a suspected IPV.

#### *Process to Determine IPV Lock-Out*

If the agency suspects a Medicaid overpayment, the overpayment is referred to a DWS Benefit Accuracy Analyst (BAA). The BAA reviews the available evidence to determine if the individual committed an IPV. The agency must have clear and convincing evidence that the individual knowingly, willingly, or recklessly provided false or misleading information with an intent to receive benefits to which he or she was not eligible to receive.

- Evidence may include applications or review forms, incomplete or inaccurate verification forms, income or tax records showing a history of unreported income, proof an individual posed as someone else or allowed someone else to use the individual's medical card, etc.
- Evidence may include case notes of conversations with the individual that show the agency asked specific questions, and later the agency shows such responses from the individual are erroneous.

If enough evidence exists to substantiate the overpayment calculation, and the classification of the cause, the BAA ensures the amount of the overpayment is correct, and the classification is correct and makes a referral for adjudication. If evidence is not sufficient to support the overpayment referral calculation, the BAA requests an investigation to gather additional evidence. After a thorough investigation, if the State suspects a Medicaid overpayment occurred, and the cause of the overpayment is classified as a suspected IPV, the agency sends the individual a written notice, which includes, but is not limited to, the following:

1. The overpayment amount
2. The classification as a suspected IPV
3. Appeal rights and time frames
4. Who to contact if they disagree with the suspected IPV

The individual is allowed 30 days from the date the written notice is issued to appeal the overpayment and suspected IPV. If the individual does not respond within 30 days, an adjudicator reviews the overpayment and suspected IPV. If the adjudicator upholds the overpayment and suspected IPV, the adjudicator issues the order of default to the individual. The lock-out becomes effective as described in the "Lock-Out Period" section below. The order of default will include, but is not limited to, the following information:

1. Overpayment amount and time period of the overpayment



2. Evidence used in the decision
3. The date the disqualification will begin and end
4. Additional appeal rights to have the order set aside.

#### *Lock-Out Period*

The period of ineligibility begins the month following the month the adjudicator issues the final IPV lock-out order, allowing for proper advance notice. The lock-out remains in place for six-months from that date. As part of the appeal rights, the individual can request to receive continued benefits while they are appealing the IPV decision. If the IPV decision is upheld, and the individual requested continued benefits, an overpayment will be assessed for the months the individual continued to receive Medicaid.

The individual has 30 days after DWS issues the hearing decision to request a Superior Agency Review of the overpayment and IPV. The UDOH conducts the Superior Agency Review.

#### *Exemptions from IPV Lock-Out:*

The State allows the following exemptions from an IPV lock-out:

1. If the individual becomes eligible for another Medicaid program, the lock-out will end as of the first of the month the individual becomes eligible for that program. (Example: an individual becomes pregnant or moves to Disabled Medicaid).
2. The individual may request an undue hardship if a medical practitioner determines lack of medical care places the individual's life in jeopardy or in danger of permanent disability.
  - a. The agency will notify the individual of the option to contact UDOH to claim undue hardship.
  - b. UDOH must receive verification of the reason the undue hardship exists.
  - c. UDOH will make the determination of whether to grant a hardship exemption.
  - d. If a hardship exemption is granted, UDOH will notify DWS to not apply the lock-out.

#### *Enrollment Limit and IPV Lock-Out*

Individuals who have served a lock-out period, and later reapply may not re-enroll in Medicaid Expansion if enrollment is suspended. The individual will have to wait for an open enrollment period to become eligible again for Medicaid Expansion. However, they may apply and have eligibility determined for other Medicaid programs for which they may be eligible.

#### *Impact to Beneficiaries*

The implementation of this proposal may cause approximately 750 individuals per year to lose eligibility for six-months as a result of committing an IPV. The State anticipates this may deter individuals from committing an IPV. Currently, the State does not impose a lock-out as a result of committing an IPV for any Medicaid program.

The State believes that imposing a lock-out period for individuals who knowingly withhold or intentionally report inaccurate household information, will ensure that limited state resources are used for individuals who truly meet the eligibility requirements of Medicaid Expansion. Accurate eligibility information is imperative to the integrity of the Medicaid program and is key to maintaining the fiscal sustainability of the program overall. Although this proposal may have an impact on coverage levels if an individual chooses to commit an IPV, the demonstration as a whole will allow the State to provide greater access to low-income individuals who are eligible, thus improving the sustainability of the safety net.

### 3. Housing Related Services and Supports (HRSS)

#### *Background Information*

Individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma encounter a variety of health and social challenges. Challenges include such things as acute and chronic medical and behavioral health conditions, criminal justice system involvement, and extended periods of unemployment and poverty. Individuals having these experiences often lack health insurance and may have limited access to health care. These challenges pose significant barriers to achieving housing stability, pursuing mental health or substance use disorder recovery, improving health outcomes, and reducing health care costs. To address barriers that influence individuals' health, the State seeks expenditure authority under this demonstration application to provide an array of evidence-based services and supports to the Medicaid Expansion.

As directed by Senate Bill 96 (2019), the State, in collaboration with stakeholders, is developing a Utah-specific solution to provide evidence-based services and supports to improve health outcomes of identified populations. Because food insecurity, transportation insecurity, interpersonal violence or trauma pose potential barriers to housing and health, housing supports also include evidence-based services to address these barriers. Through this waiver, the State requests authority to provide housing supports across the Medicaid Expansion. Under the authority granted to the State through this waiver, the State also requests authority to target services to targeted populations through its administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the targeted services and/or targeted populations.

For initial implementation, the State intends to provide these evidence-based services and supports to the Targeted Adult Population. The State's efforts to reduce barriers that impact individuals' health will focus on providing HRSS to eligible populations. Participation in HRSS will be voluntary. Individuals' ongoing need for HRSS will be verified every six months.

#### *Definitions*

The State intends to offer the following HRSS:

1. ***Tenancy Support Services*** – are services provided directly to eligible members that include:
  - a. Conducting a tenant screening and housing assessment to identify the member's preferences (e.g., housing type, location, living alone or with someone else, identifying a roommate, accommodations needed, etc.) and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
  - b. In collaboration with the eligible member, developing an individualized housing support plan based on the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

- c. Participating in person centered planning meetings to assist the member to develop a housing support plan
  - i. Assisting the member to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers;
- d. Assisting with the housing application process, and selection process, including filling out housing applications and obtaining and submitting appropriate documentation;
- e. Assisting the member to complete reasonable accommodation requests as needed to obtain housing;
- f. Assisting with the housing search process;
- g. Identifying available resources to cover expenses such as rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
- h. Ensuring that the living environment is safe and ready for move-in;
- i. Assisting in, arranging for and supporting the details of the move;
- j. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized;
- k. Connecting the member to education and training on tenants' and landlords' role, rights, and responsibilities;
- l. Assisting in reducing risk of eviction by providing services that help the member improve conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicate with landlords and neighbors to reduce the risk of eviction; address biopsychosocial behaviors that put housing at risk; and provide ongoing support with activities related to household management;
- m. Assistance with housing voucher or subsidy applications and recertification processes.

Because individuals with Serious Mental Illness who receive Targeted Case Management services under Utah's Medicaid State Plan currently have access to the component parts of Tenancy Support Services, these individuals will not be eligible to receive the Tenancy Support Services offered through this demonstration.

2. **Community Transition Services** – are services provided to assist an eligible member to secure, establish, and maintain a safe and healthy living environment. Services include:
  - a. One-time purchase of essential household items and services needed to establish basic living arrangements in a community setting, to include basic furnishings, kitchen, bathroom and cleaning equipment and goods;
  - b. One-time payment of a security deposit and the first and last month's rent, when a member moves to a new residence. The State will impose a maximum of two such payments per member during the pilot period. The State seeks authority to cover the first and last month's

rent because expecting both the first, and last month's rent is a ubiquitous requirement in Utah's extremely competitive housing market. The services would also include payment of one-time, non-refundable fees to submit rental applications, establish utility services and other services essential to the operation of the residence.

This service is furnished only to the extent it is determined reasonable and necessary as clearly identified through a member's housing support plan, when the member is unable to meet such expenses, and funding for such items is not available through any other funding source.

Because this service, and its component parts, are not otherwise available through Medicaid State Plan services, the State seeks authority to offer "Community Transition Services" to all individuals identified in this section.

3. **Supportive Living/Housing Services** – Supportive living and housing services link decent, safe, affordable, community-based housing with flexible, voluntary support services designed to help the individual or family stay housed.

Supportive Living/Housing Services do not include room and board costs.

Supportive Living/Housing Services may include a wide variety of coordinated services needed by individuals, including:

- a. Health and Medical Services—Routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services;
- b. Mental Health Services—screening, assessments, counseling, psychiatric services, clubhouses, peer services, and assertive community treatment;
- c. Substance Abuse Services—relapse prevention, counseling, intensive outpatient services, medication assisted treatment, detoxification, residential services and formal and informal (AA/NA) recovery support services;
- d. Independent Living Services—Financial management services, entitlement assistance, training in cooking and meal preparation, and mediation training;
- e. General Supportive Services—Services such as case management, community support, meals, peer support, crisis intervention, representative payee supports and non-medical transportation.

Current Medicaid members with serious mental illness may receive Supportive Living/Housing Services (or its component parts) through Utah's Prepaid Mental Health Plans. Adult Expansion members with Serious Mental Illness may also receive the component parts of Supportive Living/Housing Services through the Prepaid Mental Health Plans.

### *Eligibility*

1. The following table details the eligibility criteria for HRSS.

<b>Eligibility Criteria for HRSS</b>		
<b>Eligible Population</b>	<b>Age</b>	<b>Needs-Based Criteria (Must meet one of the following items)</b>
Adults	19-64	<ol style="list-style-type: none"> <li>1. Living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12- months or on at least 4 separate occasions in the last 3 years; 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;</li> <li>2. Currently living in supportive housing, but who has previously met the definition of chronically homeless defined in Item 1.;</li> <li>3. Is an individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails;</li> <li>4. Is an individual discharged from the Utah State Hospital who was admitted to the hospital due to an alleged criminal offense;</li> <li>5. Is an individual involved in a Drug Court or Mental Health Court, including Tribal courts.</li> <li>6. Is an individual receiving General Assistance from the Utah Department of Workforce Services, who has been diagnosed with a substance use or mental health disorder; or</li> <li>7. Is an individual discharged from the State Hospital who was civilly committed.</li> </ol>

Table 1

2. The following table identifies populations eligible for individual HRSS.

<b>Populations Eligible for Individual HRSS</b>		
<b>Tenancy Support Services</b>	<b>Community Transition Services</b>	<b>Supportive Living/Supportive Housing Services</b>
All individuals must meet at least one of the needs-based criteria identified in Table 1	All individuals must meet at least one of the needs-based criteria identified in Table 1	All individuals must meet at least one of the needs-based criteria identified in Table1

<p>Individuals who do not have a Serious Mental Illness diagnosis</p> <ul style="list-style-type: none"> <li>Individuals with Serious Mental Illness currently have access to Tenancy Support Services (or component parts) through <i>Targeted Case Management for Individuals with Serious Mental Illness Services</i> available through the Medicaid State Plan</li> </ul>		<p>Individuals who do not have a Serious Mental Illness diagnosis</p> <ul style="list-style-type: none"> <li>Individuals with Serious Mental Illness currently have access to Supported Living /Supportive Housing Services (or component parts) through 1915(b) authority through Utah’s Prepaid Mental Health Plans</li> </ul>
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Table 2

- If the State identifies additional populations to be added through the administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated, specific eligibility criteria for a new population will be included within that administrative rule.

### Impact to Beneficiaries

As a growing body of evidence shows, social determinants, such as housing instability, play a significant role in individual health outcomes. “*A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing*”<sup>2</sup> published by the U.S. Department of Health & Human Services states the following:

***“Ample evidence documents the potential for people with complex health and behavioral health conditions who have been homeless to achieve housing stability, pursue recovery, manage chronic health conditions, and stay out of hospitals, if they receive appropriate health care, other services and supports, and care coordination.”***

An excerpt from the *National Academies of Sciences, Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*<sup>3</sup> describes:

***“A pilot study conducted in Portland, Oregon, examined the effects of single-site supportive housing on health care costs, health care utilization, and health outcomes for 98 “highly medically vulnerable” individuals experiencing homelessness (Wright et al.,***

<sup>2</sup> US Health and Human Services Primer on Using Medicaid for People Experiencing Chronic Homelessness <https://aspe.hhs.gov/system/files/pdf/77121/PSHprimer.pdf>

<sup>3</sup> National Academies of Sciences, Engineering, and Medicine. 2018. *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*. Washington, DC: The National Academies Press. doi: <https://doi.org/10.17226/25133>.

**2016, p. 21). This study, using retrospective survey responses and Medicaid administrative claims data, showed that placing individuals experiencing homelessness and high medical costs into supportive housing significantly reduced Medicaid expenditures for inpatient hospital and emergency department services for physical health issues, with an average annual reduction of \$8,724 in the year after moving in (Syrop, 2016). The self-reported data also showed a reduction in hospital stays and emergency department visits, indicating a shift toward using primary care services rather than acute care services. Although these results are promising, the absence of a comparison group and the use of retrospective self-reported data limit interpretations of this study.”**

One of the key distinctions of Tenancy Support Services and Supportive Living/Supportive Housing services proposed in this section is to provide services, or component parts, to vulnerable and complex populations beyond only those with serious mental illness, who already have access to these services.

The State intends to further demonstrate that health care costs and utilization can be reduced when individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma receive needed evidence-based services and supports.

The State believes coverage of HRSS is consistent with the overall goals of the Medicaid program and recent guidance provided by CMS, through the June 26, 2015, CMCS Informational Bulletin titled, “*Coverage of Housing-Related Activities and Services for Individuals with Disabilities.*” The document states in part, “*This Informational Bulletin is intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities with the goal of promoting community integration for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness.*”

The Informational Bulletin identifies 1115 Research and Demonstration Programs as a potential authority through which housing related services may be provided, including the following: “*Some section 1115 demonstrations include housing-related services consistent with the statutory authorities described in this bulletin. For example, states can provide services to individuals already in the community, by helping the individual problem solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing. For people leaving institutions, states assist with locating housing, completing forms for subsidies, moving, and household set ups.*”

The State will use the CMS guidance to design HRSS to increase individuals’ ability to attain and retain safe, affordable housing, which will reduce barriers that impact individuals’ health and wellness.

The State intends to further demonstrate that health care costs and utilization can be reduced when individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma receive needed evidence-based services and supports.

### *Estimated Enrollment*

The State estimates the following annual enrollment for each service:

- Tenancy Support Services: 5,000 individuals
- Community Transition Services: 5,000 individuals
- Supportive Living/Housing Services: 1,000 individuals

#### 4. Not Allow Presumptive Eligibility Determined by a Hospital

The State proposes to not allow presumptive eligibility determined by a hospital as a qualified entity, for the Medicaid Expansion. Currently, the State does not allow presumptive eligibility determinations for the Targeted Adult Population. This will allow the State to complete a full determination of eligibility before enrolling the individual, thereby improving program integrity and better assuring that each individual has met the requirements of the program before paying for their medical care. Coverage will no longer be based solely on a limited review of information by hospitals.

#### *Impact to Beneficiaries*

Presumptive eligibility determined by a hospital is currently allowed for the Adult Expansion population, but is not allowed for the Targeted Adult Population. The requested change will align the policy for both populations. The State anticipates that by no longer allowing hospitals to make presumptive eligibility determinations, approximately 500-750 individuals per month will no longer receive eligibility through presumptive eligibility. However, the State believes there will be no impact to individuals, as these individuals may still apply and have a full determination of eligibility completed for up to three months prior to the month of initial application. Approximately 54 percent of individuals approved for hospital presumptive eligibility are ultimately approved for ongoing Medicaid.

#### 5. Targeted Adult Medicaid Eligibility Definitions

With this amendment, the State is requesting to expand its eligibility criteria definitions for two of the Targeted Adult subgroups. This will allow the State to increase the number of individuals who are eligible for the Targeted Adult Population, allowing more individuals to receive the additional benefits of 12-months continuous eligibility (and dental benefits if they are actively receiving substance use disorder treatment).

Currently, individuals must meet the following criteria to be eligible for the Targeted Adult Population:

- Adults age 19-64, without a dependent child
- A U.S. Citizen or qualified alien
- A resident of Utah, and not in a public institution
- Household income at or below five percent of the FPL
- Ineligible for other Medicaid programs that do not require a spenddown
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Must also meet at least one of the following criteria:
  - Chronically homeless- this is defined as:
    - (1) living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12- months or on at least 4 separate occasions in the last 3 years; 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) currently living in supportive housing, but who has previously met the definition of chronically homeless defined in (1).



- Involved in the justice system AND in need of substance use or mental health treatment- this is defined as:
  - (1) an individual who has successfully 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 Utah Administrative Code);
  - (2) an individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or
  - (3) an individual involved in a Drug Court or Mental Health Court, including Tribal courts.
  
- Needing substance abuse or mental health treatment- this is defined as:
  - (1) 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;
  - (2) an individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder. The General Assistance program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; or
  - (3) an individual discharged from the State Hospital who was civilly committed.

With this amendment, the State proposes to add or change the following for each subgroup below:

- Chronically Homeless subgroup:
  - Add “an individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter”.
  - Move the following group from the subgroup “Needing substance abuse or mental health treatment” to the “Chronically Homeless” subgroup; “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”.
  
- Involved in the justice system and in need of substance use or mental health treatment subgroup:
  - Add “an individual who is court ordered to receive substance abuse or mental health treatment through a district court or Tribal court”.
  - Add “an individual on probation or parole with serious mental illness and/or serious substance use disorder”.

The State currently has authority through its 1115 Demonstration Waiver to suspend enrollment for the three subgroups of the Targeted Adult Population. Under the authority granted to the State through this waiver, the State is requesting the ability to suspend enrollment for the subsets within the three subgroups (ie. individuals living in supportive housing, individuals receiving General Assistance, etc.) through its administrative

rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the targeted services and/or targeted populations. If enrollment is suspended for a specific subgroup, the State will develop a transition plan to move individuals currently eligible for the specific Targeted Adult Population subgroup to the Adult Expansion Population.

#### *Impact to Beneficiaries*

The State estimates an additional 7,000 individuals will become eligible for Targeted Adult Medicaid by expanding the criteria.

### 6. Flexibility to Make Changes through the State Administrative Rulemaking Process

Under the authority granted to the State through this waiver, the State requests the ability to make the changes listed below for the Medicaid Expansion through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

These changes include the following:

- Begin enrollment the first of the month after application for Adult Expansion beneficiaries with income over 100 percent FPL (prospective enrollment)

Impact to beneficiaries - The State estimates one month out of twelve will be removed from a beneficiary's eligibility span. This would reduce total beneficiary months by 8.3% for this group.

- Not allow retroactive eligibility for Adult Expansion beneficiaries with income over 100 percent FPL

Impact to beneficiaries - The State estimates a reduction of 1.4% beneficiary months for this group due to not allowing retroactive eligibility.

- Change the benefit package for Adult Expansion and Targeted Adult demonstration groups (excluding medically frail) to the State's non-traditional benefit package

Impact to beneficiaries - The State estimates a reduction in demonstration expenditures for the Adults without Dependent Children and Targeted Adults equaling \$8.06 per beneficiary per month.

- Exempt certain groups from the ESI requirement

Impact to beneficiaries - The State estimates that 50% of beneficiaries with access to employer-sponsored insurance will not enroll in that insurance if exempted from the requirement.

- Suspend housing supports

Impact to beneficiaries - The State estimates a reduction in demonstration expenditures for Targeted Adults equaling \$234.56 per beneficiary per month. The State also estimates a reduction in demonstration expenditures for Adult Expansion equaling \$31.04 per beneficiary per month.

- Make enrollment in an integrated plan or other managed care mandatory or optional for different adult expansion groups

Impact to beneficiaries - The State estimates no difference in enrollment or cost due to this change.

- Open or suspend enrollment for each population group within Targeted Adult Medicaid

Impact to beneficiaries - Beneficiaries formerly enrolled in the Targeted Adult demonstration will no longer have access to 12-month continuous eligibility. The State estimates this will reduce total beneficiary months by 5.4%. Beneficiaries formerly enrolled in the Targeted Adult demonstration who also had a substance use disorder will lose access to dental benefits. Currently there are approximately 250 beneficiaries accessing the dental benefit.

### Section III. Demonstration Hypotheses and Evaluation

The State intends to contract with an independent evaluator to develop a plan for evaluating the hypotheses indicated below. The State, in consultation with the evaluator, will identify validated performance measures that assess the impact of the Demonstration on beneficiaries. In addition, the State intends to work with the evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State’s independent evaluator to draft an evaluation plan.

The evaluation budget will be included with the evaluation plan.

The State will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The State intends to test the following hypotheses contained in table 3 below, during the Demonstration period:

**Table 3 - Waiver Hypotheses**

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
<b>Medicaid Expansion</b>			
The Demonstration will improve access to medical assistance in Utah.	<ul style="list-style-type: none"> <li>● Number of adults ages 19-64 in Utah without health coverage</li> </ul>	Utah Behavioral Risk Factor Surveillance System (BRFSS)	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will improve the health and well-being of enrolled	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative

individuals by increasing access to primary care and improving appropriate utilization of emergency department (ED) services by the Medicaid Expansion Population.	<ul style="list-style-type: none"> <li>• Number of non-emergent ED visits</li> <li>• Number of cancer screenings</li> <li>• Number of well-care visits</li> </ul>		measures to include quasi-experimental comparisons
The Demonstration will reduce uncompensated care provided by Utah hospitals.	<ul style="list-style-type: none"> <li>• Amount of statewide hospital-reported uncompensated care</li> </ul>	Hospital Costs Report	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will assist individuals in enrolling in ESI plans in a cost effective manner.	<ul style="list-style-type: none"> <li>• Overall cost of care for ESI-enrolled individuals compared to comparable non-ESI enrollees.</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Community Engagement</b>			
The community engagement requirement will encourage skills development through an evaluation of job search readiness and the completion of employment related training workshops. In addition, by increasing the individual's job skills and encouraging job search activities, the community engagement requirement will promote gainful employment.	<ul style="list-style-type: none"> <li>• Number of trainings completed/ ended</li> <li>• Number of job searches</li> <li>• Number of job registrations</li> <li>• Amount of earned income</li> </ul>	eREP & UWORKS system data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Community engagement	<ul style="list-style-type: none"> <li>• Number of prescriptions</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative

requirements that promote engagement with the employment process will improve the health outcomes of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	<ul style="list-style-type: none"> <li>• Number of non-emergent ED visits</li> <li>• Number of cancer screenings</li> <li>• Number of well-care visits</li> </ul>		and qualitative measures to include quasi-experimental comparisons
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid	Beneficiary Surveys	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Lock-Out for Intentional Program Violation</b>			
The Demonstration will discourage individuals from committing an IPV by disqualifying individuals who commit an IPV.	Percentage of IPV's compared to a comparison group	Enrollment and IPV Lock-Out Data- eREP Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Housing Supports</b>			
The Demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Not Allowing Presumptive Eligibility</b>			
The demonstration will allow individuals to enroll retroactively covering unforeseen hospital expenses at a rate equivalent to hospital presumptive eligibility pre-demonstration.	<ul style="list-style-type: none"> <li>• Pre-demonstration, proportion of enrollees enrolling through hospital presumptive eligibility plus retroactive enrollment.</li> <li>• Post demonstration, proportion of enrollees enrolling through retroactive enrollment.</li> </ul>	Medicaid Data Warehouse  eRep Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Premiums</b>			
Individuals sharing in the total cost of care by paying premiums will access preventive services at a rate equivalent or greater than individuals who do not pay premiums.	<ul style="list-style-type: none"> <li>• Number of prescriptions</li> <li>• Number of non-emergent ED visits</li> <li>• Number of cancer screenings</li> <li>• Number of well-care visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Non-emergent Use of the Emergency Room</b>			

Charging a surcharge for this service will decrease inappropriate use of the emergency room without impacting other health measures	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> <li>● Number of non-emergent ED visits</li> <li>● Number of cancer screenings</li> <li>● Number of well-care visit</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
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The State will test the following hypothesis if the relevant provisions of the waiver are activated by the State.

<b>Prospective Enrollment</b>			
The implementation of the proposal will generate cost savings over the term of the waiver.	<ul style="list-style-type: none"> <li>● Average cost per member in month of application for comparison group</li> <li>● Average cost per member in the first three eligible months after application for demonstration group and comparison group</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> <li>● Number of non-emergent ED visits</li> <li>● Number of cancer screenings</li> <li>● Number of well-care visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Elimination of Retroactive Eligibility</b>			
The implementation of the proposal will generate cost savings over the term of the waiver.	<ul style="list-style-type: none"> <li>● Average cost per member in retro months prior to application for comparison group</li> <li>● Average cost per member in the</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

	first three eligible months after application for demonstration group and comparison group		
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> <li>● Number of non-emergent ED visits</li> <li>● Number of cancer screenings</li> <li>● Number of well-care visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

In addition to the data outlined above, the State will also gather HEDIS and CAHPS data to evaluate the overall well-being of this population group.

#### Section IV. Demonstration Benefits and Cost Sharing Requirements

Individuals eligible under this demonstration will receive benefits as listed in table 4 below. Note that the housing related supports and services will be available to specific waiver populations, as outlined in the “Housing Related Supports and Services” section above.

**Table 4- Eligibility Group and Benefit Package**

Eligibility Group	Benefit Package
Adults with Dependent Children	<ul style="list-style-type: none"> <li>● Non-Traditional Benefits (see description below)</li> </ul>
Adults without Dependent Children	<ul style="list-style-type: none"> <li>● State Plan Benefits</li> </ul>
ESI Eligible Adults with Dependent Children	<ul style="list-style-type: none"> <li>● Premium Reimbursement with Non-Traditional Benefit Wrap-around</li> </ul>
ESI Eligible Adults without Dependent Children	<ul style="list-style-type: none"> <li>● Premium Reimbursement with State Plan Benefit Wrap-around</li> </ul>
Medically Frail	<ul style="list-style-type: none"> <li>● Adults with Dependent Children normally receive non-traditional benefits, but may choose traditional state plan benefits</li> </ul>
Targeted Adults	<ul style="list-style-type: none"> <li>● State Plan Benefits</li> <li>● State plan dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special</li> </ul>



	Terms & Conditions of the 1115 Demonstration Waiver) <ul style="list-style-type: none"> <li>● 12-months continuous eligibility</li> </ul>
Housing Related Services and Supports for Individuals Meeting Needs Based Criteria	<ul style="list-style-type: none"> <li>● Tenancy Support Services</li> <li>● Community Transition Services</li> <li>● Supportive Living/Housing Services</li> </ul>

### Non-Traditional Benefit Package

Adults with dependent children will receive the State’s non-traditional benefit package, authorized under the State’s 1115 Demonstration Waiver. This benefit package contains most of the services covered under Utah’s Medicaid state plan according to the limitations specified in the state plan. This benefit package is reduced from that available under the state plan as detailed in the table 5 below.

**Table 5- Benefits Different from State Plan**

Service	Special Limitations for the Non-traditional Benefit
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.

### Medically Frail

As stated above, Adult Expansion beneficiaries will receive either traditional state plan Medicaid benefits if they do not have a dependent child living in the home, or they will receive non-traditional Medicaid benefits if they do have a dependent child living in the home. However, if an Adult Expansion beneficiary with a dependent child at home is identified as medically frail, as defined by 42 CFR 440.315, they may choose between traditional state plan Medicaid benefits or non-traditional Medicaid benefits, as authorized under the State’s 1115 Demonstration Waiver.

An individual is medically frail, as defined by 42 CFR 440.315, if the individual has a:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
- Disability determination based on Social Security criteria

### Premiums

With this amendment, the State is proposing to implement monthly premiums for individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL. Monthly premiums will be set at the following amounts regardless of household size or household income.

- \$20 per month for a single individual
- \$30 per month for a married couple

Under the authority granted to the State through this waiver, the State requests the ability to raise these premium amounts to mirror annual increases in the federal poverty level through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

Premiums will not be charged for the month of application or any months of retroactive coverage. Premiums must be paid in the month prior to the month of eligibility to avoid disenrollment. Failure to pay the required premium will result in loss of eligibility for Adult Expansion Medicaid.

#### *Premium Exemptions*

The following individuals are exempt from paying premiums:

- Individuals with verified membership in a federally recognized tribe
- Individuals identified as medically frail, as described in 42 CFR 440.315

Individuals who receive ESI reimbursements will have premiums deducted from their ESI reimbursement amount.

The total of the individual's or couple's premium amount and any applicable copayments will not exceed 5 percent of the household's income, per 42 CFR 447.56(f).

#### *Payment of Past Due Premiums after Losing Eligibility*

Individuals who have been disenrolled for failure to pay premiums will be required to pay any past due premiums in order to reinstate Medicaid. However, if it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

#### *Impact to Beneficiaries*

The State estimates approximately 40,000 individuals will be required to pay a monthly premium to receive Adult Expansion Medicaid. Based on other State's experiences with premiums, the State estimates approximately three percent of these individuals will lose eligibility due to failure to pay the monthly premium.

#### *Surcharge for Non-Emergent Use of the Emergency Department*

In order to discourage inappropriate use of the emergency department, Utah is proposing to apply a surcharge directly to the individual's premium, rather than increasing the copay for non-emergent use of the emergency department as originally suggested in the draft waiver proposal released in September 2019. Because emergency room copays are implemented as a reimbursement decrease to hospitals and it is unclear whether or not hospitals would collect these enhanced copays from individuals, the State determined that a premium surcharge for inappropriate use of the emergency room would be a better way to implement this provision. The State is proposing a \$10 surcharge for each non-emergent use of the emergency department, up to a maximum of \$30 per quarter, per individual. This surcharge will only apply to individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL.

After the State identifies the first occurrence of non-emergent use of the emergency department, the individual will be sent notification regarding improper use. They will be informed that improper use has occurred, provided with education on appropriate usage of the emergency department, and notified of the

surcharges that will follow if improper use continues. They will be informed that future non-emergent visits to the emergency department will incur a \$10 surcharge (up to a maximum of \$30 per quarter, per individual).

If a future inappropriate visit is identified, a \$10 surcharge per occurrence will be added to their premium amount with their next premium invoice. They will again receive notification of their improper use of the emergency department, as well as education on how to correctly utilize their Medicaid benefits.

All notices sent to the individual will include the right to appeal the surcharge. All hearings in regards to the surcharge will be conducted by the UDOH administrative law judges, rather than the Department of Workforce Services eligibility hearing officers.

Individuals with five or more occurrences of non-emergent use of the emergency department within the most recent twelve months will be referred to the Medicaid Restriction Program. The Restriction Program may take additional action, including limitations on where an individual may receive services. This restriction process is already in place for Medicaid members today.

#### *Surcharge Exemptions:*

This surcharge will not apply to the following:

1. An individual identified as medically frail
2. An individual receiving ESI reimbursement
3. A member of a federally recognized tribe

If an individual's eligibility ends or the individual moves to another program, the surcharge will be forgiven after 90 days. If the eligibility is ended for failure to pay premiums, the member must pay any outstanding premiums including any surcharges, before eligibility may be re-established.

#### *Impact to Beneficiaries*

The State estimates approximately 1,500 to 2,000 individuals per month will be required to pay a surcharge for non-emergent use of the emergency department.

#### *Cost Sharing*

*Cost Sharing for Individuals without ESI:* Cost sharing requirements provided under the State Plan will apply to Demonstration individuals who do not have ESI.

*Cost Sharing for ESI:* For ESI eligible individuals, the State will pay cost sharing imposed by the ESI up to the State Plan levels. ESI eligible individuals will have the same cost sharing that they would have under the State Plan. The State will pay such cost sharing directly to providers, provided that such providers are enrolled in the Medicaid program.

*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.

## Section V. Delivery System

Services for the Adult Expansion Population will be provided through FFS during the month of application and potentially the following month depending on the date of approval. In addition, Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the FFS network. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

Adult Expansion beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. In addition, in Utah's five largest counties, individuals in the Adult Expansion program will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity. In the remaining counties, beneficiaries will be enrolled in a pre-paid mental health plan for their behavioral health services.

### Individuals with Access to ESI

Demonstration individuals who receive ESI reimbursement will receive services through the delivery systems provided by their respective qualified plan for ESI. Wrap-around benefits provided by Medicaid will be delivered through FFS.

### Proposed Managed Care Flexibility

In Utah, approximately 83 percent of all Medicaid members are enrolled in an Accountable Care Organization (ACO) for their physical health benefits. Under federal regulation, these ACOs are comprehensive full risk managed care organizations (MCO) and are subject to extensive federal regulations at 42 CFR 438. Utah Medicaid ACOs must be licensed in the state of Utah and are regulated by the Department of Insurance pursuant to Title 31A Chapter 8 UCA.

In addition, more than 90 percent of all Medicaid Members are enrolled in Prepaid Mental Health Plans (PMHP) for behavioral health services. PMHPs are administered by county mental health and substance abuse authorities that are statutorily required to provide these services to the residents of their counties. Both ACOs and PMHPs were created under 1915(b) authority.

ACOs were implemented on January 1, 2013 in the four Wasatch Front counties. In July 2015 the ACO delivery system was extended to nine additional counties. ACOs are available in all other counties on a voluntary basis.

While containing cost is one measure of the effectiveness of the Utah Medicaid ACOs, containing costs cannot come at the risk of access to or quality of services. It also should not come at the unfair expense of other stakeholders. The use of managed care as a delivery system should also encourage improvements in the delivery of healthcare. To that end, from the onset of the ACO model, the Department's contract with each ACO includes specific requirements to comply with the reporting of HEDIS (Healthcare Effectiveness Data and Information Set) measures and to participate in CAHPS (Consumer Assessment of Healthcare Providers and Systems.)

Utah intends to use managed care as the primary service delivery system for populations covered under this waiver. As part of this amendment request, Utah is asking for greater flexibility and authority to use alternative approaches to come into compliance with 42 CFR 438 in the following areas. This will allow the State to administer its managed care delivery system upon approval of this waiver without delays related to additional federal approvals.

### *Demonstration of Actuarial Soundness of Rates*

The State is requesting authority to demonstrate actuarial soundness of managed care rates for groups covered by this waiver without prospective CMS review ordinarily required under 42 CFR 438.7(a). The State will submit a rate certification to CMS but will have authority to implement the rates and draw down federal funds prior to CMS review and final approval of the proposed rates for the populations covered under this waiver.

The State is working with its contracted actuary, Milliman, Inc. to determine actuarially sound rates for three specific populations within the waiver expansion group. The State has sufficient historical claims data for parents with dependent children. In addition, the State has more than a year of historical claims experience to establish rates for the Targeted Adult Medicaid group. For adults without dependent children, Milliman, Inc. has recommended that the state segment this group into at least two age bands 19-33 and 34-64. The actuary will use the Adults with Dependent Children, the Targeted Adult Medicaid group and expansion experience from other states to inform the creation of a rate for Adults Without Children. In addition, initially the rates will include a risk corridor based on a medical loss ratio specified in the plan contract.

The State intends to submit plan contracts and rates to CMS ninety (90) days prior to the contract /rate period. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, the State is requesting authority to make such changes effective the month following the month in which the State is notified of the change by CMS. The State is requesting that FMAP be available for any expenditures related to managed care rates paid to contractors from the date of waiver approval.

The State will submit subsequent modifications to rates to CMS prior to the intended effective date. The State is requesting authority to apply the same authority to subsequent contract amendments.

### *Flexibility in Managed Care Contract Review*

The State is requesting authority to have more flexibility in the administration of its managed care contracts for the populations covered under this waiver. The State will submit its initial contract to CMS for review and approval ninety (90) days prior to the contract /rate period. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by the Center for Medicaid and CHIP Services (CMCS) and the Office of the Actuary.

If any changes are required to either contract language or rates, the State is requesting authority to make such changes effective the month following the month in which the State is notified of the change by CMS. The State is requesting that FMAP be available for any expenditures related to contracts from the date of waiver approval.

The State will submit subsequent contract amendments to CMS prior to the intended effective date. The State is requesting authority to apply the same authority to subsequent contract amendments.

### *Demonstration of Directed Payment Compliance*

The State is requesting authority to implement directed payments which are included in the contracts and rates pertaining to the population groups covered under this waiver consistent with the requirements of 42 CFR 438.6(c) prior to formal approval from CMS. The State intends to submit any new or updated Directed

Payment 438.6(c) templates ninety (90) days prior to the contract /rate period. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, such changes will go into effect the month following the month in which the State is notified of the change. The State is requesting that FMAP be available for any directed payments made to providers from the date of waiver approval.

#### *Access to Care and Availability of Services*

The State is requesting authority to adopt an approach to network adequacy, access to care, and availability of services. The State is currently incorporating standards into its current managed care contracts based on time and distance as well as provider type, to determine the sufficiency of a plan's network. As part of the initial readiness review of managed care contracts covering the populations under this waiver, the State will validate the adequacy of each plan's network based on established standards. The State will conduct an annual review of these standards for each plan.

In addition, the State has a Constituent Services/Access to Care Monitoring tool. This tool is used to capture all constituent complaints, including access to care complaints. The State monitors access to care on an ongoing basis. The State will also rely on direct measures of access such as consumer and secret shopper surveys to demonstrate satisfactory access. Utah managed care plans are required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for all Medicaid eligible populations.

## **Section VI. Enrollment in Demonstration**

### *Individuals Currently Eligible for Medicaid*

Individuals currently enrolled in the Adult Expansion Population under Utah's 1115 Demonstration waiver will remain as the Adult Expansion Population under the new demonstration. These individuals will be notified of any benefit changes or new program requirements. When the State elects to enroll the Adult Expansion group in managed care, enrollment in managed care plans for the Demonstration group will occur as it does for those covered under the State plan.

### *Individuals Eligible for ESI Reimbursement*

As approved in the March 29, 2019, amendment to Utah's 1115 Demonstration waiver, Adult Expansion beneficiaries that have access to, or are enrolled in, a qualified ESI will receive premium reimbursement for the cost of the eligible individual's premium amount. ESI eligible individuals will be notified of the following:

- Eligibility for ESI reimbursement
- Requirement to purchase their ESI plan, if not already enrolled
- Availability of wrap-around benefits, including cost sharing protections
- Failure to purchase or maintain the ESI plan will result in ineligibility for Medicaid

If an individual voluntarily disenrolls from the ESI coverage, the individual will become ineligible for Medicaid coverage under this Demonstration. If the individual involuntarily disenrolls from the ESI plan, such as when the plan no longer meets the criteria for a qualified health plan, the individual will remain enrolled in the Demonstration and will receive direct Medicaid coverage.

### Individuals Currently Enrolled in the Federal Marketplace

When the State has expanded to 133 percent of FPL, individuals enrolled in Federal Marketplace coverage will need to request a Medicaid determination through the Federal Marketplace or apply directly with the State for Medicaid coverage. Individuals enrolled in the Federal Marketplace at that time will not be automatically moved or assessed for Medicaid eligibility until their coverage is renewed, the individual requests a Medicaid determination, or applies directly with the State. Once eligible for Medicaid the individual should terminate their marketplace plan within 30 days.

Until such time that the Federal Marketplace can update their systems to automate the assessment of Utah eligibility standards and transfer accounts to the State directly, Utahns applying for health coverage through the Federal Marketplace will also have to apply directly for Medicaid with the State. Once the federal system changes have been made, new marketplace applicants may be assessed as eligible for Medicaid and their applications will be automatically referred to the State for processing eligibility.

### Section VII. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality -Attachment 1 for the State's historical and projected expenditures for the requested period of the Demonstration.

Table 6 shows the projected demonstration enrollees in each demonstration year (DY). These enrollment projections include members in the demonstrations included in this amendment.

<b>Enrollment</b>	<b>DY 18<sup>4</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	14,000	14,350	14,709
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	9,779	10,292	10,832
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	30,946	32,570	34,280
<b>Annual Total</b>	<b>116,458</b>	<b>120,489</b>	<b>124,680</b>

Table 6

Table 7 shows the projected demonstration expenditures in each demonstration year (DY). These amounts are calculated by applying the estimated per member per month estimates in the Budget Neutrality attachment to the enrollment figures from Table 6.

<b>Expenditures (Total Fund)</b>	<b>DY 18<sup>5</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	\$127,914,000	\$276,122,000	\$298,026,000
Expansion Parents up to 100% FPL	\$114,116,000	\$246,336,000	\$265,877,000

<sup>4</sup>Reflects anticipated average enrollment January 2020 through June 2020

<sup>5</sup> Reflects anticipated total expenditures January 2020 through June 2020



Expansion Parents above 100% FPL up to 133% FPL	\$38,541,000	\$85,430,000	\$94,680,000
Expansion Adults without Children up to 100% FPL	\$187,889,000	\$405,586,000	\$437,759,000
Expansion Adults without Children above 100% FPL up to 133% FPL	\$170,956,000	\$378,934,000	\$419,966,000
<b>Annual Total</b>	<b>\$639,416,000</b>	<b>\$1,392,408,000</b>	<b>\$1,516,308,000</b>

Table 7

Table 8 shows the projected enrollees under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

<b>Enrollment</b>	<b>DY 18<sup>6</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Former Targeted Adults	13,283	13,615	13,955
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	8,841	9,306	9,794
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	27,980	29,449	30,995
<b>Annual Total</b>	<b>111,837</b>	<b>115,647</b>	<b>119,603</b>

Table 8

Table 9 shows the projected expenditures under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

<b>Expenditures (Total Fund)</b>	<b>DY 18<sup>7</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	\$102,102,000	\$220,403,000	\$237,886,000
Expansion Parents up to 100% FPL	\$108,842,000	\$234,951,000	\$253,589,000
Expansion Parents above 100% FPL up to 133% FPL	\$33,201,000	\$73,592,000	\$81,561,000
Expansion Adults without Children up to 100% FPL	\$180,244,000	\$389,083,000	\$419,947,000
Expansion Adults without Children above 100% FPL up to 133% FPL	\$148,170,000	\$328,428,000	\$363,991,000
<b>Annual Total</b>	<b>\$572,559,000</b>	<b>\$1,246,457,000</b>	<b>\$1,356,974,000</b>

Table 9

### Section VIII. Proposed Waivers and Expenditure Authorities

The State requests the following waivers and expenditure authorities to operate the demonstration.

<sup>6</sup>Reflects anticipated average enrollment January 2020 through June 2020

<sup>7</sup> Reflects anticipated total expenditures January 2020 through June 2020

Waiver Authority	Reason and Use of Waiver
Section 1902(a)(10) and (a)(52)- Eligibility	To the extent necessary to enable the State to prohibit re-enrollment and deny eligibility for the Medicaid Expansion for a period of six months for individuals who commit an intentional program violation.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Medicaid Expansion beneficiaries compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide housing supports and services.
Section 1902(a)(1)- Statewide Operation	To the extent necessary to enable the State to implement housing supports in geographically limited areas of the state.
Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	<p>To the extent necessary to enable the State to suspend eligibility for, and not make medical assistance available to beneficiaries subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs.</p> <p>To the extent necessary to enable the state to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.</p>
Section 1906(i)(26)- Compliance with ABP Requirements	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.
Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A	To the extent necessary to enable the State to require monthly premiums for individuals in the Adult Expansion Population who have household income above 100 up to and including 133 percent of the FPL.

Table 10

**Expenditures**

*Adult Expansion Demonstration Group:* 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.

*Housing Services and Supports:* Expenditures to provide housing services and supports that would not otherwise be matchable under Section 1903.

## **Section IX. Compliance with Public Notice and Tribal Consultation**

### *Public Notice Process*

The State certifies that public notice of the State's request of this demonstration amendment, and notice of public hearing were advertised in the newspapers of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice and full public notice were posted on the State's Medicaid website at <https://medicaid.utah.gov/1115-waiver>.

The State certifies that two public hearings to take public comment on this request were held. The first public hearing was held on October 7, 2019, from 4:00 p.m. to 6:00 p.m., at the Multi-Agency State Office Building, located at 195 N 1950 W, Salt Lake City, UT. The second public hearing was held on October 10, 2019, from 2:00 p.m. to 4:00 p.m. during the Medical Care Advisory Committee (MCAC) meeting, at the Cannon Health Building located at 288 N 1460 W, Salt Lake City, UT. Telephonic conferencing was available for both public hearings.

### *Public Comment*

The State accepted public comment during a 30-day public comment period, which was held September 27, 2019 through October 27, 2019. The State received comments from 99 individuals and agencies. This includes comments provided during both public hearings, email and online portal comments, and mailed comments. The State reviewed and considered all public comments received.

The majority of commenters did not agree with the State's request to implement most components of the amendment. They expressed concerns with the impacts of the following proposals, including; intentional program violation lock-out, community engagement requirement, enrollment limits, waiving the EPSDT requirement for 19 and 20 year olds, and not allowing hospitals to make presumptive eligibility determinations. They believe these components will lead to a loss of coverage for individuals who would otherwise be eligible for Medicaid benefits or assistance, if not for these provisions.

Commenters were generally supportive of providing housing supports and services.

Commenters also expressed concerns regarding the State's proposed hypotheses for evaluating and monitoring the demonstration. They believed the proposed waiver hypotheses and evaluation framework fail to address the impact of several significant risks and potential changes to Utah's Medicaid program. In response to this concern, the State will work with the independent evaluator with whom the State contracts, to refine or possibly amend the proposed hypotheses, and to develop an evaluation plan. The State has also committed to engage the MCAC in the evaluation process.

In response to concerns regarding the \$25 copay for non-emergent use of the emergency department, the State is removing this request from the amendment. However, the State is proposing to apply a \$10 surcharge per occurrence to the individual's premium amount (up to a maximum of \$30 per quarter, per individual), for individuals who improperly use the emergency department. Information regarding this proposal can be found in section IV.

### Tribal Consultation

In accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. The State notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, the State began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on October 11, 2019, to present this demonstration amendment.

The Navajo Nation submitted a letter during the public comment period that contained several concerns and requests. They are as follows:

### Tribal Consultation

The Navajo Nation states that the Tribal consultation with the Tribal Leaders is occurring in November, after the waiver is submitted.

**Response:** As stated above, in accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. Tribal Consultation policy can be found at <http://health.utah.gov/indianh/pdfs/2017ConsultationPolicy.pdf>. The State complied with the consultation policy in developing this waiver request. The State began the Tribal consultation process by presenting an overview of the waiver amendment to the UIHAB on October 11, 2019. After reviewing this proposal with the UIHAB and answering questions, Nate Checketts, Utah Medicaid Director, offered to provide additional Tribal consultation prior to the anticipated submission date at the end of October 2019. It was explained that the public comment period and waiver submission date do not always align with Tribal meetings. Members of the UIHAB gave no indication that additional consultation was needed prior to waiver submission. The UIHAB moved to have Nate Checketts participate in a Tribal Leader meeting on November 8th to present the waiver amendment. Nate Checketts agreed to participate in this meeting.

### Exemption Requests

The Navajo Nation recommends the requested exemption for members of a federally recognized Tribe from the community engagement requirement, enrollment limit, and ESI requirement, also apply to all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

**Response:** During the State's discussion with CMS regarding allowing an exemption, it was brought to the State's attention that the Office of Civil Rights has concerns with the exemption applying to all AI/AN persons, as it could raise civil rights concerns. This concern was also stated in a CMS letter to Tribal Leaders dated January 17, 2018. Based on this, the State proposed allowing the exemption for members of federally recognized tribes, which CMS has found to be consistent with the tribes' status as political entities. This request was approved by CMS for the community engagement requirement. As such, the State is requesting this same exemption apply to the request for an enrollment limit and the ESI requirement.

### Increase in Income Limit

The Navajo Nation recommends the increase to 138 percent at a minimum, but should further increase to 200 percent FPL, and it should apply for all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

**Response:** Under the Affordable Care Act, the State can only increase the income to 133 percent of the FPL, which the State intends to do. Senate Bill 96 also limits the FPL that UDOH can request in this waiver.

### Housing Related Services and Supports (HRSS)

The Navajo Nation recommends clarity of the rulemaking process and any changes should not be at the expense of other services approved and proposed in the amendment for the targeted adult group.

**Response:** Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all Medicaid rulemaking during the monthly UIHAB meeting, as well as the MCAC, which are both open to the public.

### Targeted Adult Medicaid Subgroups

The Navajo Nation recommends continuous coverage for 12 months; however, they oppose the ability for the state to suspend enrollment.

**Response:** The State currently has approval to suspend enrollment for Targeted Adult Medicaid. The State is requesting to continue this authority, and to apply this authority to the individual subgroups. If an individual is ineligible for the Targeted Adult Medicaid program due to enrollment being suspended, eligibility for Adult Expansion Medicaid will be determined.

### Flexibility to Make Changes through the State Administrative Rulemaking Process

The Navajo Nation recommends the state to conduct timely and proper Tribal Consultation to Tribal leaders in Utah. They recommend the State remove these provisions prior to submission to CMS.

**Response:** The State intends to follow the consultation process during the rulemaking process for any policy changes. This is currently the State's process, and this will continue.

### Managed Care Delivery:

The Navajo Nation recommends an exemption for federally recognized Tribes regardless of where the beneficiaries reside and it should apply to all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Navajos commute between non-mandatory and mandatory counties; therefore, increasing access to ACOs and/or non-ACOs is recommended based on existing health care access challenges.

**Response:** Services provided at an I/T/U are exempt (carved out) from managed care. All services provided by an I/T/U are billed directly to State Medicaid. An AI/AN individual can be enrolled in managed care and still receive services at an I/T/U. The I/T/U does not have to be on an ACOs network,

### Tribal Consultation Policy

Per UDOH Tribal Consultation Policy, the consultation process will include, but is not limited to:

- An initial meeting to present the intent and broad scope of the policy and waiver application to the UIHAB.
- Discussion at the UIHAB meeting to more fully understand the specifics and impact of the proposed policy initiation or change;
- Open meeting for all interested parties to receive information or provide comment;

- A presentation by tribal representatives of their concerns and the potential impact of the proposed policy;
- Continued meetings until concerns over intended policy have been fully discussed;
- A written response from the Department of Health to tribal leaders as to the action on, or outcome of tribal concerns.

Tribal consultation policy can be found at <http://health.utah.gov/indianh/consultation.html>.

#### **Section X. Demonstration Administration**

Name and Title: Nate Checketts, Deputy Director, Utah Department of Health

Telephone Number: (801) 538-6689

Email Address: [nchecketts@utah.gov](mailto:nchecketts@utah.gov)

## ATTACHMENT 1

### **Compliance with Budget Neutrality Requirements**



DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
<b>Current Eligibles</b>										
<i>Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19</i>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months	0.0%	0	377,866	0.0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	5.3%	0	\$ 949.03	5.3%	\$ 999.33	\$ 1,052.29	\$ 1,108.07	\$ 1,166.79	\$ 1,228.63	
Total Expenditure					\$ 377,612,830	\$ 383,420,334	\$ 355,641,571	\$ 372,830,227	\$ 390,798,881	\$ 1,880,303,842
<b>Demo Pop I - PCN Adults with Children</b>										
<i>PCN ends 3/31/19</i>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months	5.9%	0	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	5.3%	0	\$ 46.18	5.3%	\$ 48.63	\$ 51.21	\$ 53.92	\$ 56.78	\$ 59.79	
Total Expenditure					\$ 5,399,987	\$ 4,517,106	\$ -	\$ -	\$ -	\$ 9,917,093
<b>Demo Pop III/V - UPP Adults with Children</b>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months	34.9%	0	6,067	34.9%	8,182	11,034	14,881	20,068	27,064	
PMPM Cost	5.3%	0	\$ 150.08	5.3%	\$ 158.03	\$ 166.41	\$ 175.23	\$ 184.52	\$ 194.30	
Total Expenditure					\$ 1,293,029	\$ 1,836,200	\$ 2,607,542	\$ 3,702,908	\$ 5,258,410	\$ 14,698,089
<b>Demo Pop I - PCN Childless Adults</b>										
<i>PCN ends 3/31/19</i>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	\$ 51.57	\$ 54.30	\$ 57.18	\$ 60.21	\$ 63.40	
Total Expenditure					\$ 3,806,153	\$ 3,165,223	\$ -	\$ -	\$ -	\$ 6,971,376
<b>Demo Pop III/V - UPP Childless Adults</b>										
<b>Pop Type: Medicaid</b>										
Eligible Member Months	159	0		2.5%	163	167	171	176	180	
PMPM Cost	68.45	0		5.3%	\$ 72.08	\$ 75.90	\$ 79.92	\$ 84.16	\$ 88.62	
Total Expenditure					\$ 10,702	\$ 11,237	\$ 11,799	\$ 12,388	\$ 13,008	\$ 59,133
<b>Targeted Adults</b>										
<i>Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment. PMPM will increase due to adding the housing support benefit and new managed care directed payments</i>										
<b>Pop Type: Expansion</b>										
<i>Started 11/1/17</i>										
Eligible Member Months		0	0	2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost		0	\$ -	5.3%	\$ 979.53	\$ 1,031.45	\$ 1,522.79	\$ 1,603.50	\$ 1,688.48	
Total Expenditure					\$ 76,403,340	\$ 80,452,717	\$ 191,871,540	\$ 276,122,333	\$ 298,025,737	\$ 922,875,668
<b>Dental - Targeted Adults</b>										
<i>Started 3/1/19 Porcelain crowns anticipated start date of 1/1/20 increases PMPM</i>										
<b>Pop Type: Expansion</b>										
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	\$ -	\$ 33.33	\$ 37.27	\$ 39.24	\$ 41.32	
Total Expenditure					\$ -	\$ 400,000	\$ 1,375,111	\$ 1,484,192	\$ 1,601,925	\$ 4,861,228
<b>System of Care</b>										
<i>Anticipated start date of 1/1/20</i>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months		0		5.3%	-	720	1,440	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	\$ -	\$ 2,100.00	\$ 2,211.30	\$ 2,328.50	\$ 2,328.50	
Total Expenditure					\$ -	\$ 1,512,000	\$ 3,184,272	\$ 3,353,038	\$ 3,353,038	\$ 8,049,310
<b>Dental - Blind/Disabled</b>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			\$ 18.42	\$ 18.97	\$ 19.54	\$ 20.13	\$ 20.73	
Total Expenditure					\$ 7,595,690	\$ 7,823,560	\$ 8,058,267	\$ 8,300,015	\$ 8,549,016	\$ 40,326,548
<b>Dental - Aged</b>										
<i>Anticipated start date of 1/1/20</i>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months	2.5%	0	108,000			54,000	110,700	113,468		
PMPM Cost	5.3%	0				\$ 30.75	\$ 32.38	\$ 34.10		
Total Expenditure					\$ -	\$ -	\$ 1,660,500	\$ 3,584,438	\$ 3,868,774	\$ 9,113,712
<b>Former Foster</b>										
<b>Pop Type: Hypothetical</b>										



DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			\$ 990.87	\$ 1,038.43	\$ 1,088.28	\$ 1,140.51	\$ 1,195.26	
Total Expenditure					\$ 9,909	\$ 10,384	\$ 10,883	\$ 11,405	\$ 11,953	\$ 54,534
<b>Substance Use Disorder (SUD)</b>										
<b>Pop Type: Hypothetical</b>										
Eligible Member Months	6.9%	18	36,913	6.9%	39,456.31	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18		5.0%	\$ 3,321.96	\$ 3,488.06	\$ 3,662.46	\$ 3,845.58	\$ 4,037.86	
Total Expenditure					\$ 131,072,269	\$ 147,108,390	\$ 148,527,403	\$ 166,698,858	\$ 187,093,676	\$ 780,500,596
<b>Withdrawal Management</b>										
<b>Pop Type: Hypothetical</b>										
Started 5/1/19										
Eligible Member Months	0.0%	0	4,018	0.0%	670		4,018	4,018	4,018	
PMPM Cost	5.0%	0		5.0%	\$ -	\$ 700.00	\$ 735.00	\$ 771.75	\$ 810.34	
Total Expenditure					\$ -	\$ 468,738	\$ 2,953,046	\$ 3,100,699	\$ 3,255,733	\$ 9,778,216
<b>Expansion Parents &lt;=100% FPL</b>										
<b>Pop Type: Expansion</b>										
Assumes start date of 1/1/20										
Eligible Member Months	2.5%		339,828	2.5%	-	169,914	348,324	357,032		
PMPM Cost	5.3%			5.3%	\$ -	\$ 671.61	\$ 707.21	\$ 744.69		
Total Expenditure					\$ -	\$ 114,115,918	\$ 246,336,326	\$ 265,876,956	\$ 626,329,200	
<b>Expansion Adults w/out Dependent Children &lt;=100% FPL</b>										
<b>Pop Type: Expansion</b>										
Assumes start date of 1/1/20										
Eligible Member Months	2.5%		400,973	2.5%	-	200,487	410,997	421,272		
PMPM Cost	5.3%			5.3%	\$ -	\$ 937.16	\$ 986.83	\$ 1,039.13		
Total Expenditure					\$ -	\$ 187,887,968	\$ 405,584,361	\$ 437,757,341	\$ 1,031,229,669	
<b>Expansion Parents 101-133% FPL</b>										
<b>Pop Type: Expansion</b>										
Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premium										
Eligible Member Months	5.25%		121,473	5.25%	-	58,671	123,503	129,987		
PMPM Cost	5.3%			5.3%	\$ -	\$ 656.90	\$ 691.72	\$ 728.38		
Total Expenditure					\$ -	\$ 38,541,205	\$ 85,429,087	\$ 94,679,562	\$ 218,649,854	
<b>Expansion Adults w/out Dependent Children 101-133% FPL</b>										
<b>Pop Type: Expansion</b>										
Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premium										
Eligible Member Months	5.25%		384,418	5.25%	-	185,674	390,844	411,363		
PMPM Cost	5.3%			5.3%	\$ -	\$ 920.73	\$ 969.53	\$ 1,020.91		
Total Expenditure					\$ -	\$ 170,955,560	\$ 378,934,111	\$ 419,966,044	\$ 969,855,715	

Start date of 5/1/19 (2 months of SFY19)

Assumes start date of 1/1/2020 (SFY20)

\$ 6,533,573,782

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
<b>Current Eligibles</b>			<i>Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19</i>					
<b>Pop Type:</b>	<b>Medicaid</b>							
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	\$ 949.03	5.3%	\$ 999.33	\$ 1,052.29	\$ 1,108.07	\$ 1,166.79	\$ 1,228.63	
Total Expenditure			\$ 377,612,830	\$ 383,420,334	\$ 355,641,571	\$ 372,830,227	\$ 390,798,881	\$ 1,880,303,842
<b>Demo Pop I - PCN Adults w/Children</b>			<i>PCN ends 3/31/19</i>					
<b>Pop Type:</b>	<b>Hypothetical</b>							
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	\$ 46.18	5.3%	\$ 48.63	\$ 51.21	\$ 53.92	\$ 56.78	\$ 59.79	
Total Expenditure			\$ 5,399,987	\$ 4,517,106	\$ -	\$ -	\$ -	\$ 9,917,093
<b>Demo Pop III/V - UPP Adults with Children</b>								
<b>Pop Type:</b>	<b>Hypothetical</b>							
Eligible Member Months	6,067	34.9%	8,182	11,034	14,881	20,068	27,064	
PMPM Cost	\$ 150.08	5.3%	\$ 158.03	\$ 166.41	\$ 175.23	\$ 184.52	\$ 194.30	
Total Expenditure			\$ 1,293,029	\$ 1,836,200	\$ 2,607,542	\$ 3,702,908	\$ 5,258,410	\$ 14,698,089
<b>Demo Pop I - PCN Childless Adults</b>			<i>PCN ends 3/31/19</i>					
<b>Pop Type:</b>	<b>Medicaid</b>							
Eligible Member Months	70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost	\$ 48.97	5.3%	\$ 51.57	\$ 54.30	\$ 57.18	\$ 60.21	\$ 63.40	
Total Expenditure			\$ 3,806,153	\$ 3,165,223	\$ -	\$ -	\$ -	\$ 6,971,376
<b>Demo Pop III/V - UPP Childless Adults</b>								
<b>Pop Type:</b>	<b>Medicaid</b>							
Eligible Member Months	159	4.9%	167	175	184	193	202	
PMPM Cost	\$ 68.45	5.3%	\$ 72.08	\$ 75.90	\$ 79.92	\$ 84.16	\$ 88.62	
Total Expenditure			\$ 10,702	\$ 11,237	\$ 11,799	\$ 12,388	\$ 13,008	\$ 59,133
<b>Targeted Adults</b>			<i>Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.</i>					
<b>Pop Type:</b>	<b>Expansion</b>		<i>Started 11/1/17</i>					
Eligible Member Months		2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost		5.3%	\$ 979.53	\$ 1,031.45	\$ 1,522.79	\$ 1,603.50	\$ 1,688.48	
Total Expenditure			\$ 76,403,340	\$ 80,452,717	\$ 191,871,540	\$ 276,122,333	\$ 298,025,737	\$ 922,875,668
<b>Dental - Targeted Adults</b>			<i>Started 3/1/19 Porcelain crowns anticipated start date of 1/1/20 increases PMPM</i>					
<b>Pop Type:</b>	<b>Expansion</b>							
Eligible Member Months		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost		5.3%	\$ -	\$ 33.33	\$ 37.27	\$ 39.24	\$ 41.32	
Total Expenditure			\$ -	\$ 400,000	\$ 1,375,111	\$ 1,484,192	\$ 1,601,925	\$ 4,861,228
<b>System of Care</b>			<i>Anticipated start date of 1/1/20</i>					
<b>Pop Type:</b>	<b>Hypothetical</b>							
Eligible Member Months			-	720	1,440	1,440		
PMPM Cost		5.3%	\$ -	\$ 2,100	\$ 2,211	\$ 2,328		
Total Expenditure			\$ -	\$ 1,512,000	\$ 3,184,272	\$ 3,353,038	\$ 8,049,310	
<b>Dental - Blind/Disabled</b>								
<b>Pop Type:</b>	<b>Hypothetical</b>							
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	\$ 18.42	\$ 18.97	\$ 19.54	\$ 20.13	\$ 20.73	
Total Expenditure			\$ 7,595,690	\$ 7,823,560	\$ 8,058,267	\$ 8,300,015	\$ 8,549,016	\$ 40,326,548
<b>Dental - Aged</b>								

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
<b>Hypothetical</b>			<i>Anticipated start date of 1/1/20</i>					
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	\$ -	\$ -	\$ 30.75	\$ 32.38	\$ 34.10	
Total Expenditure			\$ -	\$ -	\$ 1,660,500	\$ 3,584,438	\$ 3,868,774	\$ 9,113,712
<b>Former Foster Care</b>								
<b>Hypothetical</b>								
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	\$ 990.87	\$ 1,038.43	\$ 1,088.28	\$ 1,140.51	\$ 1,195.26	
Total Expenditure			\$ 9,909	\$ 10,384	\$ 10,883	\$ 11,405	\$ 11,953	\$ 54,534
<b>Substance Use Disorder (SUD)</b>								
<b>Hypothetical</b>								
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	\$ 3,321.96	\$ 3,488.06	\$ 3,662.46	\$ 3,845.58	\$ 4,037.86	
Total Expenditure			\$ 131,072,269	\$ 147,108,390	\$ 148,527,403	\$ 166,698,858	\$ 187,093,676	\$ 780,500,596
<b>Withdrawal Management</b>								
<b>Hypothetical</b>			<i>Started 5/1/19</i>					
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	\$ -	\$ 700.00	\$ 735.00	\$ 771.75	\$ 810.34	
Total Expenditure			\$ -	\$ 468,738	\$ 2,953,046	\$ 3,100,699	\$ 3,255,733	\$ 9,778,216
<b>Expansion Parents &lt;=100% FPL</b>								
<b>Expansion</b>			<i>Assumes start date of 1/1/20</i>					
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	\$ -	\$ -	\$ 671.61	\$ 707.21	\$ 744.69	
Total Expenditure			\$ -	\$ -	\$ 114,115,918	\$ 246,336,326	\$ 265,876,956	\$ 626,329,200
<b>Expansion Adults w/out Dependent Children &lt;=100% FPL</b>								
<b>Expansion</b>			<i>Assumes start date of 1/1/20</i>					
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	\$ -	\$ -	\$ 937.16	\$ 986.83	\$ 1,039.13	
Total Expenditure			\$ -	\$ -	\$ 187,887,968	\$ 405,584,361	\$ 437,757,341	\$ 1,031,229,669
<b>Expansion Parents 101-133% FPL</b>								
<b>Expansion</b>			<i>Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums</i>					
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	\$ -	\$ -	\$ 656.90	\$ 691.72	\$ 728.38	
Total Expenditure			\$ -	\$ -	\$ 38,541,205	\$ 85,429,087	\$ 94,679,562	\$ 218,649,854
<b>Expansion Adults w/out Dependent Children 101-133% FPL</b>								
<b>Expansion</b>			<i>Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums</i>					
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	\$ -	\$ -	\$ 920.73	\$ 969.53	\$ 1,020.91	
Total Expenditure			\$ -	\$ -	\$ 170,955,560	\$ 378,934,111	\$ 419,966,044	\$ 969,855,715

Start date of 5/1/19 (2 months of SFY19) \$ 6,533,573,782


Assumes start date of 1/1/2020 (SFY20)


**DEMONSTRATION WITH WAIVER (WW NONE) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
<b>Current Eligibles</b>								
<b>Pop Type:</b> Medicaid		Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19						
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	\$ 949.03	5.3%	\$ 999.33	\$ 1,052.29	\$ 1,108.07	\$ 1,166.79	\$ 1,228.63	
Total Expenditure			\$ 377,612,830	\$ 383,420,334	\$ 355,641,571	\$ 372,830,227	\$ 390,798,881	
							\$ 1,880,303,842	
<b>Demo Pop I - PCN Adults w/Children</b>								
<b>Pop Type:</b> Hypothetical		PCN ends 3/31/19						
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	\$ 46.18	5.3%	\$ 48.63	\$ 51.21	\$ 53.92	\$ 56.78	\$ 59.79	
Total Expenditure			\$ 5,399,987	\$ 4,517,106	\$ -	\$ -	\$ -	
							\$ 9,917,093	
<b>Demo Pop III/V - UPP Adults with Children</b>								
<b>Pop Type:</b> Hypothetical								
Eligible Member Months	6,067	34.9%	\$ 8,182	\$ 11,034	\$ 14,881	\$ 20,068	\$ 27,064	
PMPM Cost	\$ 150.08	5.3%	\$ 158.03	\$ 166.41	\$ 175.23	\$ 184.52	\$ 194.30	
Total Expenditure			\$ 1,293,029	\$ 1,836,200	\$ 2,607,542	\$ 3,702,908	\$ 5,258,410	
							\$ 14,698,089	
<b>Demo Pop I - PCN Childless Adults</b>								
<b>Pop Type:</b> Medicaid		PCN ends 3/31/19						
Eligible Member Months	70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost	\$ 48.97	5.3%	\$ 51.57	\$ 54.30	\$ 57.18	\$ 60.21	\$ 63.40	
Total Expenditure			\$ 3,806,153	\$ 3,165,223	\$ -	\$ -	\$ -	
							\$ 6,971,376	
<b>Demo Pop III/V - UPP Childless Adults</b>								
<b>Pop Type:</b> Medicaid								
Eligible Member Months	159	4.9%	167	175	184	193	202	
PMPM Cost	\$ 68.45	5.3%	\$ 72.08	\$ 75.90	\$ 79.92	\$ 84.16	\$ 88.62	
Total Expenditure			\$ 10,702	\$ 11,237	\$ 11,799	\$ 12,388	\$ 13,008	
							\$ 59,133	
<b>Former Targeted Adults</b>								
<b>Pop Type:</b> Expansion		Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility. PMPM will increase due to adding new managed care directed payments. PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.						
		Started 11/1/17						
Eligible Member Months		2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost		5.3%	\$ 979.53	\$ 1,031.45	\$ 1,281.14	\$ 1,349.04	\$ 1,420.54	
Total Expenditure			\$ 76,403,340	\$ 80,452,717	\$ 155,909,778	\$ 220,402,517	\$ 237,885,946	
							\$ 771,054,298	
<b>Dental - Targeted Adults</b>								
<b>Pop Type:</b> Expansion		Started 3/1/19						
Eligible Member Months		2.5%	-	12,000	18,450			
PMPM Cost		5.3%	\$ -	\$ 33.33	\$ 37.27	\$ 39.24	\$ 41.32	
Total Expenditure			\$ -	\$ 400,000	\$ 687,556	\$ -	\$ -	
							\$ 1,087,556	
<b>System of Care</b>								
<b>Pop Type:</b> Hypothetical		Anticipated start date of 1/1/20						
Eligible Member Months			-	720	1,440	1,440	1,440	
PMPM Cost		5.3%	\$ -	\$ 2,100	\$ 2,211	\$ 2,328	\$ 2,328	
Total Expenditure			\$ -	\$ 1,512,000	\$ 3,184,272	\$ 3,353,038	\$ 3,353,038	
							\$ 8,049,310	
<b>Dental - Blind/Disabled</b>								
<b>Pop Type:</b> Hypothetical								
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	\$ 18.42	\$ 18.97	\$ 19.54	\$ 20.13	\$ 20.73	
Total Expenditure			\$ 7,595,690	\$ 7,823,560	\$ 8,058,267	\$ 8,300,015	\$ 8,549,016	
							\$ 40,326,548	
<b>Dental - Aged</b>								
<b>Pop Type:</b> Hypothetical		Anticipated start date of 1/1/20						

DEMONSTRATION WITH WAIVER (WW NONE) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	\$ -	\$ -	\$ 30.75	\$ 32.38	\$ 34.10	
Total Expenditure			\$ -	\$ -	\$ 1,660,500	\$ 3,584,438	\$ 3,868,774	\$ 9,113,712
<b>Former Foster Care</b>								
Pop Type:	Hypothetical							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	\$ 990.87	\$ 1,038.43	\$ 1,088.28	\$ 1,140.51	\$ 1,195.26	
Total Expenditure			\$ 9,909	\$ 10,384	\$ 10,883	\$ 11,405	\$ 11,953	\$ 54,534
<b>Substance Use Disorder (SUD)</b>								
Pop Type:	Hypothetical							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	\$ 3,321.96	\$ 3,488.06	\$ 3,662.46	\$ 3,845.58	\$ 4,037.86	
Total Expenditure			\$ 131,072,269	\$ 147,108,390	\$ 148,527,403	\$ 166,698,858	\$ 187,093,676	\$ 780,500,596
<b>Withdrawal Management</b>								
Pop Type:	Hypothetical		Started 5/1/19					
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	\$ -	\$ 700.00	\$ 735.00	\$ 771.75	\$ 810.34	
Total Expenditure			\$ -	\$ 468,738	\$ 2,953,046	\$ 3,100,699	\$ 3,255,733	\$ 9,778,216
<b>Expansion Parents &lt;=100% FPL</b>								
Pop Type:	Expansion		Assumes start date of 1/1/20					
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	\$ -	\$ -	\$ 640.57	\$ 674.52	\$ 710.27	
Total Expenditure			\$ -	\$ -	\$ 108,841,789	\$ 234,951,327	\$ 253,588,841	\$ 597,381,956
<b>Expansion Adults w/out Dependent Children &lt;=100% FPL</b>								
Pop Type:	Expansion		Assumes start date of 1/1/20 PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.					
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	\$ -	\$ -	\$ 899.03	\$ 946.68	\$ 996.85	
Total Expenditure			\$ -	\$ -	\$ 180,242,854	\$ 389,081,237	\$ 419,945,107	\$ 989,269,198
<b>Expansion Parents 101-133% FPL</b>								
Pop Type:	Expansion		Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.					
Eligible Member Months		5.25%	-	-	53,048	111,667	117,529	
PMPM Cost		5.3%	\$ -	\$ -	\$ 625.86	\$ 659.03	\$ 693.96	
Total Expenditure			\$ -	\$ -	\$ 33,200,871	\$ 73,591,888	\$ 81,560,602	\$ 188,353,362
<b>Expansion Adults w/out Dependent Children 101-133% FPL</b>								
Pop Type:	Expansion		Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment. PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.					
Eligible Member Months		5.25%	-	-	167,879	353,386	371,939	
PMPM Cost		5.3%	\$ -	\$ -	\$ 882.60	\$ 929.37	\$ 978.63	
Total Expenditure			\$ -	\$ -	\$ 148,169,813	\$ 328,428,021	\$ 363,991,028	\$ 840,588,862

 Start date of 5/1/19 (2 months of SFY19)

 Assumes start date of 1/1/2020 (SFY20)

## ATTACHMENT 2

### **Public Notice Requirements**





**Order Confirmation for 0001268486**

Client	UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME		
Client Phone	8015386641	Account #	9001406923
Address	PO BOX 143102	Ordered By	Suzanne
	SALT LAKE CITY UT 841143103	Account Exec	ltapuso2
		PO Number	QAZ: Public Notice for l
Email	cdevashrayee@utah.gov		

<b>Total Amount</b>	<b>\$473.72</b>
<b>Payment Amt</b>	<b>\$0.00</b>
<hr/>	
<b>Amount Due</b>	<b>\$473.72</b>

Text: QAZ: Public Notice for Utah 1115 Waiver Amendment -"Fallback" Plan

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**Ad Number** 0001268486-01 **Ad Type** Legal Liner

**Ad Size** 3 X 93 li **Color**

**WYSIWYG Content**

**PUBLIC NOTICE  
Utah 1115 Waiver Amendment - "Fallback" Plan**

The Utah Department of Health will hold public hearings to discuss an amendment to the 1115 Primary Care Network Demonstration. The Department will accept public comment regarding this demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

The Department is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. The request includes the following provisions:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult members
- Implement a Medicaid lock-out period for committing an intentional program violation
- Provide housing related services and supports
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion members
- Allow for certain flexibilities in operating managed care
- Require premiums for Adult Expansion members with income over 100 percent FPL
- Require a \$25 copayment for non-emergent use of the emergency department for Adult Expansion members with income over 100 percent FPL through 133 percent FPL
- Expand the definitions for Targeted Adult Medicaid to include additional adults
- Obtain authority through this waiver amendment to potentially implement defined flexibility and cost savings provisions through the state administrative rulemaking process:
  - Require that Adult Expansion members with income over 100% FPL pay their monthly premium prior to receiving Medicaid for the eligible month
  - Not allow retroactive eligibility for Adult Expansion members with income over 100% FPL and enroll these adults prospectively in Medicaid
  - Change the benefit package for all adults on Medicaid expansion (including Targeted Adults, but excluding medically frail) to the State's non-traditional benefit package
  - Exempt certain groups from the mandatory employer sponsored insurance (ESI) requirement
  - Suspend housing supports
  - Make enrollment in an integrated plan or other managed care mandatory or options for different groups on Medicaid expansion
  - Open or suspend enrollment for each population group or subgroup within Targeted Adult Medicaid

In addition, the Department will also request to continue the following approved programs and provisions from Utah's current 1115 Primary Care Network Demonstration:

- Enrollment limits for the Adult Expansion and Targeted Adult members
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement for Adult Expansion members
- Provide premium reimbursement and wrap-around Medicaid coverage, to eligible Adult Expansion members who have access to ESI

**Public Hearings:**

The Department will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019 from 4:00 p.m. to 6:00 p.m., in room 1020C of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.
- Thursday, October 10, 2019 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.

**Public Comment:**

A copy of the full public notice and proposed application is available online at <https://medicaid.utah.gov/1115-waiver>.

The public may comment on the proposed application request during the 30-day public comment period from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: <https://medicaid.utah.gov/1115-waiver>

Email: [Medicaid1115waiver@utah.gov](mailto:Medicaid1115waiver@utah.gov)

Mail: Utah Department of Health  
Division of Medicaid and Health Financing  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Attn: Jennifer Meyer-Smart

1268486

UPAXLP

<b>Product</b>	<b>Placement</b>	<b>Position</b>
Salt Lake Tribune	Legal Liner Notice	998
<b>Scheduled Date(s):</b>	09/27/2019	
utahlegals.com	utahlegals.com	utahlegals.com
<b>Scheduled Date(s):</b>	09/27/2019	
Deseret News	Legal Liner Notice	998
<b>Scheduled Date(s):</b>	09/27/2019	







## Full Public Notice

### Utah 1115 Demonstration Amendment Fallback Plan

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) intends to submit a request to the Centers for Medicare and Medicaid Services (CMS) to amend its 1115 Demonstration Waiver as a result of Senate Bill 96- "Medicaid Expansion Amendments", which passed during the 2019 Utah Legislative Session. DMHF will hold two public hearings to discuss the amendment. In addition, DMHF will accept public comment regarding the demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

With this amendment, the State is seeking approval to implement the following provisions for its Medicaid expansion as directed by Senate Bill 96:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including Adult Expansion and Targeted Adult Populations
- Lock-out from the Medicaid Expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports for groups within Medicaid Expansion
- Not allowing hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a \$25 copayment for non-emergent use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid.
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP)

The State is also requesting to continue the following components for the Adult Expansion demonstration group which are currently authorized under the State's 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance (ESI) to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

**I. Program Description:**

The waiver populations defined below will be impacted by this demonstration amendment:

1. Adult Expansion Population, defined as:
  - Adults ages 19 through 64
  - A U.S. Citizen or qualified alien
    - Non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
  - A resident of Utah
  - Not pregnant
  - Residents of a public institution are not eligible unless furloughed for an inpatient stay
  - Have a household income at or below 133 percent of FPL using the MAGI methodology which includes a five percent FPL disregard
  - Ineligible for other Medicaid programs that do not require a spenddown to qualify
  - Must not be eligible for Medicare under parts A or B of title XVIII of the Act
  - Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.
  
2. Targeted Adult Population, defined as:
  - Adults age 19 through 64, without a dependent child
  - A U.S. Citizen or qualified alien
  - A resident of Utah
  - Residents of a public institution are not eligible unless furloughed for an inpatient stay
  - Household income at or below five percent of the FPL
  - Ineligible for other Medicaid programs that do not require a spenddown
  - Must not be eligible for Medicare under parts A or B of title XVIII of the Act
  - Must also meet at least one of the following criteria:
    - Chronically homeless
    - Involved in the justice system and in need of substance use or mental health treatment
    - Needing substance use or mental health treatment

**Overview of New Proposals:**

The State is requesting to implement the following components with this amendment:

### 1. Income Limit Increase for Adult Expansion Population

The State proposes to increase the income limit for the Adult Expansion Population from 95 percent FPL, to 133 percent FPL, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion, which includes both the Adult Expansion and the Targeted Adult demonstration groups. If the allowable enhanced FMAP is ever reduced to below 90 percent, the State will sunset the Adult Expansion demonstration group no later than July 1 after the date on which the FMAP is reduced.

The Adult Expansion Population is defined as individuals who meet the following criteria:

- Adults ages 19 through 64
- A U.S. Citizen or qualified alien
  - Non-qualified non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
- A resident of Utah
- Not pregnant
- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 133 percent of FPL using the MAGI methodology which includes a five percent FPL disregard
- Ineligible for other Medicaid programs that do not require a spenddown to qualify
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.

### 2. Lock-Out due to Intentional Program Violation

The State proposes to apply a six-month period of ineligibility if an individual commits an intentional program violation (IPV) to become, or remain eligible for Medicaid. This request applies to the Medicaid Expansion, which includes both the Adult Expansion Population and Targeted Adults.

### 3. Housing Related Services and Supports

The State proposes to offer housing related services and supports (HRSS) to the Medicaid Expansion, who meet needs-based criteria. HRSS includes; tenancy support services, community transition services and supportive living/supportive housing services.

### 4. Not Allow Presumptive Eligibility Determined by a Hospital

The State proposes to not allow presumptive eligibility determined by a hospital as a qualified entity, for the Adult Expansion Population. Currently, the State does not allow presumptive eligibility determinations for the Targeted Adult Population. This will allow the State to complete a full determination of eligibility before enrolling the individual, thereby improving program integrity and better assuring that each individual has met the requirements of the program before paying for their medical care. Coverage will no longer be based solely on a limited review of information by hospitals.

### 5. Flexibility to Make Changes through the State Administrative Rulemaking Process

Under the authority granted to the State through this waiver, the State requests the ability to make the changes listed below for the Medicaid Expansion through the state administrative rulemaking process

pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

These changes include the following:

- Begin enrollment the first of the month after application for Adult Expansion Medicaid beneficiaries with income over 100 percent FPL (prospective eligibility)
- Not allowing three months of retroactive coverage for Adult Expansion Medicaid beneficiaries who have income over 100 percent FPL
- Change the benefit package for Adult Expansion and Targeted Adult demonstration groups (excluding medically frail) to the State's non-traditional benefit package
- Exempt certain groups from the employer sponsored insurance requirement
- Make enrollment in an integrated plan or other managed care mandatory or optional for different adult expansion groups
- Suspending housing related services and supports in order to stay within appropriations for this provision.
- Suspend enrollment for the subsets within the three subgroups on Targeted Adult Medicaid

#### 6. Expanding Targeted Adult Medicaid Eligibility Definitions

With amendment, the State is requesting to expand its eligibility criteria definitions for the three Targeted Adult subgroups. This will allow the State to increase the number of individuals who are eligible for the Targeted Adult Population, allowing more individuals to receive the added benefits of 12-months continuous eligibility (and dental benefits, if they are actively receiving substance use disorder treatment).

Currently, individuals must meet the following criteria to be eligible for the Targeted Adult Population:

- Adults age 19-64, without a dependent child
- A U.S. Citizen or qualified alien
- A resident of Utah, and not in a public institution
- Household income at or below five percent of the FPL
- Ineligible for other Medicaid programs that do not require a spenddown
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Must also meet at least one of the following criteria:
  - Be chronically homeless
  - Involved in the justice system AND in need of substance abuse or mental health treatment
  - In need of substance abuse or mental health treatment

The State proposes to add or change the following for each criteria subgroup:

- Chronically Homeless
  - Add "an individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter"
  - Move the following group from the subgroup "Needing substance abuse or mental health treatment" to the "Chronically Homeless" subgroup; "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”

- Involved in the justice system and in need of substance use or mental health treatment
  - Changing the criteria of “an individual involved in a Drug Court or Mental Health Court, including Tribal courts”, to “an individual who is court ordered to receive substance abuse or mental health treatment through a district court or Tribal court, or involved in a Drug Court or Mental Health Court”.
  - Add “an individual on probation or parole with serious mental illness and/or serious substance use disorder”.

7. Require premiums for Adult Expansion Medicaid beneficiaries with income over 100 percent through 133 percent of the FPL

Information regarding premiums is provided in section “IV. Benefits and Cost Sharing Requirements” below.

8. Require a \$25 copayment for non-emergent use of the emergency department for Adult Expansion Medicaid beneficiaries with income over 100 percent FPL through 133 percent FPL

Information regarding the \$25 copayment is provided in section “IV. Benefits and Cost Sharing Requirements” below.

**Overview of Continuing Programs and Benefits:**

The State is also requesting to continue the following components and programs with this amendment for the expanded Adult Expansion Population, which are currently authorized under the State’s 1115 Demonstration Waiver:

1. Enrollment Limits

The State requests to continue to apply enrollment limits to the Adult Expansion and Targeted Adult Populations under this demonstration amendment. Enrollment limits for these populations are currently approved under the State’s 1115 Demonstration Waiver that was amended on March 29, 2019. The State proposes to apply enrollment limits when projected costs exceed annual state appropriations. There will not be a set enrollment cap, but rather it will be based on available funding. When enrollment is suspended, the State will continue to accept and review applications to determine if individuals are eligible for other Medicaid programs. If the individual is not eligible for any other Medicaid program, other than Adult Expansion, eligibility will be denied. The State will not have a waitlist to automatically enroll individuals when enrollment is re-opened. Individuals will need to apply during the next open enrollment period. All eligible individuals that apply before an enrollment limit is in place will be enrolled in the program. Individuals already enrolled in the program at the time enrollment is suspended will remain enrolled.

3. Community Engagement through a Self Sufficiency Requirement

With this waiver amendment, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion Population, not to include Targeted Adults. The community engagement requirement was originally approved for this population, as part of the

Medicaid expansion authorized in the March 29, 2019 amendment to the State's 1115 Demonstration Waiver.

#### 4. Employer Sponsored Insurance (ESI Reimbursement)

As approved on March 29, 2019 under the State's 1115 Demonstration waiver, the State proposes to require individuals who are eligible for the Adult Expansion Population, and have access to ESI, to purchase such plans. The State will reimburse the eligible individual for the health insurance premium amount for that individual. Failure to enroll in, and purchase, the insurance plan will result in ineligibility for Medicaid.

#### 5. Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

The State currently has authority to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for adults age 19 and 20 years old in the Adult Expansion and Targeted Adult Population. The State requests to continue this authority for the Adult Expansion and Targeted Adult Population, if approved under this amendment.

### **II. Demonstration Goal/Objective:**

The goals and objectives of the demonstration are to:

- Provide health care coverage for low-income and other vulnerable Utahns that would not otherwise have access to, or be able to afford health care coverage
- Improve participant health outcomes and quality of life
- Lower the uninsured rate of low income Utahns
- Support the use of employer-sponsored insurance by encouraging community engagement and providing premium reimbursement for employer-sponsored health plans
- Provide continuity of coverage for individuals

### **III. Proposed Delivery System:**

Services for the Adult Expansion Population will be provided through FFS during the month of application and potentially the following month depending on the date of approval. In addition, Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the FFS network. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

Adult Expansion beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. In addition, in Utah's five largest counties, individuals in the Adult Expansion program will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity. In the remaining counties, beneficiaries will be enrolled in a pre-paid mental health plan for their behavioral health services.

#### ***Employer Sponsored Insurance- Individuals with Access to ESI***

Demonstration individuals who receive ESI reimbursement will receive services through the delivery systems provided by their respective qualified plan for ESI. Wrap-around benefits provided by Medicaid will be delivered through FFS.

**Managed Care Flexibilities**

Utah intends to use managed care as the primary service delivery system for populations covered under this waiver. As part of this amendment request, Utah is asking for greater flexibility and authority to use alternative approaches to come into compliance with 42 CFR 438 in the following areas. This will allow the state to administer its managed care delivery system upon approval of this waiver without delays related to additional federal approvals.

- Demonstration of actuarial soundness of rates
- Flexibility in managed care contract review
- Demonstration of directed payment compliance
- Access to care and availability of services

**IV. Benefits and Cost Sharing Requirements:**

Individuals eligible under this demonstration will receive benefits as listed in the table below.

**Eligibility Group and Benefit Package**

Eligibility Group	Benefit Package
Adults with Dependent Children	<ul style="list-style-type: none"> <li>● Non-Traditional Benefits (see description below)</li> </ul>
Adults without Dependent Children	<ul style="list-style-type: none"> <li>● State Plan Benefits</li> </ul>
ESI Eligible Adults with Dependent Children	<ul style="list-style-type: none"> <li>● Premium Reimbursement with Non-Traditional Benefit Wrap-around</li> </ul>
ESI Eligible Adults without Dependent Children	<ul style="list-style-type: none"> <li>● Premium Reimbursement with State Plan Benefit Wrap-around</li> </ul>
Medically Frail	<ul style="list-style-type: none"> <li>● Adults with Dependent Children normally receive non-traditional benefits, but may choose traditional state plan benefits</li> </ul>
Targeted Adults	<ul style="list-style-type: none"> <li>● State Plan Benefits, and dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms &amp; Conditions #23(h)) of the 1115 Demonstration Waiver</li> <li>● 12-months continuous eligibility</li> </ul>



Housing Related Services and Supports for Individuals Meeting Needs Based Criteria	<ul style="list-style-type: none"> <li>● Tenancy Support Services</li> <li>● Community Transition Services</li> <li>● Supportive Living/Housing Services</li> </ul>
--	---

**Non-Traditional Benefit Package**

Adults with dependent children will receive the State’s non-traditional benefit package, authorized under the State’s 1115 Demonstration Waiver. This benefit package contains most of the services covered under Utah’s Medicaid state plan according to the limitations specified in the state plan. This benefit package is reduced from that available under the state plan as detailed in the table below.

**Benefits Different from State Plan**

Service	Special Limitations for the Non-traditional Benefit
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.

**Medically Frail**

As stated above, Adult Expansion beneficiaries will receive either traditional state plan Medicaid benefits if they do not have a dependent child living in the home, or they will receive non-traditional Medicaid benefits if they do have a dependent child living in the home. However, if an Adult Expansion beneficiary is identified as medically frail, as defined by 42 CFR 440.315, they may choose between traditional state plan Medicaid benefits or non-traditional Medicaid benefits, as authorized under the State’s 1115 Demonstration Waiver.

An individual is medically frail, as defined by 42 CFR 440.315, if the individual has a:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
- Disability determination based on Social Security criteria

**Premiums**

With this amendment, the State is proposing to implement monthly premiums for individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL . Monthly premiums will be set at the following amounts regardless of household size or household income.

- \$20 per month for a single individual
- \$30 per month for a couple

Under the authority granted to the State through this waiver, the State requests the ability to raise these premium amounts to mirror annual increases in the federal poverty level through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

Premiums will not be charged for the month of application or any months of retroactive coverage. Premiums must be paid in the month prior to the month of eligibility to avoid disenrollment. Failure to pay the required premium will result in loss of eligibility for Adult Expansion Medicaid.

**Premium Exemptions**

The following individuals are exempt from paying premiums:

- Individuals with verified membership in a federally recognized tribe
- Individuals identified as medically frail, as described in 42 CFR 440.315

Individuals who receive employer sponsored insurance reimbursements will have premiums deducted from their ESI reimbursement amount.

The total of the individual’s or couple’s premium amount and any applicable copayments will not exceed 5 percent of the household’s income, per 42 CFR 447.56(f).

**Payment of Past Due Premiums after Losing Eligibility**

Individuals who have been disenrolled for failure to pay premiums will be required to pay any past due premiums in order to reinstate Medicaid. However, if it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

**Cost Sharing**

**Copayment for Non-Emergent Use of the Emergency Department**

In accordance with Section 1916(f) of the Social Security Act, the State proposes to require a \$25 copayment for non-emergent use of the emergency department for individuals in the Adult Expansion Population who have household income above 100 percent FPL through 133 percent FPL. Members of federally recognized tribes will be exempt from this provision.

*Cost Sharing for Individuals without ESI:* Cost sharing requirements provided under the State Plan will apply to Demonstration individuals who do not have ESI.

*Cost Sharing for ESI:* For ESI eligible individuals, the State will pay cost sharing imposed by the ESI up to the State Plan levels. ESI eligible individuals will have the same cost sharing that they would have under the State Plan. The State will pay such cost sharing directly to providers, provided that such providers are enrolled in the Medicaid program.

*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.

**V. Annual Enrollment and Expenditures:**

The table below shows the projected demonstration enrollees in each demonstration year (DY).

<b>Enrollment</b>	<b>DY 18<sup>1</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	14,000	14,350	14,709

<sup>1</sup>Reflects anticipated average enrollment January 2020 through June 2020

Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	9,779	10,292	10,832
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	30,946	32,570	34,280
<b>Annual Total</b>	<b>116,458</b>	<b>120,489</b>	<b>124,680</b>

The table below shows the projected expenditures for each demonstration year (DY).

<b>Expenditures (Total Fund)</b>	<b>DY 18<sup>2</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	\$127,914,000	\$276,122,000	\$298,026,000
Expansion Parents up to 100% FPL	\$114,116,000	\$246,336,000	\$265,877,000
Expansion Parents above 100% FPL up to 133% FPL	\$38,541,000	\$85,430,000	\$94,680,000
Expansion Adults without Children up to 100% FPL	\$187,889,000	\$405,586,000	\$437,759,000
Expansion Adults without Children above 100% FPL up to 133% FPL	\$170,956,000	\$378,934,000	\$419,966,000
<b>Annual Total</b>	<b>\$639,416,000</b>	<b>\$1,392,408,000</b>	<b>\$1,516,308,000</b>

The table below shows the projected enrollees under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

<b>Enrollment</b>	<b>DY 18<sup>3</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Former Targeted Adults	13,283	13,615	13,955
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	8,841	9,306	9,794
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	27,980	29,449	30,995
<b>Annual Total</b>	<b>111,837</b>	<b>115,647</b>	<b>119,603</b>

Table 8

The table below shows the projected expenditures under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

<sup>2</sup> Reflects anticipated total expenditures January 2020 through June 2020

<sup>3</sup> Reflects anticipated average enrollment January 2020 through June 2020

<b>Expenditures (Total Fund)</b>	<b>DY 18<sup>4</sup></b>	<b>DY 19</b>	<b>DY 20</b>
Targeted Adults	\$102,102,000	\$220,403,000	\$237,886,000
Expansion Parents up to 100% FPL	\$108,842,000	\$234,951,000	\$253,589,000
Expansion Parents above 100% FPL up to 133% FPL	\$33,201,000	\$73,592,000	\$81,561,000
Expansion Adults without Children up to 100% FPL	\$180,244,000	\$389,083,000	\$419,947,000
Expansion Adults without Children above 100% FPL up to 133% FPL	\$148,170,000	\$328,428,000	\$363,991,000
<b>Annual Total</b>	<b>\$572,559,000</b>	<b>\$1,246,457,000</b>	<b>\$1,356,974,000</b>

**VI. Waivers and Expenditure Authorities:**

The State will request the following waivers and expenditure authorities in order to administer this demonstration.

<b>Waiver Authority</b>	<b>Reason and Use of Waiver</b>
Section 1902(a)(10) and (a)(52)- Eligibility	To the extent necessary to enable the State to prohibit re-enrollment and deny eligibility for the Adult Expansion Medicaid demonstration group for a period of six months for individuals who commit an intentional program violation.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Adult Expansion eligibles compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide housing supports and services.
Section 1902(a)(1)- Statewide Operation	To the extent necessary to enable the State to implement housing supports in geographically limited areas of the state.
Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A	To the extent necessary to enable the State to require monthly premiums for individuals in the Adult Expansion Population who have household income above 100 up to and including 133 percent of the FPL.
Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	To the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to beneficiaries subject to the community engagement requirements who fail to comply with those requirements as

<sup>4</sup> Reflects anticipated total expenditures January 2020 through June 2020

	described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs. To the extent necessary to enable the state to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.
Section 1906(i)(26)- Compliance with ABP Requirements	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.

**Expenditure Authority**

*Adult Expansion Demonstration Group:* 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.

*Housing Services and Supports:* Expenditures to provide housing services and supports that would not otherwise be matchable under Section 1903.

**VII. Hypotheses and Evaluation Parameters of the Demonstration:**

During the approved demonstration period, the State will test the hypotheses indicated in the table below. The State intends to contract with an independent evaluator to develop a plan for evaluating these hypotheses.

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
<b>Adult Expansion</b>			
The Demonstration will improve access to medical assistance in Utah.	<ul style="list-style-type: none"> <li>Number of adults ages 19-64 in Utah without health coverage</li> </ul>	Utah Behavioral Risk Factor Surveillance System (BRFSS)	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will improve the health and well-being of enrolled individuals by increasing access to primary care and improving appropriate utilization of emergency	<ul style="list-style-type: none"> <li>Review of claims for Primary Care</li> <li>Review of claims for ED visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

department (ED) services by Adult Expansion members.			
The Demonstration will reduce uncompensated care provided by Utah hospitals.	<ul style="list-style-type: none"> <li>Amount of statewide hospital-reported uncompensated care</li> </ul>	Hospital Costs Report	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will assist previously uninsured individuals in purchasing employer sponsored insurance to help reduce the number of uninsured adults.	<ul style="list-style-type: none"> <li>Number of enrolled members with employer-sponsored insurance</li> </ul>	Enrollment data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Community Engagement</b>			
The community engagement requirement will encourage skills development through an evaluation of job search readiness and the completion of employment related training workshops. In addition, by increasing the individual's job skills and encouraging job search activities, the community engagement requirement will promote gainful employment.	<ul style="list-style-type: none"> <li>Number of trainings completed/ended</li> <li>Number of job searches</li> <li>Number of job registrations</li> <li>Amount of earned income</li> </ul>	eREP & UWORKS system data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Community engagement requirements that promote engagement with the employment process will improve the health outcomes of Medicaid beneficiaries	<ul style="list-style-type: none"> <li>Number of prescriptions</li> <li>Number of non-emergent ED visits</li> <li>Number of cancer screenings</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	<ul style="list-style-type: none"> <li>Number of well-care visits</li> </ul>		
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid	Beneficiary Surveys	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Premiums</b>			
Individuals sharing in the total cost of care by paying premiums will access preventive services at a rate equivalent or greater than individuals who do not pay premiums.	<ul style="list-style-type: none"> <li>Number of prescriptions</li> <li>Number of non-emergent ED visits</li> <li>Number of cancer screenings</li> <li>Number of well-care visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Lock-Out for Intentional Program Violation</b>			
The Demonstration will discourage individuals from committing an IPV by disqualifying individuals who commit an IPV.	Percentage of IPVs compared to a comparison group	Enrollment and IPV Lock-Out Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Housing Supports</b>			



The demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Not Allowing Presumptive Eligibility</b>			
The demonstration will allow individuals to enroll retroactively covering unforeseen hospital expenses at a rate equivalent to hospital presumptive eligibility pre-demonstration.	Pre-demonstration, proportion of enrollees enrolling through hospital presumptive eligibility plus retroactive enrollment.  Post demonstration, proportion of enrollees enrolling through retroactive enrollment.	Medicaid Data Warehouse  eRep Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Non-emergent Use of the Emergency Room</b>			
Charging a higher copay for this service will decrease inappropriate use of the emergency	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> <li>● Number of non-emergent ED visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include

room without impacting other health measures	<ul style="list-style-type: none"> <li>• Number of cancer screenings</li> <li>• Number of well-care visit</li> </ul>		quasi-experimental comparisons
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The State will test the following hypothesis if the relevant provisions of the waiver are activated by the State.

<b>Prospective Enrollment</b>			
The implementation of the proposal will generate cost savings over the term of the waiver.	<ul style="list-style-type: none"> <li>• Average cost per member in month of application for comparison group</li> <li>• Average cost per member in the first three eligible months after application for demonstration group and comparison group</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	<ul style="list-style-type: none"> <li>• Number of prescriptions</li> <li>• Number of non-emergent ED visits</li> <li>• Number of cancer screenings</li> <li>• Number of well-care visits</li> </ul>	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
<b>Elimination of Retroactive Eligibility</b>			

<p>The implementation of the proposal will generate cost savings over the term of the waiver.</p>	<ul style="list-style-type: none"> <li>● Average cost per member in retro months prior to application for comparison group</li> <li>● Average cost per member in the first three eligible months after application for demonstration group and comparison group</li> </ul>	<p>Claims/encounter data</p>	<p>Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons</p>
<p>The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.</p>	<ul style="list-style-type: none"> <li>● Number of prescriptions</li> <li>● Number of non-emergent ED visits</li> <li>● Number of cancer screenings</li> <li>● Number of well-care visits</li> </ul>	<p>Claims/encounter data</p>	<p>Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons</p>

In addition to the data outlined above, the state will also gather HEDIS and CAHPS data to evaluate the overall well-being of this population group.

**VIII. Review of Documents and Submission of Comments**

Location and Internet Address of Demonstration Amendment for Public Comment and Review:

A copy of the DMHF’s proposed demonstration amendment is available for review online at: <https://medicaid.utah.gov/1115-waiver>.

A copy of the DMHF's proposed demonstration amendment may be requested in writing from:  
Utah Department of Health  
Division of Medicaid and Health Financing  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Attn: Jennifer Meyer-Smart

Submitting Public Comments:

The public may comment on the proposed demonstration amendment during the 30-day public comment period, from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: <https://medicaid.utah.gov/1115-waiver>.

Email: [Medicaid1115waiver@utah.gov](mailto:Medicaid1115waiver@utah.gov)

Mail: Utah Department of Health  
Division of Medicaid and Health Financing  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Attn: Jennifer Meyer-Smart

Public Hearings:

The DMHF will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019  
4:00 p.m. to 6:00 p.m.  
Multi-Agency State Office Building  
195 N 1950 W, Salt Lake City, Utah  
Room 1020C
- Thursday, October 10, 2019  
2:00 p.m. to 4:00 p.m. (Medical Care Advisory Committee (MCAC) meeting)  
Cannon Health Building  
288 N 1460 W, Salt Lake City, Utah  
Room 125

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.



## **PUBLIC NOTICE**

### **Utah 1115 Waiver Amendment - "Fallback" Plan**

The Utah Department of Health will hold public hearings to discuss an amendment to the 1115 Primary Care Network Demonstration. The Department will accept public comment regarding this demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

The Department is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. The request includes the following provisions:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult members
- Implement a Medicaid lock-out period for committing an intentional program violation
- Provide housing related services and supports
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion members
- Allow for certain flexibilities in operating managed care
- Require premiums for Adult Expansion members with income over 100 percent FPL
- Require a \$25 copayment for non-emergent use of the emergency department for Adult Expansion members with income over 100 percent FPL through 133 percent FPL
- Expand the definitions for Targeted Adult Medicaid to include additional adults
- Obtain authority through this waiver amendment to potentially implement defined flexibility and cost savings provisions through the state administrative rulemaking process:
  - Require that Adult Expansion members with income over 100% FPL pay their monthly premium prior to receiving Medicaid for the eligible month
  - Not allow retroactive eligibility for Adult Expansion members with income over 100% FPL and enroll these adults prospectively in Medicaid
  - Change the benefit package for all adults on Medicaid expansion (including Targeted Adults, but excluding medically frail) to the State's non-traditional benefit package
  - Exempt certain groups from the mandatory employer sponsored insurance (ESI) requirement
  - Suspend housing supports
  - Make enrollment in an integrated plan or other managed care mandatory or options for different groups on Medicaid expansion
  - Open or suspend enrollment for each population group or subgroup within Targeted Adult Medicaid

In addition, the Department will also request to continue the following approved programs and provisions from Utah's current 1115 Primary Care Network Demonstration:

- Enrollment limits for the Adult Expansion and Targeted Adult members
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement for Adult Expansion members
- Provide premium reimbursement and wrap-around Medicaid coverage, to eligible Adult Expansion members who have access to ESI

**Public Hearings:**

The Department will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019 from 4:00 p.m. to 6:00 p.m., in room 1020C of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.
- Thursday, October 10, 2019 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.

**Public Comment:**

A copy of the full public notice and proposed application is available online at <https://medicaid.utah.gov/1115-waiver>.

The public may comment on the proposed application request during the 30-day public comment period from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: <https://medicaid.utah.gov/1115-waiver>

Email: [Medicaid1115waiver@utah.gov](mailto:Medicaid1115waiver@utah.gov)

Mail: Utah Department of Health  
Division of Medicaid and Health Financing  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Attn: Jennifer Meyer-Smart

## ATTACHMENT 3

### **Public Comments and State Responses**





## Summary of Public Comments and State Responses

### 1115 Waiver Amendment Medicaid Expansion

The State received comments from 99 individuals, advocacy groups and other community partners. The State appreciates all comments and feedback submitted regarding this waiver application. A summary of the comments submitted related to the waiver amendment and the State's responses to those comments are detailed below. Some comments were outside the scope of the waiver application and are not addressed in the State's responses.

#### **General Comments**

1. Many commenters stated they believe this proposal is contrary to the purpose of the Medicaid program and it would be illegal for the Secretary of Health and Human Services to approve the State's request. They also stated the State should expedite the implementation of full expansion by requesting it through a State Plan Amendment without any restrictions. They do not believe the State should wait for approval of the 1115 waiver amendment.

**Response:** In November 2018, Utah voters approved Proposition 3. The proposition expanded Medicaid to 133 percent of the federal poverty level (FPL) for adults ages 19-64, mandated an annual inflationary increase for all Medicaid providers across the entire Medicaid program (both in and out of expansion), and raised the State's sales tax. In February 2019, the Utah Legislature passed and Governor Herbert signed Senate Bill 96 citing concerns that Proposition 3's sales tax was insufficient to cover both the expansion and the mandatory provider rate increases and that growth in the Medicaid program might not be sustainable for the State in the long term. Senate Bill 96 directed the Utah Department of Health (UDOH) to seek a series of waivers that, if approved, would expand Medicaid up to 133 percent FPL, obtain enhanced match (90 percent federal/10 percent state), and implement other provisions designed to create an expansion program that closed the coverage gap while putting in place program integrity requirements and fiscal circuit breakers. Senate Bill 96 outlines a Medicaid expansion proposal that the Utah Legislature and Governor Herbert believe is feasible for Utah.

Section 1901 of Title XIX of the Social Security Act defines the purpose of the Medicaid program as follows:

*For the purpose of enabling 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, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.*

Many commenters stated that the purpose of the Medicaid program was to furnish medical assistance; however, they did not acknowledge the phrase that immediately preceded it. The Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. In Utah, the State Constitution requires that income taxes be spent on education and that the State must have a balanced budget. As a result, the sales tax is the primary source of funding for the State's General Fund. Medicaid, transportation and other infrastructure, public health and other social services, law enforcement and public safety, along with general government operations, all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent. These growing costs occurred while Utah served the original populations targeted by Title XIX - families with dependent children and individuals that are aged, blind, or disabled. With the waiver approved in March 2019 and with this waiver request, the State included additional adults with dependent children and adults without dependent children who historically have not been served by Medicaid. While the State has been able to allocate existing resources to accommodate current Medicaid needs and has authorized an increase in sales tax to fund this waiver request, it may not be practicable in the State of Utah for Medicaid expenditures to continue to grow as a share of the available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a reliable long term funding source for the program absent additional budgetary flexibilities. This waiver proposal requests that the Secretary of Health and Human Services approve this waiver to furnish medical assistance to Utahns ages 19-64 in a way deemed practicable by the Utah Legislature and Governor Herbert as defined through Senate Bill 96.

Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act:

*(a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States—*

*(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and*

*(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate,*

Both under this administration and under President Obama's administration, the Centers for Medicare and Medicaid Services (CMS), has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking. It is not uncommon for CMS's interpretation of its authorities to evolve. As CMS Administrator Seema Verma said to state Medicaid directors in November 2017, "So now it is up to you, the states, to put your innovative ideas into practice. We very much look forward to your proposals and helping you implement successful initiatives that improve the health and lives of the diverse set of beneficiaries you serve." The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to approve this waiver proposal, which will improve the health and lives of an estimated 120,000 to 140,000 Utahns.

On July 27, 2019, CMS released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely the Secretary will use his authority at this time to allow enhanced funding for an expansion that includes an enrollment cap, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

First, the landscape regarding Medicaid expansion may change. Most notably, the U.S. Court of Appeals for the 5th Circuit will be issuing a decision in the *Texas v. U.S.*, litigation challenging the Affordable Care Act (ACA). Comments attributed to administration officials in news articles regarding CMS's position on partial expansion seem to tie this administration's position to a hope that *Texas v. U.S.* will overturn the ACA. However, as shown by the Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012), court decisions are not entirely predictable. Therefore, in light of the possibility that the legal situation regarding the ACA may change (or may not) in the near future, the State is submitting its entire request for review by the Secretary.

Second, the State's waiver request contains many other program features beyond the request for enhanced match for expansion with an enrollment cap. The State believes the other components of its waiver request can be approved and are important to operating an efficient and effective Medicaid Expansion program.

### **Lock-Out from the Medicaid Expansion for Committing an Intentional Program Violation (IPV)**

2. Many commenters stated that this request is not needed because fraud is already defined under state law and prosecuted accordingly. They would like to know how an IPV is different from a fraud

determination. In addition, they state the amendment already clearly indicates that individuals can be charged for overpayments while appealing an IPV.

**Response:** A determination of fraud is made through a judicial procedure. Section 76-8-1205 Utah Code Annotated, defines public assistance fraud.

**76-8-1205 Public assistance fraud defined.**

Each of the following persons, who intentionally, knowingly, or recklessly commits any of the following acts is guilty of public assistance fraud:

- (1) a person who uses, transfers, acquires, traffics in, falsifies, or possesses SNAP benefits as defined in Section 35A-1-102, a SNAP identification card, a certificate of eligibility for medical services, a Medicaid identification card, a fund transfer instrument, a payment instrument, or a public assistance warrant in a manner not allowed by law;
- (2) a person who fraudulently misappropriates funds exchanged for SNAP benefits as defined in Section 35A-1-102, or an identification card, certificate of eligibility for medical services, Medicaid identification card, or other public assistance with which the person has been entrusted or that has come into the person's possession in connection with the person's duties in administering a state or federally funded public assistance program;
- (3) a person who receives an unauthorized payment as a result of acts described in this section;
- (4) a provider who receives payment or a client who receives benefits after failing to comply with any applicable requirement in Sections 76-8-1203 and 76-8-1204;
- (5) a provider who files a claim for payment under a state or federally funded public assistance program for goods or services not provided to or for a client of that program;
- (6) a provider who files or falsifies a claim, report, or document required by state or federal law, rule, or provider agreement for goods or services not authorized under the state or federally funded public assistance program for which the goods or services were provided;
- (7) a provider who fails to credit the state for payments received from other sources;
- (8) a provider who bills a client or a client's family for goods or services not provided, or bills in an amount greater than allowed by law or rule;
- (9) a client who, while receiving public assistance, acquires income or resources in excess of the amount the client previously reported to the state agency administering the public assistance, and fails to notify the state agency to which the client previously reported within 10 days after acquiring the excess income or resources;
- (10) a person who fails to act as required under Section 76-8-1203 or 76-8-1204 with intent to obtain or help another obtain an "overpayment" as defined in Section 35A-3-102; and
- (11) a person who obtains an overpayment by violation of Section 76-8-1203 or 76-8-1204.

The determination of an IPV has been part of policy for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid for many years. The determination of an IPV is made through an administrative adjudicative proceeding under the Utah Administrative Procedures Act. The burden of proof is with the State. The standard of evidence is clear and convincing in both an administrative or judicial proceeding. The determination of an IPV through an

administrative proceeding with the possibility of a lock out of the Medicaid program is less onerous than a conviction based on a judicial criminal proceeding that could result in a third or second degree felony.

3. Several commenters stated they believe beneficiaries will be confused by what they must report and will get caught up in “red tape” trying to provide information, therefore causing them to lose coverage.

**Response:** Members are informed of what is required to be reported and when they must report. Current policy requires Medicaid members to report changes that affect eligibility within 10 days from the date of the change. The waiver makes no change to current reporting requirements.

4. Several commenters stated that while they appreciate the attempt to prevent fraud and abuse, they believe that individuals who might lose coverage due to this proposal, should be allowed a swift and effective appeals process, so they do not lose coverage due to an administrative mistake.

**Response:** All federally mandated appeal rights will be in place, as they are today. After the State has investigated a case for an IPV, and the Administrative Law Judge has concurred with the decision, an individual may be locked out for 6 months of the Adult Expansion Medicaid Program. The individual will receive notice of the decision. The notice includes the right to appeal and would be reviewed through the current administrative hearing process at the Department of Workforce Services (DWS).

5. Several commenters stated they believe the lock-out provision will only divert money from providing care to administering this provision. They also believe it will increase the administrative burden on patients on the Medicaid program.

**Response:** The determination of an IPV is currently in Medicaid policy. This is not new nor is it a change. The DWS Investigation unit conducts the investigation. Therefore there is no significant change to the current administrative burden to the State or members.

6. Several commenters stated they believe this provision includes vague or broad descriptions of an IPV. They believe this will lead to subjective decisions which likely will be influenced by implicit biases, resulting in certain populations, likely people of color and other marginalized groups- being more apt to be found to commit an IPV.

**Response:** The determination of an IPV has been in place for at least two decades for the SNAP, TANF and Medicaid programs. The burden of proof rests with the State. The State complies with judicial standards of evidence. When fault is alleged, the State must prove by clear and convincing evidence that the overpayment was obtained intentionally, knowingly, recklessly as "intentionally, knowingly, and recklessly" are defined in Section [76-2-103](#), by false statement, misrepresentation, impersonation, or

other fraudulent means, including committing any of the acts or omissions described in Sections [76-8-1203](#), [76-8-1204](#), or [76-8-1205](#).

**7.** Several commenters stated the lock-out period is problematic when coupled with the enrollment limit. They stated if someone was subject to a lock-out and an enrollment limit was enacted, they would continue to be locked-out for a longer time frame.

**Response:** The lock-out period continues to run regardless of enrollment being open or closed. While possible that the enrollment closes during someone's lock-out period, the lock-out period only applies to the Adult Expansion Medicaid Program, and other programs may still be available. If other programs are not available, these adults can reapply when enrollment opens again.

**8.** Several commenters express concern for the IPV definition including "failure to report a required change within 10 days". They would like this specific piece of the IPV definition removed.

**Response:** An IPV is different from an inadvertent error. In order to be considered an IPV, an individual would have to knowingly not report a required change within 10 days after the change occurs, and the individual knew the reporting requirements, and the intent was to obtain benefits they were not entitled to receive. The burden of proof is on the State to prove this occurred. The "failure to report in 10 days" provision is currently included in the definition of an IPV. This is not a change to policy.

**9.** Several commenters stated an individual's socioeconomic status can influence an individual's ability to adhere to program rules. They believe this is a difficult requirement for any income level. They also stated that individuals could be confused as to what they need to report, which would result in losing coverage over bureaucracy.

**Response:** Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. The State is not proposing to change current reporting requirements or the definition of an IPV. The State is only proposing to apply a lock-out period if an IPV determination is made.

**10.** One commenter stated they will have to provide sliding fee scale services to individual's locked out and that this seems to be too harsh for what seems to be less serious offenses.

**Response:** An IPV is different from an inadvertent error. To be considered an IPV, the individual has to knowingly and intentionally make statements or withhold information to obtain benefits they are not or were entitled to receive. The State would not consider this as a "less serious offense", given the intent of the violation.

**11.** Several commenters stated that disenrollment policies reduce access to care, disrupt the continuity of care, and cause increased utilization of emergency departments. They believe this proposal will lead to these issues. They also believe locking individuals out of coverage does not achieve Medicaid objectives, and is not allowable under Section 1115 authority.

**Response:** The State currently has IPV policy in place. Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. As stated in the response to Comment 1, the State must operate within the limits of its budget and therefore it is practical that only those individuals truly eligible for Medicaid should receive benefits. CMS will determine whether or not this and any other provision is allowable under this waiver authority.

**12.** One commenter stated the purported justification for Utah's Medicaid 1115 waiver is fiscal responsibility. However, implementation of the lock-out process would require Utah Medicaid to divert already thin administrative resources to oversee and conduct the program. They also state the potential dollar amount of savings that Utah Medicaid would achieve from locking low-income individuals out of Medicaid for 6-months is not provided, and input cannot be given without this.

**Response:** The State already has an IPV policy and process in place. IPV's are currently determined. The only change to the State's current process is the lock-out period. In response to the information regarding potential dollar savings, the State has met the transparency requirements found at 42 CFR 431.408. The waiver application and budget neutrality attachment reflect the required information.

**13.** One commenter stated the lock-out provision could have huge financial implications to individuals. They believe it is also not clear what overpayments a patient could be responsible for if the state determines an IPV occurred. For example, would an individual be forced to repay a capitation payment amount made to a managed care plan, even when they received no services?

**Response:** Under current Medicaid policy, if it is determined that an individual was not eligible to receive Medicaid, an overpayment is assessed for the months they were not eligible. The amount of the overpayment is based on claims paid on behalf of the individual as well as any capitation payments paid on behalf of the individual (if the individual was with a managed care plan). This will not change under the IPV lock-out policy. The only change under this proposal, is that if an individual has committed an IPV, they will have a 6-month lock-out period.

**14.** One commenter stated that charging individuals with overpayments for coverage received while awaiting an appeal decision could discourage individuals from appealing the decision, leading to unnecessary coverage losses and additional financial burdens.

**Response:** This proposed provision is consistent with current Medicaid regulation found in 42 CFR 230 which reads:

### **§431.230 Maintaining services.**

(a) If the agency sends the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

### **Housing Related Services and Supports (HRSS)**

**15.** Many commenters stated they are very supportive of the proposal to provide housing related services and supports. However, they believe it should be extended to all Adult Expansion members, not just the Targeted Adult Population. They believe providing to just a sub-group of the population contradicts the intent of Senate Bill 96.

**Response:** Based on the estimated cost to provide housing related services and the amount of funding designated for these services within overall Medicaid Expansion funding, the State determined to initially limit coverage to the Targeted Adult Population. Based on program flexibility the State is seeking to modify covered populations through administrative rule. After gaining additional cost and utilization experience, if funding is available, the State will consider covering housing related services for additional populations.

**16.** One commenter noted they strongly oppose the proposal to allow the State to make changes to this component through state administrative rulemaking, rather than the 1115 review and approval process. They believe this is contrary to transparency requirements.

**Response:** The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would



then use its administrative rulemaking process to activate the options approved in the waiver. The State believes the rulemaking process is transparent and would follow the process outlined under the Utah Administrative Rulemaking Act , Title 63G Chapter 3 Utah Code Annotated which provides for public input.

After passing through an internal review and approval process, UDOH files all proposed rules with the Division of Administrative Rules. The proposed rules are then published in the Utah State Bulletin, which the public can access at <https://rules.utah.gov/> to review the proposed changes. Upon publication, the public has 30 days to review and comment on the proposed changes, and may send their written comments to the contact person listed. UDOH reviews all comments provided during the public comment period, and has seven days after the comment period to determine whether it will go forward to make the rule effective, change the proposed rule, or simply let the rule lapse. UDOH also presents all rules to its Medical Care Advisory Committee and the Utah Indian Health Advisory Board.

In accordance with the provisions of the rulemaking act, individuals may also petition UDOH for a public hearing to discuss the proposed rule. UDOH would then grant the request, appoint a hearing officer, and make appropriate arrangements to accommodate a public gathering.

UDOH may also initiate a public hearing to discuss the proposed changes if it feels the need is warranted and that the changes require further outreach. In this case, UDOH may arrange to publish notice of the hearing in the State Bulletin when it files the proposed rule, or may arrange to publish this notice in the bulletin or newspaper after the rule filing.

UDOH also has the option of sending proposed changes to Medicaid providers, advocacy groups, shareholders, or others in the healthcare industry during the rulemaking process. This action is usually based on certain issues surrounding the rulemaking, or where UDOH just wants further input and consultation with the aforementioned groups.

In regards to the waiver process, CMS is under no statutory obligation to review 1115 waiver amendments in a timely fashion. The State has had many experiences where waiver amendments have sat with CMS for months and even years before final action was taken. In full compliance with federal transparency requirements, the State is seeking for a limited, defined scope of authority from CMS where the State could modify certain rules related to the approved waiver criteria definitions using a more timely and locally responsive administrative rules process.

**17.** One commenter stated while they support any initiative designed to help Utah's extremely low-income populations, they believe Medicaid is medical insurance, not a housing program, and therefore they do not support this proposal. They believe precious resources should not be directed away from core functions of the Medicaid program.

**Response:** Language in Senate Bill 96 requires UDOH to seek CMS authority to provide housing supports for eligible Medicaid expansion enrollees. In addition to the statutory mandate, the State acknowledged that a growing body of empirical evidence shows that addressing social determinants of health such as housing supports, has the potential to reduce medical utilization and cost. For example, a health care utilization study conducted in Seattle by Mackelprang and colleagues (2014) examined EMS utilization before and after entering a single-site Housing First program. The 91 program participants had substance use disorders. The study did not monitor health outcomes, but examined and categorized the reasons for EMS calls through examination of administrative data, both for two years prior to enrollment in supported housing and two years following enrollment. The study found a 54 percent reduction in EMS calls for those who entered supportive housing.

### **Not Allowing Hospitals to Make Presumptive Eligibility Determinations for the Adult Expansion Demonstration Population**

**18.** Many commenters stated they are opposed to this provision. They believe hospital presumptive eligibility is an important entry point for individuals to receive Medicaid. They believe approval of this proposal will lead to individuals facing significant out of pocket costs, and increased uncompensated care costs for providers. They also stated while they believe retroactive eligibility is an important safeguard they do not believe it is sufficient.

**Response:** Senate Bill 96 directs the state not to implement hospital presumptive eligibility for adults on the Adult Expansion Medicaid program. Most Medicaid programs (including Adult Expansion Medicaid program) offer retroactive eligibility for the three months prior to the month the application is received. Three months retroactive coverage is not a benefit available in the commercial, marketplace, or Medicare plans. Due to the availability of retroactive coverage, uncompensated care costs and individual out-of-pocket expenses will only occur when an individual was never eligible for Medicaid.

**19.** One commenter stated that because the State has already waived retroactive eligibility, this proposal will lead to hospitals not being reimbursed for low income uninsured patients. They also believe this will lead to crippling financial liabilities for patients.

**Response:** The State has not had retroactive eligibility waived for the Adult Medicaid Expansion. These adults can continue to request retroactive eligibility when applying for Medicaid.

If the State obtains authority to waive retroactive eligibility at a later date through an administrative rule process, then the public and the State will be able to discuss at that time how to balance the need of the State to reduce expenditures and the impact on members and hospitals.

**20.** One commenter stated the waiver does not address the gap between those who have qualified under presumptive eligibility and those who successfully complete the Medicaid application process. They believe this does not address the actual impact.

**Response:** The State believes it has addressed this in the waiver amendment. The amendment states that approximately 54 percent of individuals approved for hospital presumptive eligibility are ultimately approved for ongoing Medicaid.

**21.** One commenter stated that Senate Bill 96 does not require the State to eliminate presumptive eligibility, only to “limit”. They also indicate this only applied to the per capita cap waiver, not the fallback plan.

**Response:** While Senate Bill 96 uses the term “limit” in conjunction with the Hospital Presumptive Eligibility (HPE) Program, UDOH has consistently stated that this means to eliminate this group from the larger HPE program which includes several eligibility groups. There have not been any discussions about “limiting” which hospitals or providers may determine eligibility under the HPE program or allowing a limited quota of individuals to qualify at any one HPE approved site. The Senate Bill 96 provisions limiting HPE are included under both the ‘Per Capita Cap’ waiver request as well as the ‘Fallback’ waiver amendment.

### **Managed Care Flexibilities**

**22.** One commenter stated they are extremely concerned that these changes would limit oversight over patient care provided through managed care. They believe these issues require significant oversight to ensure taxpayer funds are being spent appropriately.

**Response:** This change does not limit CMS oversight. This change only allows the State to implement new rates and contracts in a timely manner while minimizing risk of federal funds disallowance. CMS still retains all oversight authority they have by federal law and regulation.

**23.** One commenter stated they are concerned that the previous Per Capita Cap waiver application indicated the State intended to submit plan contracts and rates to CMS by October 1, 2019, which is almost four weeks after the closure of the waiver comment period. It is unknown whether the State has already provided this information to CMS. They request additional clarification.

**Response:** Federal regulations encourage states to submit proposed rates and contracts at least 90 days before the contract/rate period. Rates for the Medicaid expansion group have been submitted to CMS for their review. Contracts for the expansion group are still in draft but will be sent to CMS soon. Both rates and contracts are subject to the current CMS review process.

**24.** One commenter stated they are strongly opposed to the State’s request to “implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary” as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State’s decisions. They believe this places the Medicaid program at increased financial risk, contrary to the waiver’s global concern with making Medicaid a fiscally sustainable program.

**Response:** Under current regulations (42 CFR 438.806) a state must obtain prior approval of a managed care organization (MCO) (comprehensive risk) contract and rates. Prior approval by CMS is a condition for federal financial participation. All managed care rates are calculated under very specific rate setting guidance from CMS by the State’s contracted actuarial firm, Milliman, Inc. The rates must be certified by the actuary as being actuarially sound. The current CMS process for rate approval takes months to complete. At the end of the process, CMS typically approves the rates originally submitted by the State.

The State waits until the rates are approved to reimburse the plan the current rate. This causes a delay in appropriate reimbursement and a significant administrative burden to the State and the plan when the State recoups and repays the plans the approved rates.

Under this waiver request, the State will still submit rates and contracts to CMS for final approval. The purpose of this waiver request is to allow the State to pay the current proposed rate and be assured federal financial participation pending CMS’s review. This waiver will put the State at less risk by assuring federal match. If CMS requires any change to the rate or contract, the State will not be at risk of losing any federal match for the past period and will only be required to make changes prospectively resulting in far less administrative burden.

**25.** One commenter stated they are strongly opposed to the State’s request for more flexibility in implementing contracts and rates prior to formal approval by CMS as this proposal leaves the State open to what could be significant financial losses or untenable contract situations should CMS not concur with the State’s decisions.

**Response:** Please see the State’s response to Comment 24.

**26.** One commenter stated they are strongly opposed to the State’s request for more flexibility in implementing directed payments and rates prior to their formal approval by CMS as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State’s decisions.

**Response:** Directed payments are part of the rate setting process. Please see the State’s response to Comment 24.

**27.** One commenter stated they are strongly opposed to the State’s proposal to “adopt an approach to network adequacy, access to care, and availability of services” without any firm definition of how those parameters would be established.

**Response:** Currently CMS does not provide any specific guidance or standards to states regarding network adequacy, access to care, and availability of services. The State is currently working to establish these standards and parameters in accordance with the requirements in federal regulation. The State intends to adopt these standards through administrative rule making allowing for full transparency and public comment.

### **Benefits**

**28.** One commenter stated they are extremely disappointed that adults with dependent children receive fewer benefits than adults without children. They believe benefits should be the same.

**Response:** Currently, adults without dependent children (including Targeted Adult Medicaid members) receive traditional Medicaid benefits. Adults with dependent children receive non-traditional Medicaid benefits. This includes Parent Caretaker Relative Medicaid members. The State chose to keep benefits received by Adult Expansion Medicaid members consistent with the benefit packages offered today.

### **Demonstration Hypotheses and Evaluation**

**29.** One commenter suggests there should be a comparison of how the people on ESI are doing health wise compared to those who receive regular Medicaid.

**Response:** As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The suggested hypotheses may be refined and/or amended after consulting with the evaluator.

**30.** One commenter stated they do not agree with the hypotheses for community engagement, which proposes to compare health outcomes of Medicaid beneficiaries subject to the requirement with those who are not. They believe these are biased comparisons because people who are subject to the requirement are, by virtue of the fact they do not qualify for an exemption, almost certain to be more healthy than those not subject to the requirement.

**Response:** As stated above, the State will work with an independent evaluator to develop an evaluation plan. However, the State will follow CMS guidance specific to community engagement initiatives, in

developing an evaluation plan. The evaluation plan also requires CMS approval prior to conducting the evaluation. The State will consider this concern in consultation with the independent evaluator.

**31.** One commenter stated they are concerned with how the waiver will be evaluated. They stated they are left to wonder how the impact or effectiveness in terms of increasing coverage or access, and improving quality and efficiency will be monitored and safeguarded.

**Response:** As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The evaluation plan requires CMS approval prior to conducting the evaluation.

### **Enrollment Limit**

**32.** Several commenters referred to CMS's August 16, 2019, letter to Utah, which denies Utah's request to implement an enrollment limit for the expansion population, as this would be akin to partial expansion, and would make the State ineligible for the requested 90/10 FMAP.

**Response:** CMS has officially responded to the State's Per Capita Cap waiver indicating it will not approve this provision at this time; however, Senate Bill 96 requires that the State request this program feature again in the 'Fallback' waiver amendment.

**33.** Many commenters stated an enrollment limit would leave many people without access to critical care. They believe anyone who is eligible should receive Medicaid, as it is an entitlement program. They believe this provision does not meet the objectives of Medicaid. They are also concerned that there will be no waitlist, which they believe creates barriers to individuals needing care.

**Response:** As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. While the State understands the commenters' concerns, enrollment in this adult expansion population will be limited by the amount of the state tax collected and other funds appropriated by the Legislature to fund the state share of the cost to operate this Medicaid program. Current estimates place funded enrollment at 120,000-140,000.

As was done previously with the Primary Care Network (PCN) and the Targeted Adult Medicaid program, the State is requesting the ability to open and close enrollment for this program in order to stay within the budget. Once the budget limit has been reached, enrollment will be closed. Enrollment numbers will be evaluated periodically to determine if additional individuals can be covered. If additional individuals can be covered, enrollment will be opened and applications will be accepted. All

individuals applying during the open enrollment period will be reviewed for eligibility and enrolled in the program if eligible.

**34.** One commenter sought clarity on how the enrollment limit will work with retroactive eligibility.

**Response:** If an individual applies for Adult Expansion during an open enrollment period, and they request retroactive medical coverage, they will be allowed retroactive coverage (if otherwise eligible). This applies even if the retroactive months were during a closed enrollment period. However, if the individual applies when enrollment is closed (and is therefore not eligible), retroactive coverage will not be allowed, even if the retroactive months were during open enrollment. The individual must apply during an open enrollment period to receive retroactive coverage.

**35.** One commenter stated that enrollment limits would force health centers to supplement the Medicaid program in a way Congress did not intend to subsidize the care of those who are otherwise eligible.

**Response:** The State is operating its current “Bridge” expansion program with an enrollment limit. This waiver proposal is expected to continue coverage for an estimated 120,000 to 140,000 Utahns. Some of these are individuals who previously had no health care coverage, many of whom sought care through health centers. Continuation of this coverage for these adults helps relieve the financial burden of health centers for the care of the uninsured.

**36.** One commenter stated the State did not provide the required assessment to the impact on enrollment for this proposal.

**Response:** The State’s estimates for impacts to enrollment are stated within the applicable waiver application sections. The budget neutrality documents require enrollment figures to be equivalent for “without waiver” and “with waiver.” Budget neutrality is calculated at a per-member level and there are no calculated savings that result from reduced enrollment.

**37.** One commenter stated that the State cites “fiscal sustainability” as a reason for an enrollment limit. However, they add that it is hardly clear that Utah’s Medicaid program faces a crisis of sustainability that necessitates a waiver of eligibility provision. They add that the waiver provides no evidence to suggest that the value of any potentially achievable sustainability would outweigh the potential negative effects of the waiver on coverage.

**Response:** As stated in the response to Comment 1, Medicaid’s General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent over the last 19 years. Senate Bill

96 directs the State to request approval of an enrollment limit to stay within the appropriations for this program.

### **Community Engagement Requirement**

**38.** One commenter sought assurances that the State will follow fair hearing processes when applying the community engagement requirements.

**Response:** Individuals who become ineligible due to failure to comply with the work requirement will retain all federally mandated appeals rights. All decision notices sent to enrollees contain information on how to appeal decisions. The current process for appeals will be followed.

**39.** Many commenters stated they disapprove of the community engagement requirement, as it does not promote the objectives of Medicaid, as shown by recent court rulings.

**Response:** The State received approval to implement a community engagement requirement. As stated in the CMS approval letter dated March 29, 2019, "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.""

**40.** Many commenters stated this requirement will increase the administrative burden on impacted individuals, likely decreasing the number of people with coverage. They cited Arkansas as an example of individuals losing coverage. They also believe the administrative cost to the State will be high.

**Response:** Utah's community engagement requirement is significantly less onerous than Arkansas's requirement. Utah is structuring its community engagement requirement to be similar to SNAP. Individuals who are meeting the SNAP requirement or who are already exempt under the SNAP requirement will meet the Medicaid community engagement requirement. In addition, due to similarity to SNAP, Utah already has the technology and the infrastructure to support a community engagement requirement for Medicaid. Therefore, the administrative cost to Utah will be minimal. Finally, due to the simplicity of Utah's community engagement requirement and the options for exemption or hardship, Utah's estimates on the impact on enrollment may differ from those estimated by other states.

**41.** Many commenters stated they believe the current exemptions will not capture all individuals who have, or at risk of serious and chronic health issues that prevent them from working.



**Response:** Many adults with chronic conditions are able to work and may want to do so. Any adult can access employment services or choose to participate. However, the State is developing a list of potential serious or chronic health conditions that would meet the definition of physically or mentally unable to work. The State is considering using these conditions to automatically exempt an adult with one of these conditions.

**42.** Several commenters stated concerns with the impact to children if their parents lose coverage due to the community engagement requirement and enrollment limit. They state that studies show that if parents do not have medical coverage, their children are less likely to have medical coverage.

**Response:** Children may be determined eligible for Medicaid independently from their parents. Many children receive Medicaid or CHIP even though their parents were not previously eligible for coverage or are currently not covered by Medicaid. Members will be provided with clear information on how to meet the community engagement requirement. In addition, the State has provided members with multiple pathways to meet an exemption or request a hardship waiver when one is warranted. The State intends to monitor and evaluate the implementation of the community engagement requirement to minimize any potential negative impact on children.

**43.** Several commenters requested exemptions for specific illnesses or diseases, such as cancer and HIV. They indicated Michigan and Arizona as states who have done so, by including these in the definition of medically frail.

**Response:** The State appreciates this feedback from commenters. The current exemptions proposed in the waiver are quite broad and are intended to cover any condition which prohibits an individual from participating in community engagement. In addition, the waiver also includes a request for a hardship exemption to address unique circumstances. The State is also considering creating a list of conditions that would automatically exempt an adult with one of these conditions.

**44.** One commenter stated the implementation and administrative costs will be high, as indicated by other states. They ask that the State include a projection of administrative costs associated with implementation be included in the waiver.

**Response:** Other states have designed their community engagement requirements very differently than what Utah has proposed. Some states designed entirely new systems to capture information for their community engagement program. Utah's program relies on existing resources at DWS that already provide job assessment, training, and search reporting for SNAP recipients. The State anticipates operating the community engagement requirement within its existing resources.

### **Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults**

**45.** Many commenters are strongly opposed to the request to waive EPSDT. They state EPSDT is the backbone of the Medicaid program for children and young adults and ensures that all medically necessary services they are found to need are provided. They also state that this benefit is much needed due to the mental health and SUD crisis within this population. In addition, they state that dental care would be cut at a time when young adults are entering the job market, and it has been proven that dental issues impact an individual's ability to get employment.

**Response:** Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. In addition, as of November 2017, all adults on Utah Medicaid, including 19 and 20 year olds, receive the full array of behavioral health services.

Full dental services have not been available for most adults between 19-64 with or without dependent children (only disabled 19 and 20 year old adults receive full dental benefits). Budget estimates for Senate Bill 96 did not include dental coverage for 19 and 20 year old adults. Expanding dental benefits to these adults would require an additional appropriation.

**46.** One commenter stated the Secretary does not have the authority to waive EPSDT, both because Congress' intent with respect to EPSDT coverage is abundantly clear, and because the requirement is located outside of § 1396a. They also stated that without EPSDT these individuals will not receive medically necessary services, as Utah limits coverage of certain mental health services for adults enrolled in its 1115 PCN waiver.

**Response:** Previous Secretaries have approved and reauthorized Utah's current waiver of EPSDT. Utah's 1115 Primary Care Network demonstration waiver includes a waiver of EPSDT for 19-20 year Current Eligible (Non-Traditional parents 0-40 percent FPL). In addition, effective November 1, 2017, full mental health benefits were restored for all adults as a result of a waiver amendment to the PCN Waiver. Therefore there are no differences in behavioral health benefits for adults.

**47.** One commenter stated the EPSDT waiver should be rescinded because it was not included in Senate Bill 96 and was not requested by the state legislature.

**Response:** Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. This waiver continues to exist for parents whose income is between 0 to 40 percent FPL. Although not required by Senate Bill 96, the State is requesting the same waiver of EPSDT requirements for 19-20 year old adults with higher incomes as a matter of

equity in the adults with dependent children group. Senate Bill 96 authorizes UDOH to include additional flexibilities and cost controls in this waiver request beyond those specifically identified in the bill.

### **Employer-Sponsored Insurance (ESI) Requirement**

**48.** Several commenters stated they are concerned that this proposal will divert funds that could be used for patient care to cover the administrative costs of coordinating benefits between the ESI provider and Medicaid. They do not believe this an efficient use of funds for such a small portion of the population. They also believe ESI creates administrative complexity.

**Response:** The State already has established processes for purchasing ESI and coordinating benefits and payments for members. As such, this process does not require significant new administrative infrastructure and is not expected to divert funds for patient care. ESI presents an opportunity for members to be covered with a commercial plan as their primary benefit as well as Medicaid as a secondary benefit while maintaining cost effectiveness.

**49.** One commenter stated they are concerned about the beneficiary communications around the wraparound benefit offered. They believe this will create unnecessary complexity and barriers to care for beneficiaries. They state national research shows states have not sufficiently explained the availability of wraparound services.

**Response:** For those beneficiaries that have access to ESI we will notify them in advance of the requirement to enroll and allow time for them to enroll in their coverage. After the ESI coverage is added, all future claims are processed by the ESI coverage first and the Medicaid coverage second. This is a routine and regular process for health insurance companies and Medicaid has years of experience in processing these types of claims. Some individuals may receive additional services if their health plan covers beyond the scope of Medicaid's services.

**50.** One commenter referred to concerns that remain from the previous waiver request for ESI. These concerns include: timeframe that the individual will be "locked-out" if they fail to enroll in ESI; how ESI coverage and premium amount will be verified; what safeguards will be in place to ensure someone does not lose coverage due to an individual or state error; what occurs if someone accidentally misses an enrollment period.

**Response:** The State is proposing to lock-out individuals from Medicaid when they miss the opportunity to enroll, up until such time that the person enrolls in their employer sponsored plan, lose access to their employer sponsored plan, or 12-months, whichever comes first. The State will be clear in its

communication to beneficiaries so they will know when this requirement applies to them. The State will validate the premium using all available verification methods except “customer statement”, meaning that health plan enrollment may be validated electronically, through a collateral contact with the employer or insurance company, or by other paperwork turned in by the beneficiary. In order to protect beneficiaries, they always have the right to request a fair hearing if they believe they have been closed or denied in error.

**51.** One commenter stated that the State did not include an estimate regarding the number of individuals that would lose eligibility due to failure to enroll in ESI coverage.

**Response:** The State estimates 100-200 members per year will lose eligibility due to failure to enroll in ESI coverage. This information has been added to the waiver application.

### **Changes through Administrative Rulemaking**

**52.** Several commenters expressed concern that the request to allow the State to make certain changes through the administrative rule process would relinquish federal oversight of the areas where the State is allowed to make these changes. They also believe that bypassing the full notice and comment process could place the State at an undetermined financial risk should CMS come out later with a negative decision on something that had only been processed (and approved) at the state level.

**Response:** The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State’s Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all rulemaking at its Medical Care Advisory Committee and the Utah Indian Health Advisory Board, which are open to the public. While the state administrative rule process and the federal 1115 waiver amendment process both require UDOH meet certain transparency requirements, the administrative rule making process is more timely which allows the State to implement necessary changes without significant delays.

Finally, the State anticipates that the federal government will include language in the State’s Standard Terms and Conditions that requires the State to notify CMS of any proposed and final rulemaking so

CMS can maintain its oversight of the State's waiver. Therefore, the State does not believe this process creates any additional or undetermined financial risk.

**53.** One commenter stated that if the State would like to make specific changes identified in this section of the waiver at this time, it should explicitly ask CMS to waive these provisions in its current application and include a more complete analysis of their impact on beneficiaries.

**Response:** Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver. The process the State is proposing will allow the State to make changes within the parameters established by the waiver in a transparent but more timely manner.

#### **\$25 Copay for Non-Emergent use of the Emergency Department**

**54.** Many commenters are opposed to a \$25 copay for non-emergent use of the emergency department. They believe this could deter individuals from seeking necessary care during emergency situations, and they should not be forced to self-diagnose. They believe patients should be educated regarding what is emergent vs. non-emergent, if this is approved and implemented. They also state a graduated cost structure combined with education efforts would promote the state's goal of reducing non-emergent use of the emergency room and could be of benefit to Medicaid beneficiaries.

**Response:** The State appreciates this feedback. The State is modifying its proposal to include additional education. The State anticipates providing education after the first non-emergent use of the emergency room and quarterly thereafter. If a beneficiary does not modify his/her behavior and continues to inappropriately use emergency departments for non-emergent reasons, a nominal surcharge will be added to their premium.

**55.** One commenter stated the proposal does not meet key criteria of the Section 1916(f) of the Social Security Act for when a Medicaid beneficiary can be charged a copay.

**Response:** The State appreciates this feedback. Because the State has changed its proposal regarding the \$25 copay, Section 1916(f) will no longer apply.

#### **Expansion of Targeted Adult Medicaid Subgroups**

**56.** Several commenters stated they support new subgroups but do not support closing enrollment for individual subgroups under administrative rule. They believe the State's request to make changes to this

program without going through CMS' required notice and comment procedure is contrary to Medicaid's emphasis on transparency in the 1115 waiver review and approval process.

**Response:** The State currently has approval to suspend enrollment for Targeted Adult Medicaid. The State is requesting to continue this authority, and to apply this authority to the individual subgroups. If an individual is ineligible for the Targeted Adult Medicaid program due to enrollment being suspended, eligibility for Adult Expansion Medicaid will be determined. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

### **Premiums**

**57.** One commenter stated the Medicaid Act prohibits states from charging premiums to individuals with household income below 150 percent of FPL. These limits exist outside of § 1396a, and as a result, cannot be waived under § 1115. Time and again, Congress has made clear its intent to insulate the substantive limits on premiums and cost-sharing from waiver under § 1115.

**Response:** CMS has approved premiums in other States (e.g., Iowa and Michigan). As stated in Comment 1, Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act. CMS has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking.

**58.** Many commenters stated that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. They also state premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling.

**Response:** Medicaid beneficiaries who will pay premiums are those who have been eligible for coverage in the federal marketplace and have likely paid premiums before. When members financially participate in their healthcare they are more engaged in their healthcare decisions and better prepared for future health coverage in the private sector.

**59.** One commenter stated the proposed waiver does not indicate whether services received during the suspended period would be retroactively covered.

**Response:** Individuals can request coverage for months in which they failed to pay premiums (up to 3 months). However, they must pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

**60.** One commenter stated they are concerned there is no grace period in which to pay the premium before they lose eligibility.

**Response:** The State is proposing to follow the process used for the Children’s Health Insurance Program (CHIP), which is consistent with private health insurance. Individuals must pay their premium by the end of the month it is due or they will lose eligibility. Individuals may also need to pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

**61.** Several commenters stated there will be a high administrative cost to implementing and collecting premiums. They believe the State has not included any consideration of the administrative costs of a premium.

**Response:** The State intends to build upon existing infrastructure for collecting premiums from CHIP members. This is expected to mitigate the increased administrative cost of collecting premiums for Medicaid Expansion adults with incomes from 101-133 percent FPL. The State is still developing its estimates for the cost of implementing and collecting these new premiums.

**62.** One commenter stated the State is offering an overly optimistic percentage of people who would fail to pay a premium.

**Response:** The State is estimating that disenrollment due to non-payment of premiums will be similar to experience with Marketplace plan enrollees. The State used information from Washington State’s Annual Grace Period Report (2017)<sup>1</sup> in which 5,077 enrollees out of 149,628 were terminated for non-payment of premiums. This equates to 3.4 percent and the State has assumed the same percentage.

<sup>1</sup>[https://www.wahbexchange.org/wp-content/uploads/2018/01/HBE\\_EB\\_180112\\_Annual-Grace-Period-Report.pdf](https://www.wahbexchange.org/wp-content/uploads/2018/01/HBE_EB_180112_Annual-Grace-Period-Report.pdf)

## ATTACHMENT 4

### **Tribal Consultation**







# Utah Indian Health Advisory Board (UIHAB) Meeting

10/11/2019

9:00 AM – 1:00 PM

Utah Department of Health

Cannon Health Building

288 North 1460 West

Room 125

Salt Lake City, UT 84114

(801) 538-6771 or (801) 712-9346



Meeting called by: UIHAB **DRAFT DRAFT DRAFT DRAFT DRAFT**

Type of meeting: Monthly UIHAB NATIONAL LEAD PREVENTION MONTH!

Facilitator: Melissa Zito

Note taker: Dorrie Reese Call In **1-877-820-7831 passcode 868079 #**

Please Review: Board minutes, Medicaid Rules & SPA document(s), additional materials via presenters.

## Agenda topic

<b>9:00 AM</b>	<b>UIHAB Meeting</b> Welcome & Introductions Approval of Minutes	Lorena Horse, Chair & Ed Napia, Vice Chair
<b>9:15 AM</b>	Medicaid Expansion "Fall Back" Option	Nate Checketts
<b>10:00 AM</b>	Committee Updates & Discussion <ul style="list-style-type: none"> <li>✦ UT Medicaid Eligibility Policy</li> <li>✦ Medicaid &amp; CHIP State Plan Amendments (SPA) &amp; Rules</li> <li>✦ DWS Medicaid Eligibility Operations</li> <li>✦ Federal and State Health Policy Impacting I/T/U</li> <li>✦ MCAC &amp; CHIP Advisory Committees</li> <li>✦ Opioid SOR Grant</li> </ul>	Jeff Nelson Craig Devashrayee Jacoy Richins Melissa Zito Donna Singer & Ryan Ward Jeremy Taylor & Kassie John
<b>10:30 AM</b>	I/T/U & UDOH Updates <ul style="list-style-type: none"> <li>✦ "Take 10" – Emergency Preparedness</li> <li>✦ UTERC</li> </ul>	ALL Melissa Zito Anna Boynton
<b>11:10 AM</b>	<b>BREAK</b>	
<b>11:15 AM</b>	Huntsman Cancer Institute Mobile Mammography	Lynette Phillips
<b>11:30 AM</b>	MCH Grant Follow Up from Survey	Lynne Nilson & Sharon Talboys
<b>11:50 AM</b>	Hemophilia Disease Management Program	Trevor Smith
<b>12:05 PM</b>	Utah Cancer Control Program Outreach	Marie Nagata
<b>12:40 PM</b>	Wrap Up	
<b>1:00 PM</b>	Adjourn	

# THE NAVAJO NATION



JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

Submitted via email: [Medicaid1115Waiver@utah.gov](mailto:Medicaid1115Waiver@utah.gov)

October 27, 2019

Utah Department of Health  
Division of Medicaid and Health Financing  
PO Box 143106  
Salt Lake City, UT 84114-3106  
Attn: Jennifer Meyer-Smart

RE: Amendment to the 1115 Primary Care Network Demonstration Waiver

Dear Division of Medicaid and Health Financing,

On behalf of the Navajo Nation please find the following comments in reference to the Fallback Plan on the proposed amendment of the Utah Section 1115 Demonstration waiver application pursuing to implement several new provisions that will increase coverage but impose restrictions for Utahns across the state. The Navajo Nation supports equitable health care access and quality of care to further reduce health care disparities. We support Utah to implement Medicaid Expansion as intended by the Affordable Care Act. Utah has fell short of these requirements in these proposed amendments.

## **Federal Trust Responsibility and Tribal Consultation**

The Utah Medicaid Program and Centers for Medicaid and Medicare Services (CMS) have a responsibility to fulfill trust responsibilities in providing access to health services for American Indian and Alaska Natives (AIAN). This responsibility and federal laws support unique treatment for AIANs Medicaid enrollees. In accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the state ensures meaningful consultation process and occurs in a timely manner on program decisions impacting Indian Tribes. The Tribal consultation with Tribal leaders is occurring in November, well after the waiver is submitted to CMS.

### *Section II. Program Overview and Demonstration Eligibility*

#### *A. Approved Demonstration Populations and Components*

*Continue the following components for the Adult Expansion and Targeted Adult Populations and Targeted Populations, which are currently authorized under the State's 1115 Demonstration Waiver.*

Utah proposes an exemption for members of federally recognized Tribes from ...

- community engagement requirements,
- enrollment limits, and
- Employer-Sponsored Insurance (ESI) coverage.

The Navajo Nation recommends continued exemption as a federally recognized Tribe and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Imposing work requirements is not aligned with the federal trust responsibility and congressional intent to increase access to Medicaid resources in the Indian health system.

# THE NAVAJO NATION

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JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

*The state is seeking federal approval to implement the following proposals:*

## *B. New Demonstration Waiver Requests*

### *1. Income Limit Increase for Adult Expansion Population*

*“Increase the income limit for the Adult Expansion Population to 133 percent federal poverty level (FPL), to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Population.”*

Utah proposes to increase the limit for the Adult Expansion Population to 133 percent FPL for Navajo members and federally recognized Tribes. The Navajo Nation recommends the increase to 138 percent at a minimum, but should further increase to 200 percent FPL. As well, the FPL apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Utah should fully expand so the state is not paying an extra \$2.5 million every month.

### *3. Housing Related Services and Supports (HRSS)*

*The State intends to offer the following HRSS:*

- 1. Tenancy Support Services*
- 2. Community Transition Services*
- 3. Supportive Living/Housing Services*

Utah proposes to seek authority to evidence-bases services, provide housing supports, and administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. The Navajo Nation recommends clarity of the rulemaking process and any changes should not be at the expense of other services approved and proposed in the amendment for the targeted adult group.

### *4. Targeted Adult Medicaid Eligibility Definitions*

*Expansion of the Target Adult Group*

- Chronic homeless*
- Involved in the justice system AND in need of substance abuse or mental health treatment*
- Needing substance abuse or mental health*

Utah proposes to make this new group eligible for the “Targeted Adult Group.” The Navajo Nation recommends continuous coverage/eligibility or 12 months; however, we oppose the ability for the state to suspend enrollment.

### *5. Flexibility to Make Changes through the State Administration Rule Making Process*

Utah proposes the ability to make changes for the Medicaid Expansion through state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. The Navajo Nation recommends the state to conduct timely and proper Tribal Consultation to Tribal leaders in Utah. We recommend the state remove these provisions prior to submission to CMS.

# THE NAVAJO NATION

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JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

## *Section IV. Demonstration Benefits and Cost Sharing Requirements*

*Cost Sharing for Non-Emergent Use of the Emergency Room, Cost Sharing for Individuals without ESI, Cost Sharing for Employer-Sponsored Insurance.*

Utah proposes to raise premium amounts and certain cost sharing; however, exemptions exist for premium raises and certain cost sharing for individuals with verified members in a federally recognized Tribe. The Navajo Nation recommends exemption as a federally recognized Tribes and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

## *Section V. Delivery System – Managed Care*

Utah proposes that Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the Fee-for-Service network. Beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after the approved Medicaid Expansion. Utah proposes greater authority to administer its managed care delivery system. The Navajo Nation recommends exemption for federally recognized Tribes regardless of where the beneficiaries reside and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Navajos commute between non-mandatory and mandatory counties; therefore, increasing access to ACOs and/or non-ACOs is recommended based on existing health care access challenges.

## **Conclusion**

Utahns voted for full expansion for Medicaid; however, this “Fallback Plan” amendment does increase coverage up to 138% with greater restrictions that could deter individuals from accessing necessary health care services. It is also critical for the Indian health system to receive 100% reimbursement to states for services provided to IHS-eligible individuals by Indian health care providers; else for non-Indian health care providers to limit reimbursement (FMAP) to a state’s standard FMAP rate.

We understand that CMS has the ultimate authority to approve or disapprove Medicaid waivers, please consider the federal trust responsibility to all American Indian and Alaska Natives. The state should fully expand pursuant to the Affordable Care Act.

Thank you for this consideration for comments. If you have any questions, please contact Jill Jim at [Jill.Jim@ndoh.org](mailto:Jill.Jim@ndoh.org) or (928) 871-6350.

Best Regards,

  
President Jonathan Nez  
NAVAJO NATION