DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

November 29, 2021

Emma Chacon
Interim Director
Division of Medicaid and Health Financing
Utah Department of Health
PO Box 143101
Salt Lake City, UT 84114-3101

Dear Ms. Chacon:

The Centers for Medicare & Medicaid Services (CMS) completed its review of Utah Medicaid Integrated Care (UMIC) Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC #134, of Utah's section 1115 demonstration, "Primary Care Network" (Project Numbers: 11-W-00145/8 and 21-W-00054/8), effective through June 30, 2022. CMS determined that the Evaluation Design, which was first submitted on May 6, 2021 and subsequently revised on September 29, 2021, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore, approves the state's UMIC Evaluation Design.

CMS added the approved UMIC Evaluation Design to the demonstration's STCs as Attachment P. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR § 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

In light of the timing of the amendment of the UMIC component in Utah's Primary Care Network demonstration, the state's evaluation of the UMIC program, consistent with this approved design, will be included in a Summative Evaluation Report to be due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR § 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Utah on the Primary Care Network section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2021.11.29 11:50:12 -05'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Mandy Strom, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: Primary Care Network (PCN)

AWARDEE: Utah Department of Health

Title XIX Costs Not Otherwise Matchable Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, as amended, from December 16, 2020 through June 30, 2022, be regarded as matchable expenditures under the state's Medicaid Title XIX state plan. The expenditure authorities listed below promote the objectives of title XIX.

1. **Current Eligibles.** Expenditures for optional services not covered under Utah's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR 438 *et seq*.

2. **Demonstration Population I.** Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 95 percent of the federal poverty level (FPL) (effectively 100 percent with the five percent income disregard) who are not otherwise eligible for Medicaid, as described in the Special Terms and Conditions (STCs). This expenditure authority will end effective April 1, 2019.

3. **Demonstration Population III.** Expenditures for premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' employer sponsored insurance (ESI) plan, who are not otherwise eligible for Medicaid, as described in the STCs.

4. **Demonstration Population V.** Expenditures for premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the

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

5. **Individuals who are Blind or Disabled.** Expenditures for dental benefits for individuals who are blind or disabled and who are eligible for Medicaid, as described in the STCs.

6. **Individuals who are Aged.** Expenditures for dental benefits for individuals who are age 65 and older, and are eligible for Medicaid, as described in the STCs.

7. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.

8. **Targeted Adults.** Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment.

9. **Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

10. **Adult Expansion Population.** As of January 1, 2020, expenditures to provide coverage to adults, ages 19 through 64, who are not Current Eligibles, and have household income at or below 133 percent of the FPL, as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents will receive state plan coverage, while members of the Adult Expansion Population who are custodial parents/caretaker relatives will receive the Current Eligibles benefit package, as specified in the STCs.

11. **Mandatory Employer Sponsored Insurance.** Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.

12. **Intensive Stabilization Services Program.** Expenditures to provide an assessment and service package including state plan behavioral services and home and community-based respite and non-medical transportation services reimbursed using a daily bundled rate during the first eight weeks of the 16-week intensive stabilization program for Medicaid eligible children/youth in state custody or at risk of being placed in state custody experiencing significant emotional and/or behavioral challenges.

13. Residential and Inpatient Treatment for Individuals with Serious Mental Illness

Upon CMS approval of the serious mental illness (SMI) Implementation Plan, expenditures for services furnished to eligible individuals ages 21 through 64 who receive treatment for a SMI and who are short-term residents in facilities that meet the definition of an IMD.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

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

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

To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group, with the exception of the Former Foster Care Youth from another state to whom state plan services will be provided. To enable the state to vary the amount, duration, and scope of services to individuals in the Targeted Adults, blind, aged, and disabled expenditure populations. To enable the state to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system. To enable the state to vary the amount, duration, and scope of services offered to individuals in the Adult Expansion Population demonstration, based on whether the individual is a custodial parent/caretaker or not a custodial parent/caretaker. To enable the state to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries with a primary diagnosis of OUD or another SUD and living in Salt Lake County, which are not available to other beneficiaries under the Medicaid state plan. To enable the state to provide intensive stabilization services (ISS) to Medicaid eligible children/youth under age 21 in state custody or at risk of state custody experiencing significant emotionally and behavioral challenges.

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

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

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

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

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

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

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

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

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

To enable the state not to cover certain services required to treat a condition identified during an EPSDT screening. This not applicable applies to 19 and 20 year olds in Title XIX populations who are not part of the Adult Expansion Population. This not applicable does not apply to blind and disabled enrollees who receive dental benefits through the demonstration.

7. Methods of Administration **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

To the extent necessary to relieve the state of the responsibility to assure non-emergency medical transportation to and from providers for beneficiaries with dependent children enrolled the Adult Expansion Population, except that this requirement nevertheless shall apply with respect to those eligible for EPSDT services.

8. Compliance with ABP requirements **Section 902(a)(10)(A)(i)(VIII) insofar as it incorporates section 1902(k), and sections 1902(k) and 1903(i)(26) insofar as they incorporate section 1937 and 42 CFR 440.390**

In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that non-emergency medical transportation (NEMT) is not covered for certain beneficiaries for whom its assurance would otherwise be required.

Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, November 1, 2017 through June 30, 2022, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for Demonstration

Population VI, described below, except those specified below as not applicable to these expenditure authorities.

1. **COBRA Children (Demonstration Population VI).** Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such expenditures are authorized without regard to the funding limitation under section 2105(c)(2) of the Act. Moreover, the Title XXI requirements listed below do not apply to the benefits for this population.

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

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

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

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

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

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

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

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

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

5. **Benefit Package Requirements** — **Section 2103**

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

6. Cost Sharing Section 2103(e)

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

TITLE: **Primary Care Network**

AWARDEE: **Utah Department of Health**

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I. PREFACE

The following are the Special Terms and Conditions (STCs) for Utah's Primary Care Network (PCN) Medicaid section 1115(a) demonstration program (hereinafter referred to as "demonstration") to enable the Utah Department of Health, Division of Health Care Financing (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated.

The STCs set forth conditions and limitations on the expenditure authorities and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional expenditure authorities, nor expand upon those separately granted. The demonstration will be statewide and is approved for a five-year period, from November 1, 2017 through June 30, 2022, unless otherwise specified. Approval shall be directed to the CMS Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter. All previously approved STCs, Waivers, and Expenditure Authorities are superseded by the STCs set forth below.

II. PROGRAM DESCRIPTION AND OBJECTIVES

Utah's PCN is a statewide section 1115 demonstration to expand Medicaid coverage to certain adults who are not eligible for state plan services and to offer these adults and children on the Children's

Health Insurance Program (CHIP) an alternative to traditional direct coverage public programs. When the demonstration was first approved in 2002, state plan eligibles (referred to as Current Eligibles), who are categorically or medically needy parents or other caretaker relatives, were provided a reduced benefit package and required to pay increased cost-sharing. Savings from this state plan population funded a Medicaid expansion for up to 25,000 uninsured adults age 19 to 65 with family incomes up to 150 percent of the Federal Poverty Level (FPL). This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services. Also, high-risk pregnant women, whose resources made them ineligible under the state plan, were covered under the demonstration for the full Medicaid benefits package. This demonstration provides access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services for Medicaid beneficiaries with serious mental illness (SMI) and/or SUD. Through the demonstration, the state also provides clinically appropriate treatment to beneficiaries with SMI and/or SUD who are short-term residents in residential and inpatient treatment settings that qualify as an IMD.

The goal of this approval is for the state to increase the maximum premium assistance reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount, through the state administrative rulemaking process, rather than by an amendment to the demonstration.

During the demonstration period, of January 1 2021 through June 30, 2022, the state seeks to achieve the following goals related to the latest amendment:

Premium Assistance Goals:

1. Reduce the number of uninsured individuals in Utah.
2. Allow individuals to continue to purchase health insurance as the costs of health coverage rise.

Previous Demonstration Waivers and Amendments:

- The Utah PCN 1115 demonstration waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.

- **Amendment #1 -** This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that become pregnant get the full Medicaid state plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform with changes to the benefits available under the state plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the state plan. (Approved on August 20, 2002, effective on July 1, 2002)

- **Amendment #2 -** This amendment provided a premium assistance option called Covered at

Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the state subsidizes the employee's portion of the premium for up to 5 years. The employer- sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer- sponsored plan. With this amendment, the state was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the state reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003).

- **Amendment #3 -** This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004).

- **Amendment #4 -** This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the state provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005).

- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005).

- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006).

- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006).

- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006).

- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspended Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006).

This amendment provides the option of ESI assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least five percent of the household's countable income. The state subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it is $120 per month. If dental benefits are not provided by a child's ESI plan, the state offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the Title XXI out-of-pocket cost sharing limit of five percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well- baby/well child care services, age appropriate immunizations, physician visits, hospital inpatient, and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

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

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

state under these STCs.

The ARRA COBRA subsidy can last for up to nine months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ends, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP will continue to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of programmatically-eligible individuals in the household. However, as with the existing ESI program, the state will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

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

- **Amendment #11** - This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150 percent of the FPL to 200 percent of the FPL. This amendment was approved by CMS on September 28, 2012.

- **Section 1115(e) Extension** - On June 23, 2006, the State of Utah formally requested an extension of their PCN 1115 demonstration waiver under the authority of section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.

- **Section 1115(f) Extension** – On March 1, 2010, the State of Utah formally requested an extension of the PCN demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.

- **Temporary Extension –** The December 24, 2013 amendment and temporary extension, changed the STCs so beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and state plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.

- **Temporary Extension –** The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively 100 percent of the FPL because of the 5 percent income disregard) in order to ensure

that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).

- **Temporary Extension –** On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.

- **Temporary Extension –** December 16, 2016, the demonstration was temporarily extended on through December 31, 2017.

- **Amendment #12 –** On June 29, 2017, CMS approved an amendment which allows the state to provide state plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.

- **Amendment #13 –** On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, Targeted Adults, under which eligible beneficiaries receive state plan services. This new population is made of adults without dependent children, age 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the state has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.

- **Amendment #14** – This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this waiver. The state withdrew this amendment.

- **Amendment #15** – In February 2019, the state received the authority provide comprehensive dental benefits to Targeted Adults who are receiving SUD treatment. In addition, the state received approval to provide state plan Medicaid coverage to Former Foster Care Youth who were ever enrolled in Medicaid in another state.

- **Amendment #16 –** In March 2019, the state received authority to provide full state plan benefits to adults without children who have incomes up to 95 percent of the FPL and the Current Eligible benefit package to adults with children who have incomes up to 95 percent of the FPL (together, these categories are known as the Adult Expansion Population) effective April 1, 2019. If the state determines that the state needs to close enrollment in this Medicaid eligibility group (MEG) due to budgetary restrictions, coverage will be closed and no applicants will be able to enroll in this MEG until enrollment re-opens. Beneficiaries in this category who have access to ESI coverage are required to enroll in that coverage to maintain Medicaid eligibility, and receive wraparound coverage. In addition, non-exempt Adult Expansion Population beneficiaries are required to complete community engagement requirements (or demonstrate good cause for failing to do so)

each benefit year to be eligible for continued coverage. Lastly, this approval allowed the state to provide clinically managed residential withdrawal services to adult beneficiaries who reside in Salt Lake County.

- **Amendment #18** – In November 2019, the state received the authority to provide intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS includes state plan and home community based services and are provided during the first eight -weeks of the intensive program on a fee-for-service (FFS) basis using a daily bundled rate. The state uses this authority to demonstrate that providing these services will reduce Emergency Room (ER) utilization, psychiatric hospitalizations, and residential treatment services and length of stay as well as positively impact the child/youth's physical health in terms of comprehensive care.

- **Amendment #19** – In December 2019, the state received the authority to expand the Adult Expansion Population to include adults, ages 19-64, with incomes up to and including 133 percent of the FPL, subject to previously approved community engagement requirements. In addition, the approval provided the state authority to provide dental benefits to Medicaid eligible individuals age 65 and older, as well as porcelain or porcelain-to-metal crowns and to Targeted Adults who receive treatment for SUD. This approval also revised and expanded the definition for the Targeted Adults eligibility criteria. Lastly, with this approval, the state received the ability to enroll demonstration populations in managed care plans; create and operate an integrated managed care model, called Utah Medicaid Integrated Care (UMIC), to combine the delivery of physical health and behavioral health services in five Utah counties for the Adult Expansion Population on beneficiaries. Adult Expansion Beneficiaries in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP) for their behavioral health services. Adult Expansion beneficiaries in the remaining 16 counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services. ACOs and PMHPs also deliver services to Current Eligibles.

- Amendment # 20 – In December 2020, the state received authority to receive FFP, once CMS approves the serious mental illness (SMI) Implementation Plan, for inpatient residential and other services to otherwise eligible Medicaid beneficiaries receiving treatment for a SMI while residing in facilities that meet the definition of an institution for mental diseases (IMD). In addition, this approval also authorized the state to provide porcelain or porcelain-to-metal crowns to Medicaid eligible blind or disabled adults, as well as to restrict the provider network for this population.
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III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act (ADA) of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975, and

section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality agreement for the demonstration as necessary to comply with such change as well as an allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

    b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation becomes effective, or on the last date such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid or CHIP state plan and these STCs with respect to a population eligible through the Medicaid and CHIP state plans, govern.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, beneficiary rights delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    i. An explanation of the public process used by the state, consistent with the requirements of STC 12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
    ii. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;
    iii. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

    iv. An up-to-date CHIP allotment worksheet, if necessary;

    v. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration.** States that intend to request an extension of the

demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 Code of Federal Regulations (CFR) §431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 9.

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

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

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

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §§431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §§431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite

the federal and state public notice requirements under circumstances described in 42 CFR section 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not to extend this demonstration, during the last six months of the demonstration, enrollment of the new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

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

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

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

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

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization

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

13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

14. **Administrative Authority**. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to Medicaid or CHIP programs and procedures; or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

IV. ELIGIBILITY

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

17. **Eligibility Criteria.** Mandatory and optional Medicaid state plan populations derive their

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

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

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

a. Current Eligibles are the following individuals, whose eligibility is derived from the state plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the state plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum. Expenditures on current eligibles are considered demonstration expenditures for purposes of calculation of demonstration budget neutrality. There is no enrollment limit for this group. This population is a part of the original PCN demonstration and is not participating in the ESI program.

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

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

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

ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population.

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

c. Demonstration Population III is comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes up to and including 200 percent of the FPL, who are U.S. citizens/ qualified non- citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an Utah's Premium Partnership for Health Insurance (UPP)-approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income. Demonstration Population III is subdivided into three groups:

   i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the state plan provisions implementing section 1931 of the Act. There is no enrollment limit for this group.

   ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population. There is no enrollment limit for this group.

   iii. Adult Children of Custodial Parents/Caretaker Relatives: A demonstration eligible population that meets the eligibility requirements of Demonstration Population III, as well as being age 19 through 26, enrolled in their caretaker's ESI plan, and live in their caretaker's household.

   As of January 1, 2020, beneficiaries with incomes up to and including 133 percent of the FPL who meet these criteria for enrollment in Demonstration Population III will instead be enrolled in the Adult Expansion Population. Beneficiaries who were previously enrolled in the Adult Expansion Population and are receiving UPP-approved ESI where the employee's cost to participate in the plan is at least five percent of the household's countable income, but whose incomes increased above 133 percent of the FPL and remain below 200 percent of the FPL, will be eligible for Demonstration Population III.

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

   i. Custodial Parents/Caretaker Relatives: Adults with children with family income that exceeds the levels under the state plan provisions implementing section 1931 of the Act.

   ii. Childless Adults/Non-Custodial Parents: A demonstration eligible population.

As of January 1, 2020, beneficiaries with incomes up to and including 133 percent of the FPL who meet these criteria for enrollment in Demonstration Population V will instead be enrolled in the Adult Expansion Population.

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

f. Demonstration Population VI is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:

   i. COBRA-Eligible Children: A child that meets the definition of a targeted low- income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium assistance for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.

   ii. COBRA Continuation Children: A child that meets the definition of a targeted low-income children except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium assistance.

g. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:

   i. Be chronically homeless, defined as:
      (1) An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
      (2) An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical

illness or disability;

(3) 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; or

(4) An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (i)(1), (i)(2), or (i)(3), above.

ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:

(1) An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);

(2) An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;

(3) An individual on probation or parole with serious mental illness and/or serious substance use disorder;

(4) An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or

(5) Individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.

iii. Needing substance use or mental health treatment, defined as:

(1) An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or

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

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

i. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state.

j. Intensive Stabilization Services (ISS) Population is comprised of children/youth under age

21, whose eligibility is derived from the state plan, and are experiencing significant emotional and/or behavioral challenges while in state custody or are at risk of being placed in state custody.

Table 1: Eligibility Groups

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

Medicaid Eligibility Groups	FPL and/or Other Qualifying Criteria	Not Applicables	Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)	Member-Month Reporting Category in section X.5, if applicable)
Mandatory Medicaid State Plan Groups				
Section 1925 and 1931 TANF related adult family members	Income according to the State Standard of Need	Statewideness, Comparability, Freedom of Choice, EPSDT	Current Eligibles	Current Eligibles
Section 1902(a)(10)(C)/42 CFR 435.322 & 435.330 adults who are blind or disabled	No income standard	Amount, Duration, Scope of Services, and Comparability Freedom of Choice	Blind and Disabled Adults– Dental	1902(a)(10)(C) -Blind and Disabled Adults –Dental
Section 1902(a)(10)(C)/ 42 CFR 435.330 adults who age 65 and over	No income standard	Comparability	Aged Adults - Dental	1902(a)(10(C) - Aged Adults - Dental
Optional Medicaid State Plan Groups				
Medically Needy adults who are not pregnant/postpartum, aged, blind, or disabled	Individual must "spend down" to a Medically Needy Income Standard set by the state	Statewideness, Comparability, Freedom of Choice, EPSDT	Current Eligibles	Current Eligibles
All Medicaid Eligible children/youth	Income according to the specific eligibility group	Freedom of Choice, Amount, Duration, and Scope of Services, Comparability	Intensive Stabilization Services (ISS) Children/Youth	Intensive Stabilization Services (ISS) Children/Youth
PCN Demonstration Eligible Groups				
Medicaid Eligibility Groups	**FPL and/or Other Qualifying Criteria**	**Not Applicables**	**Expenditure Reporting Form (see paragraph X.1(c), Medicaid, unless otherwise indicated)**	**Member-Month Reporting Category in section X.5, if applicable)**

Adult custodial parents/caretaker relatives and childless adults/noncustodial parents: Demonstration Population I	Individuals with incomes at or below 95% FPL	Comparability, Freedom of Choice, Statewideness, EPSDT, FQHC, Retroactive Eligibility	PCN Adults w/Children(1) (parents/ caretaker relatives) PCN Childless Adults(1) (childless adults/noncustodial parents)	PCN Adults w/ Children (1) PCN Childless Adults(1) (childless adults/non-custodial parents)
Targeted Adults	Individuals with incomes at 0% FPL	Statewideness, Comparability, Freedom of Choice,	Targeted Adults	Targeted Adults
Former Foster Care Youth	No income standard	N/A	FFCY	FFCY
Adult Expansion Population	Individuals with incomes up to and including 133% of the FPL	Statewideness, Comparability, Freedom of Choice, Eligibility and Provision of Medical Assistance, Reasonable Promptness, Method of Administration	Adult Expansion Population	Adult Expansion Population
ESI Demonstration Eligible Groups				
Adult custodial parents/caretaker relatives and childless adults/noncustodial parents and adult children (19-26) of parents/caretakers Demonstration Population III	Up to and including 200% FPL	Comparability, Freedom of Choice, EPSDT, Cost Sharing, Retroactive Eligibility	ESI Adults w/Children(3) (parents/ caretaker relatives) ESI Childless Adults(3) (childless adults/noncustodial parents) ESI Adult Children (Title XIX)(3)	ESI Adults with Children ESI Childless Adults(3) (childless adults/non-custodial parents) ESI Adult Children
CHIP children of working adults -Current Eligible CHIP Children Population	Up to and including 200% FPL	Cost Sharing Exemption for AI/AN Children, Cost Sharing, Benefit Package Requirement	ESI Children (Title XXI)(4)	ESI Children

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

V. BENEFITS

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

this demonstration is in effect.

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

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

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

20. **Minimum for Demonstration Population I – PCN Eligibles.** The benefit package for Demonstration Population I is a limited benefit package of primary and preventative care services through the PCN program. These services include primary care physician, lab, radiology, durable medical equipment, emergency room services, pharmacy, dental, and vision. Covered services are often provided with different limitations than those covered in the state plan. Inpatient hospital, specialty care, and mental health services are among the services that are not covered. The benefits are detailed in Table 2b. The benefit package for Demonstration Population I eligibles must be

comprehensive enough to be consistent with the goal of increasing the number of individuals in the state with health insurance, including at least a primary care benefit, which means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. Medicaid state plan services other than those listed in Table 2b are not covered for Demonstration Population I. Should the state amend its Medicaid state plan to provide benefit limitations that are more restrictive for the services listed in Table 2b (including elimination of any of the listed services), the revised state plan would determine the benefit, and no demonstration amendment would be needed; all other changes to the benefit for Demonstration Population I must be made through a demonstration amendment. The state must notify the Project Officer of all planned changes to benefits for Demonstration Population I, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes. As of April 1, 2019, Demonstration Population I will close and all beneficiaries enrolled in the population will move to the Adult Expansion Population.

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

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

Service	Special Limitations for Demonstration Population I
Hospital Services	Emergency Services in Emergency Room only
Physician Services	Services by licensed physicians and other health professionals for primary care services only
Vision Care	One eye examination every 12 months, no eyeglasses
Lab and Radiology Services	Lab and Radiology only as part of primary care services or as part of an approved emergency service as identified in the PCN Provider Manual
Occupational Therapy	Not covered
Chiropractic Services	Not covered
Speech and Hearing Services	Hearing evaluations for hearing loss or assessments for hearing aids are covered
Podiatry Services	Not covered
End Stage Renal Disease - Dialysis	Not covered
Home Health Services	Not covered
Hospice Services	Not covered
Private Duty Nursing	Not covered
Medical Supplies and Medical Equipment	Equipment only for recovery (see detail list in the PCN Provider Manual)
Abortions and Sterilizations	Not covered
'Inpatient Treatment for Substance Abuse and Dependency	Not covered
Organ Transplants	Not covered

Long Term Care	Not Covered
Family Planning Services	Consistent with physician and pharmacy scope of services. Not covered: Norplant, Infertility drugs, Invitro fertilization, Genetic counseling, Vasectomy, Tubal ligation.
High-Risk Prenatal Services	Not covered
Medical and Surgical Services of a Dentist	Not covered
Health Education including Diabetes and Asthma	Not covered
Pharmacy	Pharmacy services limited to 4 prescriptions per month; prior authorization required for non-PDL drugs when a PDL exists for a drug class; some injectables are covered in a pharmacy, and any other injectables identified in the PCN Provider Manual
Dental	Limited scope of services: exams, preventive services, fillings, and limited extractions
Mental Health	Not covered
Outpatient Substance Abuse	Not covered
Targeted Case Management for the Chronically Mentally Ill	Not covered
Targeted Case Management for Substance Abuse	Not covered
Targeted Case Management for Homeless	Not covered
Targeted Case Management for HIV/AIDs	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only. Non-emergency transportation is not covered.

21. Benefit Definition

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

b. **For Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI) – Premium Assistance.** The primary benefit provided to children eligible for premium assistance (through ESI or COBRA coverage) is assistance in paying the child's share of the employee's, individual's, or family's share of the monthly premium cost of qualifying

insurance plans.

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

c. Utah will ensure that all participating premium assistance insurance plans cover well-baby/well-child care services, age-appropriate immunizations, and emergency care. The state will also ensure children receive physician visits, hospital inpatient, and pharmacy benefits, at a minimum. Utah may use state rules to establish a set of additional criteria that will be used to determine which insurance plans shall be "qualified plans."

d. Benefits furnished by qualified premium assistance insurance plans are not benefits under this demonstration; the only benefit under this demonstration is premium assistance. Qualified plans are not restricted from offering additional benefits, at the option of the plan, which may vary by the plan to which the individual or family has access.

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

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

a. In accord with the enrollment and implementation procedures as defined in Section VI, the state will provide an eligible and enrolled individual or family with a premium assistance subsidy.

b. The premium assistance amount for participating plans must not exceed the maximum amount of the participant's share of the premium:

- **For ESI plans** –
  - Children = $120 per enrollee per month with state wrap around dental benefits
  - Children = $140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage
- **For COBRA plans** –
  - Children = $120 per enrollee per month with state wrap around dental benefits
  - Children = $140 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage.

c. **Adjustments for Health Care Inflation.** For adults enrolled in the premium assistance programs, the state may increase the maximum amount per month through the state's rulemaking process as long as it does not exceed the without waiver ceiling amount established in the budget neutrality calculation of estimated service expenditures and the subside amount found in Utah Administrative Code R414-320-16 .

d. For demonstration populations III and V, the maximum premium subsidy will be determined by the amounts found in Utah Administrative Code R414-320-16. Any future changes to decrease the maximum premium subsidy amount must be approved by CMS through an amendment to the demonstration in accordance with the process outlined in STC 7.

e.

For children enrolled in the premium assistance programs, the per child monthly premium assistance payment will be approximately equivalent to the per-child-per-month cost under the Title XXI state plan (excluding dental costs – currently $120 per month; or including dental costs – currently $140 per month).

f. The premium assistance subsidy will be paid directly to the individual/family up to the maximum amount specified in STC 23(b).

g. The COBRA subsidy -

i. For a qualified individual, who is determined to be an assistance-eligible individual under section 3001 of the American Recovery and Reinvestment Act of 2009 (ARRA) and can receive the nine-month ARRA COBRA subsidy, the UPP-Like COBRA program will provide additional premium assistance to subsidize the payment of the former employee's 35 percent share of the monthly premium for COBRA continuation coverage (up to the limits set below).

ii. After the expiration of the ARRA COBRA subsidy, the Utah COBRA premium assistance program will subsidize the former employee's share in accord with STC 23.

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

25. Dental Benefit for Enrollees who are Aged. All individuals who are age 65 and older, and are eligible for Medicaid, who are eligible to enroll in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.320 and 435.330, will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.

26. Targeted Adults. Beneficiaries enrolled in this eligibility category will receive full Medicaid

state plan benefits. Beneficiaries that are enrolled in this eligibility category and receiving SUD treatment will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.

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

28. **Adult Expansion Population.** Beneficiaries in this category will receive benefits as follows:
    a. Custodial Parents/Caretaker Relatives enrolled in this eligibility category will receive the same benefits as Current Eligibles, the non-traditional benefits, which are outlined in Table 2a and Attachment I. These beneficiaries will receive benefits as described in Attachment I. Utah has fully aligned the non-traditional benefit package with the Medicaid state plan except for those benefits limitations listed under table 2a. The state has ensured all requirements of section 1937 of the Act are met including the inclusion of coverage for the ten categories of essential health benefits (EHBs). The non-traditional benefit package does not differ in amount, duration or scope from Medicaid state plan benefits, except to the extent that it includes coverage required under section 1937 of the Act that is not included under the state plant and the benefit limitations listed under Table 2a. Any changes to this coverage must be approved through a future amendment to the demonstration.
    b. Childless Adults/Non-custodial Parents enrolled in this eligibility category will receive full Medicaid state plan benefits, the traditional benefits, as outlined in Attachment J. These beneficiaries will receive benefits as described in Attachment J. Utah has fully aligned its traditional benefit package with the Utah Medicaid state plan while ensuring all requirements of section 1937 of the Act are met, including the inclusion of coverage for the ten categories of EHBs. The traditional benefit package does not differ in amount, duration or scope from Medicaid State plan benefits, except to the extent that it includes coverage required under section 1937 of the Act that is not included under the state plan. Any changes to this coverage must be approved through a future amendment to the demonstration.
    c. With respect to the coverage described in STC 28 (a) and (b), the non-traditional benefits and traditional benefits provided to specified categories of beneficiaries within the Adult Expansion Population, Utah assures that these benefit packages comport with the requirements of section 1937 of the Act, except as limitations discussed in this STC, and specifically makes the following assurances:
        i. Utah assures that all services in the EHB benchmark plan used to define the benefit package have been accounted for throughout the Alternative Benefits Plan (ABP) 5 charts found in Attachments I and J and Utah assures the accuracy of all information in ABP 5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.
        ii. Utah assures EPSDT services will be provided to individuals under 21 years of age who are covered under the traditional and non-traditional benefit packages.
        iii. Utah assures that it does not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the

predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

iv. Utah assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (42 CFR 440.347(d) and 45 CFR 156.115(a)(5))(iii). Further, Utah assures that it will not impose combined limits on habilitative and rehabilitative services and devices.

v. Utah assures that substituted benefits are actuarially equivalent to the benefits they replaced from the EHB benchmark plan used to define EHB benefits, and that the state has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

vi. Utah assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act. Utah assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

vii. Utah assures that it will comply with the requirement of section 1937(b)(5) of the Act by ensuring that the benefit package includes at least the EHBs as described in section 1302(b) of the Patient Protection and Affordable Care Act.

viii. Utah assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

ix. Utah assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to beneficiaries include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

x. Utah assures necessary medical transportation (emergency and non-emergency) for the Adult Expansion Population beneficiaries who receive the traditional benefits in accordance with 42 CFR 431.53 and necessary emergency transportation for the Adult Expansion Population beneficiaries who receive the non-traditional benefits, except that Utah assures necessary medical transportation (emergency and non-emergency) for Adult Expansion Population beneficiaries who are eligible for EPSDT services..

xi. Utah assures, in accordance with 42 CFR 440.347(a) and 45 CFR 156.115(a)(4), that it will provide benefits that include preventive services identified at 45 CFR 147.130.

xii. Utah assures that, for each benefit provided under the benefit packages that is not provided through managed care, it will use the payment methodology in its approved state plan for the benefit.

xiii. Utah assures that prescription drug coverage is the same as under the approved Medicaid State Plan for prescribed drugs.

xiv. Utah assures that when it pays for outpatient prescription drugs covered under the benefit packages, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345.

xv. Utah assures that when conducting prior authorization of prescription drugs for Adult Expansion Population beneficiaries receiving the traditional and non-traditional benefit packages, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

xvi. The state assures it will comply with section 1115 Public Notice and Tribal Consultation requirements in STC 14 before amending benefits, include in public notice, the method for assuring compliance with 42 CFR 440.345 related to full access to EPSDT services and a description of the method for complying with the provisions of the amendments made by section 5006(e) of the American Recovery and Reinvestment Act of 2009.

d. Mandatory ESI Enrollees. As of January 1, 2020, beneficiaries in this eligibility group that are eligible to enroll in a qualified ESI plan (as described in STC 18(i)), are required enroll in that plan, and will be reimbursed for the full amount of the beneficiary's share of the monthly premium cost of the qualified ESI plan. In order to ensure the beneficiary receives Medicaid benefits, wrap-around benefits will be provided through a FFS delivery system.

29. Behavioral Health Benefits. The Adult Expansion Population and Current Eligibles will receive the following benefits that are the equivalent of (b)(3) services authorized under the state's 1915(b) Prepaid Mental health Plan (PMHP) waiver:

a. Psychoeducational services (mental health rehabilitation);
b. Personal services;
c. Respite care; and
d. Supportive living services (mental health services in residential treatment settings).

30. Intensive Stabilization Services (ISS) Program. Beneficiaries enrolled in this eligibility category will receive state plan and home and community based crisis stabilization services during the first eight -weeks of the intensive program on a FFS basis using a daily bundled rate. The benefits included in the daily bundled rate are detailed in Table 2c.

Table 2c: Benefits for Intensive Stabilization Services Program

Bundled Crisis Stabilization Services	State Plan or Non State Plan Services
Psychiatric Diagnostic Evaluation	State Plan Service
Mental Health Assessment by a Non-Mental Health Therapist	State Plan Service
Psychotherapy with Patient and/or Family Member	State Plan Service
Family Psychotherapy with Patient Present and Family Member Psychotherapy without Patient Present	State Plan Service
Group Psychotherapy and Multiple Family Group Psychotherapy	State Plan Service
Psychotherapy for Crisis	State Plan Service

Psychotherapy with Evaluation and Management (E/M) Services	State Plan Service
Therapeutic Behavioral Services	State Plan Service
Psychosocial Rehabilitative Services	State Plan Service
Peer Support Services	State Plan Service
Case/Care Management	State Plan Service
Non-emergency medical transportation	State Plan Service
Non-medical transportation	Currently Not Covered in State Plan
Respite	Currently Not Covered in State Plan

VI. ENROLLMENT AND IMPLEMENTATION

31. General Requirements

a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.

b. Any individual who is denied eligibility in any health coverage program authorized under this demonstration must receive a notice from the state that gives the reason for denial, and includes information about the individual's right to appeal.

c. The state will adhere to the demonstration population enrollment limits presented in Section IV.

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

a. Individuals applying for the PCN program must be screened for eligibility in Medicaid and CHIP, and enrolled in Medicaid or CHIP if determined eligible.

b. If an applicant is determined not to be eligible for other coverage (as specified in (a) above) and the applicant meets all of the eligibility criteria for PCN, and if PCN is open to new enrollment at the time of the determination, the applicant may be enrolled in PCN.

c. PCN may be closed to new enrollment either at the state's election, or because the enrollment limit specified in these STCs has been reached. If PCN is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period.

d. The state will provide for a redetermination of eligibility at least once every 12 months.

e. As of April 1, 2019, this program is closed to enrollment.

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

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

b. Adults with incomes above 133 percent, up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population III will be given the option to receive premium assistance for ESI through UPP.

c. Families with dependent children that are eligible for CHIP may elect to have their children receive premium assistance for ESI through UPP, instead of receiving CHIP coverage. However, children may opt back into direct coverage at any time.

d. The state must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium assistance subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving UPP subsidies from the state;

ii. Provide written information prior to enrollment in UPP explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and ESI coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);

iii. Ensure the consent of the responsible adult family member to receiving premium assistance under UPP instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);

iv. Allow children to opt out of ESI and begin receiving CHIP coverage at any time, with an immediate effective date upon request;

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage and the individual's/family's share of the premium;

vi. Require clients to notify the Utah Department of Health within ten days if they change their ESI plan, there is a change in the amount of their premium, or their ESI coverage is terminated;

vii. Ensure that the total amount of UPP subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation

toward their ESI coverage;

viii. Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage. The federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a redetermination of eligibility at least once every 12 months.

34. Enrollment in Utah COBRA Premium Assistance Program

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

b. Adults with incomes above 133 percent, up to and including of 200 percent of the FPL who meet all other requirements for Demonstration Population V will be given the option to receive premium assistance for COBRA through UPP.

c. Families with dependent children that are eligible for CHIP, and whose children have lost COBRA-eligible ESI coverage, may elect to have their children receive premium assistance for COBRA coverage through UPP, instead of receiving CHIP coverage.

d. The state may offer premium assistance for COBRA coverage to all adults and children who are receiving COBRA coverage and who are receiving a subsidy of 65 percent of its cost under ARRA. COBRA premium assistance may be offered to adults and children who would be eligible for PCN or CHIP, respectively, if uninsured. Families must submit applications within the 60-day period referenced above to qualify for this assistance.

e. The state must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is eligible for COBRA continuation coverage, that the COBRA benefit qualifies for the COBRA premium assistance subsidy, and that the eligible individual elects to participate and maintains participation in the COBRA plan for all individuals receiving UPP COBRA subsidies from the state;

ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between direct PCN and/or CHIP coverage and COBRA coverage, so that they can make an informed choice (if the individual is eligible for direct PCN and/or CHIP);

iii. Ensure the consent of the responsible adult family member to receiving COBRA premium assistance instead of coverage through PCN or CHIP (if the individual is eligible for direct PCN and/or CHIP);

iv. Allow children to opt out of the Utah COBRA Premium Assistance Program and begin receiving CHIP coverage at any time; with an immediate effective date upon request.

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in COBRA coverage and the individual's/family's share of the premium. Verification may include the use of the Coverage Election Notice, forms developed by the state, and use of inter-agency administrative databases such as eFILE;

vi. Require clients to notify the Utah Department of Health within 10 days if there is a change in the amount of their premium or their COBRA coverage is terminated;

vii. Ensure that the total amount of the Utah COBRA Premium Assistance Program subsidy(ies) provided to an individual or family does not exceed the amount of the former employee's financial obligation toward their COBRA coverage, which must be net of any ARRA subsidy amount received;

viii. Provide for recovery of payments made for months in which the individual or family did not receive COBRA coverage. The federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a review of benefits on a timeframe consistent with anticipated changes in COBRA coverage or premiums and a redetermination of eligibility at least once every 12 months.

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

    a. There is no sanction period before a child, who has been involuntarily disenrolled from a premium assistance program, could be enrolled in CHIP.

    b. Children involuntarily disenrolled from premium assistance will be seamlessly enrolled in the CHIP program. Utah CHIP will ensure that there is no break in coverage.

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

    a. Individuals may at any time apply for Medicaid, and if determined eligible, be enrolled in direct coverage.

    b. At least every 12 months, the state must remind each individual by mail, an eligibility redetermination, or other comparable means that he or she is entitled to apply for Medicaid

and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

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

38. **Targeted Adults Enrollment.** As of November 1, 2017, individuals who are currently eligible for Demonstration Population I and can be identified as eligible for this demonstration population, may be moved to the Targeted Adults eligibility group. Current Demonstration Population I eligible individuals who cannot be identified as eligible for the Targeted Adults population will be sent notification informing them of the availability of this program.

    a. Individuals applying for Medicaid will be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults eligibility group.

    b. The state will provide for a redetermination of eligibility at least once every 12 months.

    c. The Targeted Adults group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period.

    d. The state will provide continuous benefits for a period of 12 months to the Targeted Adults. Changes during this period will not affect a beneficiary's benefits with the exception of the following reasons:
        - Moving out of state;
        - Death;
        - Determined eligible for another Medicaid eligibility category;
        - Fraud; or
        - Client request.

        If a Targeted Adult's income rises above an income of 133 percent of the FPL, that beneficiary will no longer be eligible for the newly eligible enhanced FMAP.

    e. All eligibility criteria, including income, will be considered at the time of the individual's annual eligibility redetermination to determine if the individual continues to meet eligibility for Medicaid.

39. **Adult Expansion Population.** Individuals do not have to undergo a separate process to enroll and receive coverage in this population and there is no enrollment cap on this population.

    a. **Beneficiary Enrollment Requirements**. Effective January 1, 2020, the state may mandatorily enroll members of the Adult Expansion Population into UMIC managed care organizations

(MCO) for delivery of their physical and behavioral health services in the five urban counties in the state (Davis, Salt Lake, Utah, Washington, and Weber), except as provided in paragraph (e) of this STC. Further, the state may mandatorily enroll members of the Adult Expansion Population in an ACO and a PMHP, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC.

b. **Auto-Assignment.** If a beneficiary does not choose a managed care plan (UMIC MCO or ACO/PHMP) within the time frames defined in (b)(iii), he or she may be auto-assigned to a managed care plan. When possible, the auto assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with a managed care plan. If this is not possible, the state will equitably distribute beneficiaries among managed care plan as specified in this STC.

   i. Beneficiaries who are newly enrolling in the Adult Expansion Population and residing in a mandatory managed care county (either a UMIC MCO or ACO/PMHP model) will receive a pending managed care plan selection that will be placed on the beneficiary's case using a "round robin" method, consistent with the auto-assignment standards described in the previous paragraph, so that each managed care plan receives approximately the same number of new cases.

   ii. Returning Medicaid beneficiaries will have their previous managed care plan reinstated if it has been less than two years since they were enrolled in managed care. If it has been more than two years or if their previous managed care plan is no longer available for enrollment, their pending assignment will be based on the "round robin" method, after taking into consideration the beneficiary's history with a primary care provider.

   iii. All beneficiaries subject to mandatory enrollment into managed care will receive a letter that informs them of the need to select a plan(s) and that if they do not respond within 10 days, the state will assign a plan(s). If a beneficiary (including beneficiaries with special health care needs) contacts the state and indicates that he or she has a current primary or specialty provider, the state will assist the member in selecting a plan(s) that includes that provider in its network. After 10 days, if a member has not responded, the system-assigned (i.e., pending) plan(s) will be the member's plan(s).

c. **Open Enrollment Period.** An open enrollment period will be held for beneficiaries from mid-May to mid-June each year, during which such beneficiaries may select a different available managed care plan for enrollment.

d. **Enrollment Exemptions.** The following populations are exempt from mandatorily enrolling in UMIC MCO or ACO and PMHP:

   i. Utah Medicaid beneficiaries residing in the Utah State Hospital or the Utah State

Developmental Center;
ii. Beneficiaries with presumptive eligibility;
iii. Individuals enrolled in the Healthy Outcomes Medical Excellence (HOME) program;
iv. Medicaid members enrolled in Utah's Buyout Program; and
v. Adult Expansion Population beneficiaries mandatorily enrolled in ESI.

e. **Enrollment Exemption Process.** The state will allow a beneficiary not to enroll in or to disenroll from a managed care plan and to enroll in a FFS delivery system, or to switch from a managed care plan to another available managed care plan, in the event that enrollment in the current managed care plan or in any available managed care plan, as applicable, would not meet the beneficiary's health care needs and there is a reasonable expectation that the beneficiary's health would suffer if he or she were not permitted to switch to a different available managed care plan or enroll in FFS delivery. Exemption requests must be submitted for approval to the state Medicaid agency.

f. **Disenrollment**. The state allows enrollees to make a request to disenroll from/transfer between managed care plan plans or enroll in FFS as described in STC 41(e). The determination must be made no later than the first day of the second month following the month in which the enrollee or a plan files the request with the state. If determination is not made within this time frame, the request is deemed approved.

40. Mandatory ESI Enrollment. For beneficiaries in the Adult Expansion Population who are required to enroll in a qualified ESI plan as specified in STC 18(i), access to and enrollment in a qualified ESI plan and the beneficiary's premium amount will be verified at initial application, every three months, and at annual recertification.

41. Intensive Stabilization Services (ISS) Enrollment. The Stabilization and Mobile Response teams (clinician and care manager) will screen and request authorization/approval for ISS for Medicaid eligible children/youth who are experiencing significant emotional and/or behavioral challenges based on medical necessity, acuity, and need.

VII. COST SHARING

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

43. Demonstration Populations III and Current Eligible CHIP Children in ESI and Demonstration Populations V and VI in COBRA. Adults and children of families that choose premium assistance will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium assistance will be charged cost sharing amounts set by their ESI or COBRA coverage and will not be limited to the Title XXI five percent out-of-pocket family income maximum. All other

cost sharing, including co-payments, and co-insurance, are set by the qualified plan and the responsibility of the participant.

44. **Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** American Indian/Alaskan Native beneficiaries 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). American Indian/Alaskan Native beneficiaries who have received a service or referral from an Indian Health Care Provider are exempt from premiums/enrollment fees and cost sharing. Those who are eligible to receive services or a referral through an Indian Health Care Provider are also exempt from premiums and enrollment fees.

45. **Enrollment Fee.** The state must not impose an enrollment fee on any demonstration populations.

VIII. DELIVERY SYSTEMS

46. Utah Primary Care Network's MCOs, ACOs, and PMHPs must provide a comprehensive service delivery system that provides the full array of benefits and services offered under the program for which the relevant organization or plan has contracted to provide coverage. This includes the integration of a participant's physical health and behavioral health needs as further articulated by the delivery system requirements set forth below.

47. **Compliance with Managed Care Regulations.** The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.

48. **Description of Managed Care Program.** Under terms of this demonstration, the state is authorized to provide managed medical assistance benefits through managed care delivery systems, consistent with regulations in 42 CFR part 438. The state may mandatorily enroll Current Eligibles, Targeted Adults, Adult Expansion Population to receive the health care benefits pursuant to Section VI of the STCs.

49. **Managed Care Contracts**. In accordance with managed care regulations published at 42 CFR part 438, CMS requires that the state must submit MCO contracts to CMS for review and approval to ensure compliance with beneficiary informational requirements, quality outcome provisions, and other applicable federal requirements. The state must provide CMS with a minimum of 90 days to review and approve contracts and/or any changes to contracts. The state must submit any supporting documentation deemed necessary by CMS. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the requirements of this STC are met or any identified deficiency in a contract is corrected.

50. **ESI and COBRA Delivery Systems.** Demonstration Populations III through VI will receive

services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium assistance.

51. Dental Services.

a. Effective January 1, 2021, the state will deliver services through a fee-for-service (FFS) payment model and contract with entities to provide dental services to the blind and disabled population.
    i. The state will enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described in 51(a) above through an intergovernmental transfer (IGT) consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
    ii. The contracted entities must guarantee access statewide.

b. The state will deliver services through a FFS payment model and contract with entities to provide dental services to the Targeted Adults who are receiving SUD treatment. The state must ensure that contracted entities:
    i. Have demonstrated experience working with beneficiaries who are being treated for both a SUD and a major oral health disease;
    ii. Operate a program, targeted at the individuals described in 53(b) above, that has demonstrated effectiveness in providing dental services to such individuals who are receiving SUD treatment, as reflected in a peer-reviewed evaluation or study; and
    iii. Enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described above through an IGT consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity; and
    iv. Can guarantee access to care statewide.

c. Effective January 1, 2020, the state will deliver dental services to the aged population through a FFS payment model and by contracting with an entity that:
    i. Operates a program for aged individuals that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals;
    ii. Enters into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described in 51(c) above through an intergovernmental transfer (IGT) consistent with section 1903(w)(6)(A) of the Act. Only units of government are

eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity; and

iii. Can guarantee access to care statewide.

52. Intensive Stabilization Services (ISS) Delivery System. As of November 25, 2019, ISS will be delivered during the first eight weeks of the intensive program on a FFS basis using a daily bundled rate. Please refer to Attachment H: Intensive Stabilization Services Program Claiming Methodology Protocol.

IX. FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

53. The state will receive the enhanced Federal Medical Assistance Percentage (FMAP) for the Adult Expansion Population, as well as the Targeted Adults, who are newly eligible within the meaning of section 1905(y)(2)(A) of the Act. As part of the standard 1115 demonstration process, Utah may request to amend the demonstration, including coverage for the Adult Expansion Population, if the enhanced FMAP for the newly eligible beneficiaries in this population changes. .

54. For beneficiaries who are members of the Adult Expansion Population and Targeted Adults, the state will make an individual income-based determination for purposes of the enhanced FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan approved by CMS on December 20, 2019. In general, and subject to any adjustments described in this STC under the enhanced FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the enhanced FMAP is not available. The relevant MAGI-converted standards for each population group in the Adult Expansion Population and Targeted Adults are described in Attachment K.

55. Claiming Methodology. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to the Adult Expansion Population, the determination of which beneficiaries qualify for enhanced FMAP methodology as a newly eligible adult will be determined pursuant to a claiming methodology deliverable that will be submitted to CMS 30 days after the December 23, 2019 approval of the amendment increasing the Adult Expansion Population income eligibility limit to 133 percent of the FPL. Once approved, the claiming methodology will become Attachment L.

56. Resource Proxy Adjustment. The state has elected not to apply a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

57. Enrollment Cap Adjustment. The state has elected to not apply an enrollment cap adjustment.

58. Special Circumstances and Other Adjustments to the Adult Group FMAP Methodology. The state has elected to not apply a special circumstances adjustment.

59. Expansion State Designation. The state does not meet the definition of expansion state in 42 CFR 433.204(b) and therefore does not qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

60. Assurances. The state assures the following:

a. The application of the enhanced FMAP claiming methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

b. The application of the enhanced FMAP claiming methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

X. SUBSTANCE USE DISORDER

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

The coverage of OUD/SUD residential treatment and withdrawal management in IMDs will expand Utah's current SUD benefit package available to all Medicaid recipients as outlined in Table 3. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

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

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy (Individual; Group; Family; Collateral)	State plan (Individual services covered)	
Intensive Outpatient Program	State plan (Individual services covered)	

Partial Hospitalization Treatment (including Day Treatment for children/youth under the age of 21)	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs
Crisis Intervention (including Mobile Crisis)	State plan (Individual services covered)	
Residential Crisis Stabilization	State plan (Individual services covered)	Services provided to individuals in IMDs

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

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

a. **Access to Critical Levels of Care for SUDs:** Service delivery for new benefits, including residential treatment, crisis stabilization and withdrawal management within 12-24 months of OUD/SUD program demonstration approval;

b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical

treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

d. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Utah Administrative Code. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

g. **Sufficient Provider Capacity at Critical Levels of Care including MAT:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;

i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in this STC; and

j. **Improved Care Coordination and Transitions:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-

based services and supports following stays in these facilities within 24 months of demonstration approval.

63. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment D. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 69. The protocol will also describe the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. The SUD Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section XIV of the demonstration. In addition, for each performance measure, the SUD Monitoring Protocol will identify a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements.

64. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment between DYs 17 and 18 of the demonstration. The assessor must collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The assessment will include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment will also include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The mid-point assessment will also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The assessor will provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. A copy of the report will be provided to CMS. CMS will be briefed on the report.

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

65. **Deferral for Insufficient Progress Toward Milestones and Failure to Report Measurement**

Data. If the state does not demonstrate sufficient progress on milestones in the SUD Implementation Protocol, as determined by CMS, or fails to report data as approved in the SUD Monitoring Protocol, CMS will defer funds in the amounts specified in STC 90 for each incident of insufficient progress and failure to report in each reporting quarter.

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

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

a. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs.

b. **Evaluation Questions and Hypotheses.** The state must follow the general evaluation questions and hypotheses requirements as specified in STC 140. In addition, hypotheses for the SUD program should include an assessment of the objectives of the SUD component of this section 1115 demonstration, to include (but is not limited to): initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose.

68. SUD Health Information Technology (Health IT). The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, will be included as a section of the state's Implementation Protocol (see STC 69) to be approved by CMS. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation Protocol will include implementation milestones and dates for achieving them (see Attachment D).

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions— prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will: (a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns[3] and (b) ensure that Medicaid does not inappropriately pay for opioids–and that states implement effective controls to minimize the risk.

g. In developing the Health IT Plan, states shall use the following resources.

i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and- systems/hie/index.html. States

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid*.
[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state will include in its Monitoring Protocol (see STC 70) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 103).

j. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Wherever it is appropriate, the state must require that contractors providing services paid for by funds authorized under this demonstration shall adopt the standards, referenced in 45 CFR Part 170.

ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170 but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standards.

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

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation

Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design will be adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

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

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

XI. INTENSIVE STABILIZATION SERVICES (ISS) PROGRAM

71. Overview. This program provides ISS to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. It is intended to support Utah's System of Care, which is a customized service approach to keep families safely together while effectively helping children with emotional and/or behavioral health needs thrive in their homes, schools, and communities.

72. Operations. The program is administered through the Utah Department of Human Services (DHS). The state is contracting with five Regional Administrators throughout the state to serve 29 counties. The Regional Administrators are responsible to subcontract with Stabilization and Mobile Response teams who will screen the Medicaid children/youth based on medical necessity, acuity, and need to authorize ISS using this daily bundled rate. The ISS contracted providers are all Medicaid enrolled providers.

73. Eligibility. Medicaid eligible children/youth under age 21, whose eligibility is derived from the

state plan, and are experiencing significant emotional and/or behavioral challenges while in state custody or are at risk of being placed in state custody.

a. **Target Group.** The ISS program is available to Medicaid enrolled child/youth under age 21, who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) state plan amendment (SPA).

b. **Needs-Based Criteria.** The Medicaid enrolled child/youth is assessed using the ISS Utah Family and Children Engagement Tool (UFACET) evaluation. The Medicaid enrolled child/youth must have a rating of at least "2" or higher indicating the need for assistance with at least one of the following significant emotional and/or behavioral challenges that impair the child's ability to focus and control impulsive behaviors that affect their ability to control or regulate emotions to the point where it interferes with their daily lives and relationships and negatively affects performance at school, work and/or home: short attention span, impulsiveness, aggression, self-injurious behaviors, risk of harm to others, fighting withdrawal, excessive fear or anxiety, hostility, irritability uncooperative, oppositional, and non-compliant with rules or authority figures.

   And the child/youth must also meet at least one of the following risk factors:

   i. A history of receiving services, or at risk of receiving services, from one or more DHS agencies (child welfare, juvenile justice, service for people with disabilities, mental health or substance abuse, and/or the courts). At risk of receiving services may include one or more of the following:
      (1) The child has juvenile court charges;
      (2) The child has been on probation previously;
      (3) The child/family has an open child protection investigation;
      (4) The child is in the process of eligibility determination for disability services;
      (5) The child has received inpatient psychiatric services and/or has been referred to the Pediatric program at the Utah State Hospital; or
      (6) The child has a mental health condition or substance abuse history.

   ii. At risk of being placed into the custody of a state agency, which includes one of the following:
      (1) The child is on probation or has sufficient juvenile court charges that the judge is considering placement with the Department for community placement or secure care;
      (2) The child/family has an open in-home services case with the Division of Child and Family Services based on a finding of dependency, or a child protection investigation, and placement of the child(ren) in protective custody is being recommended;
      (3) The child has been in custody previously under similar circumstances;
      (4) The child is in the process of eligibility determination for disability services and the family is struggling to provide care for them;

(5) The child has a serious mental health condition or substance use history and the family is struggling to continue care for them;
(6) The child has experienced significant disorders post adoption; or
(7) The child has experienced multiple failed private placements.

iii. At risk of reverting back to a higher level of care due to behavioral or emotional concerns;
iv. Has been involved in the Juvenile Competency process;
v. Has been frequently utilizing hospital emergency services to manage behavioral, developmental, and/or mental health challenges; or
vi. Has been referred to the DHS High Level Staffing Committee.

74. Benefits. This program provides both state plan behavioral health services and home and community based services (HCBS) that are not currently authorized through the state plan. The state plan services included in the daily bundled rate are outlined in Table 2c and the service benefits, limitations, and provider qualifications are specified in the state plan. The HCBS provided include:

a. **Service name:** Respite
   i. **Service Description:** Services provided to Medicaid children/youth on a short-term basis due to the absence of, or need for relief for the persons who normally provide care for the Medicaid child/youth. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the Demonstration participant's home, a DHS licensed group home, or another community-based setting approved by DHS.

   ii. **Service Limits:** Room and board costs will not be paid when services are provided in the Demonstration participant's home or place of residence. The service will be approved if it complies with DHS respite policies.

   iii. **Provider Specifications:** Providers must meet qualifications as specified by DHS and must be a Medicaid enrolled provider.

b. **Service name:** Non-Medical Transportation
   i. **Service Description:** This transportation service will be provided to Medicaid children/youth that are determined by the Care Manager to be in need of short-term transportation to and/or from a non-medical activity that is an integral part of the youth's individualized service plan where there are no other feasible transportation options. Coverage of transportation for the primary caregiver is provided when the primary care giver is accompanying the child. These nonmedical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after-school programs not associated with a youth's Individual Education Plan (IEP), and parent support services that include the child.

   ii. **Service Limits:** This service must be a part of a comprehensive individualized service

plan developed by a Care Manager and requires prior authorization. The youth must be currently authorized and receiving care management services. Frequency and duration of service must be supported by a needs assessment and included in the participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting.

iii. **Provider Specifications:** Providers and their staff must meet minimum levels of education, experience, and training as delineated by DHS and the provider and staff must be enrolled as a Utah Medicaid provider.

75. Delivery System. As of November 25, 2019, the intensive stabilization services (ISS) will be delivered during the first eight weeks of the intensive program on a FFS basis using a daily bundled rate. Please refer to Attachment H: Intensive Stabilization Services Program Claiming Methodology Protocol.

76. Additional Delivery System Requirements: HCBS Services Not Authorized through the State Plan. The following additional delivery system requirements apply to all the HCBS services in this demonstration.

a. **Demonstration Participant Protections.** The state will assure that children and youth are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities. The state will also develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

b. **Fair Hearings.** All enrollees must have access to the state fair hearing process as required by 42 CFR 431 Subpart E.

c. **Conflict of Interest**: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

d. **Approved Quality Improvement Strategy:** The state is required to work with CMS to develop approvable performance measures within 90 days following approval of the 1115 for the following waiver assurances (i through vi below):

i. **Administrative Authority**: A performance measure should be developed and tracked for any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

ii. **Eligibility based on 1115 Requirements:** A performance measure should be developed that tracks eligibility for the Intensive Stabilization Services (ISS) Program that meets the 1115 requirements.

iii. **Qualified Providers**: The state must have performance measures that track that providers meet licensure/certification standards and that non-certified providers are monitored to meet state requirements.

iv. **Service Plan**: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for the Medicaid children/youth receiving ISS. Performance measures are required to demonstrate service plans address all assessed needs and personal goals, that services are delivered in accordance with the service plan including type, scope, amount, duration, and frequency specified in the service plan, and for choice of non-state plan HCBS services.

v. **Health and Welfare**: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider.

vi. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of HCBS. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered.

e. The state will submit a report to CMS which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. This information could be captured in the section 1115 Summative Evaluation Report detailed in STC 142.

f. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year. This information could be included in the annual reports submitted for section 1115 waivers detailed in STC 103.

XII. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

77. SMI Program Benefits. Upon CMS' approval of the SMI Implementation Plan, beneficiaries will have access to, the full range of otherwise covered Medicaid services, including SMI treatment services. SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI Program, to be monitored pursuant to the SMI Monitoring Plan as outlined in STCs 89 – 90 below.

78. SMI Implementation Plan.

a. The state must submit the SMI Implementation Plan within 90 calendar days after approval of the demonstration for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within sixty (60) calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI under expenditure authority #14 until CMS has approved the SMI implementation plan and the SMI financing plan described in STC 88. After approval of the required implementation plan and financing plan, FFP will be available prospectively, but not retrospectively.

   Once approved, the SMI Implementation Plan will be incorporated into the STCs and Attachment N, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI Implementation Plan within 90 calendar days after approval of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 94.

b. At a minimum, the SMI Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

   i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

      A. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in

Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

B. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
C. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
D. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
E. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
F. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

A. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);

B. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;
C. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;
D. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
E. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

A. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
B. Commitment to implementation of the SMI/SED financing plan described in STC 88(d);
C. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
D. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration

A. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;
B. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
C. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

c. **SMI Health Information Technology (Health IT) Plan.** The Health IT plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/ "ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If the state is unable to provide such an assurance, it will submit to CMS a Health IT Plan, to be included as a section of the applicable Implementation Plan (see STC 88(c) to develop the infrastructure/capabilities of the state's health IT infrastructure.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment [N]), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

The state will include in its Monitoring Plans (see STC 89) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 103).

As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory – Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable state procurements (e.g. including managed care contracts) that are associated with this demonstration.

Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest. Components of the Health IT Plan include:

i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SED/SMI care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

In developing the Health IT Plan, states should use the following resources:

1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and *"Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/)*.
2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

d. **SMI Financing Plan.** As part of the SMI implementation plan referred to in STC 88, the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment O and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI program under this demonstration. Components of the financing plan must include:

i. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

ii. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

iii. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

79. **SMI Monitoring Protocol(s).** The state must submit a Monitoring Protocol for the SMI program authorized by this demonstration within 150 calendar days after approval of the implementation plan. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within sixty (60) calendar days after receipt of CMS' comments, if any. Once approved, the SMI Monitoring Protocol will be incorporated into the STCs, as Attachment O. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports (as required by STC 103). Components of the Monitoring Protocol must include:

    a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 88) , information relevant to the state's SMI financing plan described in Attachment C, and information relevant to the state's Health IT plans described in STC 88(c);
    b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section VIII of the demonstration; and
    c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

80. **Monitoring, Reporting, and Evaluation.** The SMI Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections XIV (General Reporting Requirements) and XVIII (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidelines to ensure the evaluation design is amended to provide a rigorous evaluation of the SMI component of the demonstration.

81. **Availability of FFP for the SMI Services Under Expenditure Authority #11**. FFP is only available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

82. **SMI Mid-Point Assessment.** The state must conduct an independent mid-point assessment by September 30, 2023, whether or not the demonstration is renewed. If the demonstration is not renewed or is renewed for a term that ends on or before September 30, 2023, then this mid-point assessment must address the entire term for which the SMI Program under the demonstration was authorized. In the design, planning and conduct of the mid-point assessment, the state must require

that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, SMI providers, and beneficiaries.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after September 30, 2023. The state must brief CMS on the report.

For milestones and measure targets identified by the independent assessor as at medium- to high-risk of not being achieved, the state must submit to CMS proposed modifications to the SMI Implementation Plan, the SMI Financing Plan, and the SMI Monitoring Protocol, as appropriate, for mitigating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and/or Monitoring Protocol are subject to CMS approval.

Elements of the mid-point assessment must include, at a minimum:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI Implementation Plan, the SMI Financing Plan, and toward meeting the targets for performance measures as approved in the SMI Monitoring Protocol;
b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;
c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
d. For milestones or targets identified by the independent assessor as at medium- to high-risk of not being met, recommendations for adjustments in the state's SMI Implementation Plan and/or SMI Financing Plan or to other pertinent factors that the state can influence that will support improvement; and
e. An assessment of whether the state is on track to meet the budget neutrality requirements in these STCs.

83. Unallowable Expenditures Under the SMI Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.
b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.
c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.
d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

XIII. GENERAL REPORTING REQUIREMENTS

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

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

85. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in implementation protocol and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made. The state is expected to meet the milestones by the end of the first two years of the SMI demonstration.

86. **Submission of Post-Approval Deliverables.** The state must submit all deliverables using the process stipulated by CMS and within the timeframes outlined within these STCs.

87. **General Financial Requirements.** The state must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in Section XV. The state must submit any corrected budget and/or allotment neutrality data upon request.

88. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR Part 438,

89. **Reporting Requirements Related to Budget Neutrality.** The state shall comply with all reporting requirements for monitoring budget neutrality set forth in Section XVII of these STCs.

90. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 reporting and analytics functions, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

    c. Submit deliverables to the appropriate system as directed by CMS.

91. **Implementation Plan.** The state must submit an Implementation Plan to CMS no later than 90 calendar days after approval of the demonstration. The Implementation Plan must cover at least the key policies being tested under this demonstration, as amended. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment E. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies. Other topics to be discussed in the Implementation Plan include application assistance, reporting, and processing; notices; coordinated agency responsibilities; coordination with other insurance affordability programs; appeals;

renewals; coordination with other state agencies; beneficiary protections; and outreach.

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

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 103 below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis covering the key policies being tested under this demonstration. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g., operational updates as described in STC 103 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

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

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

b. Performance Metrics – The performance metrics will provide data to demonstrate how the

state is progressing towards meeting the milestones identified in CMS's framework for monitoring components of the state's demonstration. For example, these metrics will cover enrollment, disenrollment or termination by specific demographics and reason, , access to care, and health outcomes.

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

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

c. Budget Neutrality and Financial Reporting Requirements – Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality, including baseline cost and member months, set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings – Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. Managed Care Delivery System – An important purpose of these reports is to present the state's analysis and the status of access to care and provider network adequacy for beneficiaries receiving physical and behavioral health services through the MCOs, ACOs, and PMHPs.

i. Implementation Report. The state must submit an implementation report no later than 90 days after the initial program implementation.
ii. Quarterly Report. As part of the quarterly progress required under this STC, the state must have a section of the report that discusses the MCO, ACO, and PMHP programs.
iii. Annual Report. As part of the annual report required under this STC, the state must have a section of the report that discusses the MCO, ACO, and PMHP programs.

94. Program Integrity. As part of the expansion of coverage to the Adult Expansion Population with incomes up to and including 133 percent of the FPL, Utah will provide CMS with responses to

program integrity questions that CMS has transmitted to the state about how the state will operationalize the expansion. The responses to these questions should demonstrate how the state plans to ensure that eligibility determinations are accurate and FFP is claimed at the appropriate matching rate. The state should discuss in detail the actions that will be taken prior to and post expansion to cover the Adult Expansion Population up to 133 percent of the FPL, as well as planned oversight activities to ensure ongoing compliance with federal and state requirements. This deliverable is due to CMS 60 days after the December 23, 2019 approval.

95. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where monitoring data indicate substantial sustained directional change, inconsistent with demonstration targets, such as substantial, sustained trends indicating increases in disenrollment. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10, CMS will withdraw an authority, as described in STC 10, when metrics indicate substantial, sustained directional change, inconsistent with demonstration targets, and the state has not implemented appropriate corrective action. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

a. The draft final report must comply with the most current Guidance from CMS.

b. The state will present to and participate in a discussion with CMS on the Closeout report.

c. The state must take into consideration CMS' comments for incorporation into the final Closeout Report.

d. The final Closeout Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Closeout Report may subject the state to penalties described in STC 94.

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

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

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

XIV. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

a. In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality limit will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or l0.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 105. DY1 is the year beginning July 1, 2002 and ending June 30, 2003, and subsequent DYs are defined accordingly.

b. Premium offsets and enrollment fees that are collected by the state for enrollees under this demonstration shall be reported to CMS on the CMS-64 summary sheet. Enrollment fees shall be reported as an administrative offset on Line 9.d., columns c and d. Premium offsets shall be

reported as a services offset on Line 9.d., columns a. and b. In order to assure that the demonstration is properly credited with these collections, please provide the appropriate information on the CMS-64 narrative.

c. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit found in section XVII. Utah must complete separate waiver forms for the following eligibility groups/waiver names:

i. Current Eligible
ii. PCN Adults w/Children (1
iii. PCN Childless Adults (1)
iv. ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)
v. ESI Childless Adults (3)/ COBRA Childless Adults (5)
vi. Current Eligible CHIP Children (4) and COBRA Children (6) are reported on the applicable CMS-21 form.
vii. Dental Services for Section 1902(a)(1)(C)/42 CFR 435.322 & 435.330 Blind and Disabled Adults ("BD Dental"
viii. Targeted Adult
ix. Former Foster Care Youth From Another State ("FFCY")
x. SUD
xi. Targeted Adults Dental ("TAD")
xii. Adult Expansion Population
xiii. Employer Sponsored Insurance
xiv. Withdrawal Management
xv. Intensive Support Services (ISS)
xvi. Dental Services – Aged (Aged)
xvii. SMI

d. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a FMAP of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state will exclude from the budget neutrality test for this demonstration the portion of the mandated increase for which the federal government pays 100 percent.

100. Expenditures Subject to the Budget Agreement. For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include all Medicaid expenditures on behalf of all demonstration participants as defined in STC 109(c)(*i-xvii.*) of the STCs.

101. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are

directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name "ADM".

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

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

a. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member/months.

b. There will be fifteen demonstration populations that will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following waiver names. The groups used for calculating the budget neutrality expenditure limit are described below:

   i. "PCN Current Eligibles," as defined in section IV of these STCs.

   ii. "PCN Adults with Children(1)" is a hypothetical group under "PCN Adults with Children" and members of the Demonstration Population I, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. PCN Adults w/Children(1)" does not include members of Demonstration Population I who are childless adults/noncustodial parents, or members of Demonstration Population III.

   iii. "ESI Adults with Children(3)"is a hypothetical group under "ESI Adults with Children" and are members of the Demonstration Population III, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. "ESI Adults w/Children(3)" does not include members of Demonstration Population III who are childless

adults/noncustodial parents, or members of Demonstration Populations I.

iv. “COBRA Adults with children(5)” is a hypothetical group under “COBRA Adults with Children” and are members of the Demonstration Population V, as defined in section IV of these STCs, who could be eligible for Medicaid under section 1931 of the Act if the state further liberalized its eligibility criteria in its state plan. "COBRA Adults w/Children(X)" does not include members of Demonstration Population III, or members of Demonstration Populations I.

v. Current Eligible CHIP Children of Title XXI CHIP ESI Children (reported as "ESI Children") and Demonstration Population VI of Title XXI (CHIP COBRA Children reported as “COBRA Children”) reported as Non-Group Children will be reported separately. Expenditures for Title XXI ESI Children and COBRA Children are reported on the CMS-21.

vi. “Blind and Disabled Adults” is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.

vii. “Former Foster Care Youth from Another State” ("FFCY") is a hypothetical budget neutrality coverage group as defined in section IV of these STCs.

viii. “SUD” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

ix. “Adult Expansion Population” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

x. “Employer Sponsored Insurance” is a group from the Adult Expansion Population that is mandatorily enrolled into ESI as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

xi. “Withdrawal Management” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

xii. “Intensive Support Services” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

xiii. “Aged Adults” is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.

xiv. “Targeted Adults” is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services

xv. “Targeted Adults Dental” is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.

xvi. "Aged Adults" is a group as defined in section IV of these STCs whose enrollees receive hypothetical dental services.

xvii. "SUD" is a group as defined in section IV of these STCs whose beneficiaries receive hypothetical services.

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

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

a. Administrative costs, including those associated with the administration of the demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.

c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program shall require the state to

provide information to CMS regarding all sources of the non-federal share of funding.

107. State Certification of Funding Conditions. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes — including health care provider-related taxes — fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

108. State Assurances.

a. The acceptance of these STCs is Utah's confirmation that its information technology systems and administrative processes (including internal controls) are able to report reliably and accurately expenditures related to the 1115 demonstration to the CMS-64 system.

b. Implementing Changes Based on the Independent Audit. The state assures to CMS and the federal review team (FRT) that the budget neutrality of contemporary DYs is measurable and verifiable. This assurance will be verified in part through the Phase II audit findings. Should the Phase II audit find that the state's current information technology systems and administrative processes (including internal controls) are not sufficient to report expenditures related to the 1115 demonstration to the CMS-64 report reliably and accurately, CMS will require further corrective action until such assurances can be made.

c. The state must assure CMS at all times of the integrity and accuracy of its claims processing systems and for the administrative processes associated with claiming FFP. In order to support the continuation of this demonstration, future amendments, or extension requests, Utah must maintain the state's information technology systems and administrative processes (including internal controls) so that expenditures related to the 1115 demonstration are reliably and accurately reported on the CMS-64.

XV. GENERAL FINANCIAL REQUIREMENTS

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

to the allotment neutrality limit.

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

111. **Claiming Period.** All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

112. **Standard Medicaid Funding Process.** The standard CHIP funding process will be used during the demonstration. Utah must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the state shall provide updated estimates of expenditures for the demonstration populations. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

113. **State Certification of Funding Conditions.** The state will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

114. **Limitation Title XXI Funding.** Utah will be subject to a limit on the amount of federal Title XXI funding that the state may receive on Current Eligible CHIP Children and Demonstration Population VI expenditures during the waiver period. Federal Title XXI funding available for demonstration expenditures is limited to the state's available allotment, including currently available reallocated funds. Should the state expend its available Title XXI federal funds for the claiming period, no further enhanced federal matching funds will be available for costs of the separate child health program or demonstration until the next allotment becomes available. Total federal title XXI funds for the state's CHIP program (i.e., the approved Title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.

115. **Administrative Costs.** Total expenditures for outreach and other reasonable costs to administer

the Title XXI state plan and the demonstration that are applied against the state's Title XXI allotment may not exceed 10 percent of total Title XXI net expenditures.

116. Exhaustion of Title XXI Funds. If the state exhausts the available Title XXI federal funds in a federal fiscal year during the period of the demonstration, the state may continue to provide coverage to the approved Title XXI state plan separate child health program population, the Current Eligible CHIP Children, and Demonstration Population VI with state funds.

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

XVI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

120. Calculation of the Budget Neutrality Limit: General. For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC 130. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of Medicaid expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 135.

121. Impermissible DSH, Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including

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

122. "Hypothetical" Eligibility Groups. Budget neutrality agreements may include optional Medicaid populations that could be added under the state plan but were not included in current expenditures. However, the agreement will not permit access to budget neutrality "savings" from the addition of the groups. A prospective per capita cap on federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

123. Supplemental Budget Neutrality Test: Substance Use Disorder Expenditures. As part of the SUD initiative, the state may receive FFP (once the Implementation Protocol is approved) for the continuum of services to treat opioid use disorders (OUD) and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical. The state may only claim FFP via demonstration authority for the SUD services listed in Table 3 in STC 68 that will be provided in an IMD. However, the state will not be allowed to obtain budget neutrality "savings" from these services. Therefore, a separate expenditure cap is established for SUD services. The SUD MEG listed in the table in STC 133 is included in the SUD Supplemental Budget Neutrality Test.

a. The SUD expenditures cap is calculated by multiplying the projected PMPM for the SUD MEG, each DY, by the number of actual eligible SUD member months for the same MEG/DY—and summing the products together across all DYs. The federal share of the SUD expenditure cap(s) is/are obtained by multiplying those caps by the Composite Federal Share (see STC 130).

b. SUD Supplemental Budget Neutrality Test is a comparison between the federal share of SUD expenditure cap(s) and total FFP reported by the state for the SUD MEG.

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

Eligibility Group	Trend Rate	DY 16 PMPM	DY 17 PMPM	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM
Current Eligibles	5.3%	$999.33	$1,052.29	$1,108.07	$1,166.79	$1,228.63
Demo Pop I – Adults with Children	5.3%	$48.63	$51.21	$53.92	$56.78	$59.79
Demo Pops III & V – Adults with Children	5.3%	$158.03	$166.41	$175.23	$184.51	$388.58
Dental Services – Blind and Disabled	3.0%	$18.42	$18.97	$19.54	32.40	$34.10
Former Foster Care Youth	4.8%	$990.87	$1,038.43	$1,088.28	$1,140.51	$1,195.26
SUD Services	5.0%	$3,321.96	$3,488.06	$3,662.46	$3,845.58	$4,037.86
Dental Services – Targeted Adults	5.3%	n/a	$33.33	$34.75	$36.59	$38.53
Adult Expansion Population	4.7%	n/a	$542.08	$567.56	$594.23	$622.16
Employer Sponsored Insurance	4.7%	n/a	n/a	$230.63	$241.47	$252.82
Withdrawal Management	4.5%	n/a	$700.00	$731.50	$764.42	n/a

Intensive Support Services (ISS)	4.2%	n/a	n/a	$2,211.30	$2,304.17	$2,400.95
Dental Services - Aged	3.4%	n/a	n/a	$30.75	$31.80	$32.88
SMI Services	5.3%	n/a	n/a	n/a	$13,527	$14,244

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

126. Exceeding Budget Neutrality. The budget neutrality limit calculated in STC 130 will apply to actual expenditures for demonstration services as reported by the state under Section XVI. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

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

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

Year **Cumulative target definition** **Percentage**

DY 16	DYs 1 through 16 combined budget neutrality limit	0 percent
DY 17	DYs 1 through 17 combined budget neutrality limit	0 percent
DY 18	DYs 1 through 18 combined budget neutrality limit	0 percent
DY 19	DYs 1 through 19 combined budget neutrality limit	0 percent
DY 20	DYs 1 through 20 combined budget neutrality limit	0 percent

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

XVII. EVALUATION OF THE DEMONSTRATION

130. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 94.

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

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

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

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

All applicable Evaluation Design guidance. Hand Medicaid program sustainability.

a. Attachment A (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD and SMI/SED Evaluation Designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a Draft Evaluation Design.

134. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

135. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or

measures endorsed by National Quality Forum (NQF).

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

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

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

a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. Upon approval from CMS, the final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

138. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial, sustained directional change, inconsistent with state targets, such as substantial, sustained trends indicating increases in disenrollment. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 10. CMS would further have the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

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

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

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

Attachment A: Developing the Evaluation Design

Introduction

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

Expectations for Evaluation Designs

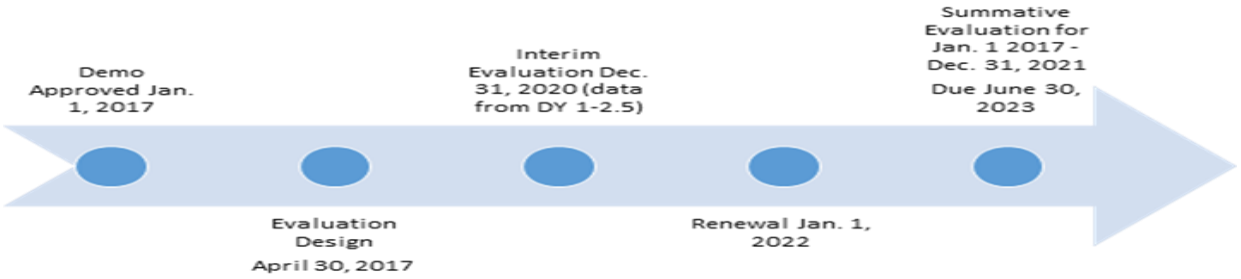
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses,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

The format for the Evaluation Design is as follows:

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

Submission Timelines

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



Required Core Components of All Evaluation Designs

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

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

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

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

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and

intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

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

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

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

1) Evaluation *Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

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

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

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

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

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

Research Question	Outcome measures used to address the research	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee- for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

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

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

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS 64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

A. Independent Evaluator. This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. This includes "No Conflict of Interest" signed conformation statements.

B. Evaluation Budget. A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

C. Timeline and Major Milestones. Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

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

Intent of this Attachment

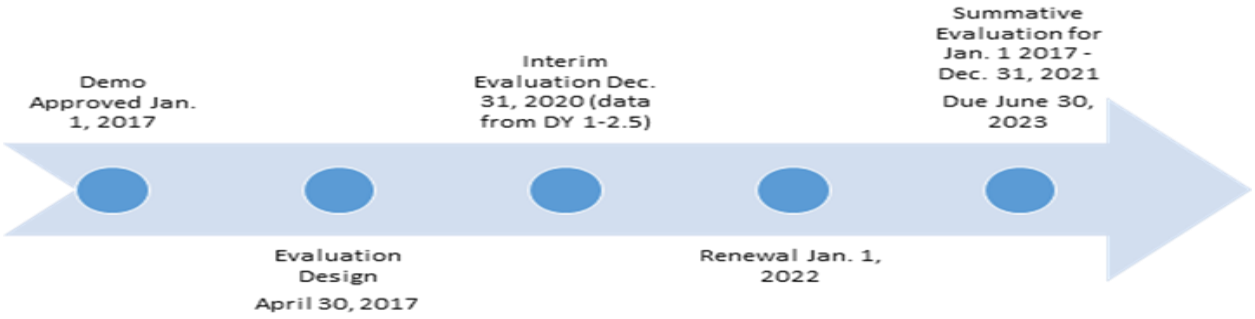
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified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

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

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

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

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

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

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

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

scientific and academic rigor, and the results are statistically valid and reliable.

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

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

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

E. Methodological Limitations

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

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

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

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

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

Attachment C: SUD Implementation Protocol

State of Utah
SUD 1115 Waiver
Implementation Plan

Division of Medicaid and Health Financing
Utah Department of Health

Table of Contents

Overview

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

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

According to the annual report from the Division of Substance Abuse and Mental Health, Department of Human Services, State of Utah, 134,764 adults in the state were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015. For youth in

grades 6 through 12, 11,804 are in need of treatment for drug and/or alcohol dependence or abuse. Seventy four percent (74%) of all adults treated by the public system are Medicaid eligible. If amendment # 15 (Attachment 9) is approved by CMS the percentage of adults needing SUD services who are Medicaid eligible will increase. At the same time 46% of all youth receiving treatment in the public system are Medicaid eligible.

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

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

MILESTONE 1: Access to Critical Levels of Care for SUD

Substance Use Disorder Delivery System

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

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

Comprehensive Benefit Design

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

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

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

3.1	Clinically Managed Low-Intensity Residential Services	24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.7	Medically Monitored Intensive Inpatient Services	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	

4	Medically Managed Intensive Inpatient	24 hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use. MAT includes methadone, Suboxone, Naltrexone	DHS/OL Licensed OTP Maintenance Providers, Licensed Prescribers	Y	

Table Two- ASAM Criteria for Withdrawal Services

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

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

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

Residential treatment

Services for Adolescents and Youth with an SUD

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

Level of Care: 0.5 (Early Intervention)

Current State:

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

Future State:
No changes are expected.

Summary of Actions Needed:
None

Level of Care: 1.0 (Outpatient Services)

Current State:

Utah Medicaid reimburses for outpatient treatment (OT) as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code

and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.

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

Future State:
No changes are expected

Summary of Actions Needed:
None

Level of Care: 2.1 (Intensive Outpatient Services)

Current State:

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

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

Future State:
No changes are expected

Summary of Actions Needed:
None

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

Current State:

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

https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20S

e rvices/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No immediate changes are expected.

Summary of Actions Needed:

None

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

Current State:

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

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

Future State:

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

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

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive

reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

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

Action Implementation Timeline

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

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

Current State

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

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

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for Level 3.7 will initially be based around a mix of current

discrete services Medicaid eligible individuals receive while in a residential treatment setting.

Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.7 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

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

Action Implementation Timeline

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

Future State:

No changes are expected

Summary of Actions Needed:

None

Sub Support Service – Addiction Recovery Management Services

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

https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20S

ervices/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected

Summary of Actions Needed:

None

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

Patient Assessments

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following (1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division Directives: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY17_Final.pdf.

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

(a) Risk of acute psychosis, intoxication/withdrawal;

(b) Biomedical conditions or complications;

(c) Emotional, behavioral, or cognitive conditions;

(d) Readiness to change;

(e) Relapse, continued use or continued problem potential; and

(f) Recovery environment.

(3) The assessment shall include relevant information on:

(a) The individual's psychosocial function, substance use including tobacco/nicotine,

mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;

(b) Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;

(c) Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;

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

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

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

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

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

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

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

Future State:

All providers will be trained on ASAM criteria

Summary of Actions Needed:

Ongoing provider training on ASAM criteria

Action Implementation Timeline

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

Independent Third Party

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

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline:

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

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

Certification of Residential Facilities

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline

- Utah Medicaid will establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than July 1, 2018.

- The Utah Division of Substance Abuse and Mental Health and the Office of Licensing will implement a process to certify public and private non-profit residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than December 31, 2018.
- PMHP contracts language regarding this requirement will be reviewed and modified if appropriate by July 1, 2018.

- Administrative rule making will be promulgated to support this milestone with an effective date of July 1, 2018.

- An addendum to the Utah Medicaid Provider Agreement will be implemented to gather information on ASAM levels of care provided by private residential treatment providers by March 31, 2018.

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

Network Development Plan

Overall Strategy- Addiction Treatment Services Providers

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

Local Substance Abuse authorities are responsible to provide SUD treatment to the residents of their county. Community mental health centers and their contracted providers are the core of public SUD services in Utah. The DSAMH monitors the Local authorities to assure appropriate access to care for county residents. In addition, the DMHF and DSMH are working with several private non-profit residential treatment

providers to expand their capacity to provide treatment to Medicaid members in need of residential treatment. The state anticipates there will be at least 240 residential treatment beds available by July 1, 2018. DSAMH also prepared an inventory of additional residential treatment providers across the state who can provide treatment if the need arises.

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline:

- DSAMH will update their provider inventory referred to above to include information on the providers at each ASAM level of care and whether or not the provider is accepting new patients by September 2018.

- DMHF and DSAMH will meet on an annual basis to evaluate the adequacy of access to SUD providers for the entire continuum of care on an annual basis beginning May 2018.

Program Integrity Safeguards

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

Risk-Based Screening

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

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

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

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

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

Provider Revalidation

The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to revalidate provider enrollments at intervals not to exceed every five years. The CMS revalidation requirement for durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments, is more frequent, at intervals not to exceed every three years.
Utah Medicaid providers receive notification letters when it is time to recredential their enrollments. Notification with instructions for revalidating are sent 90 and 60 days in advance of the revalidation deadline. Notices are mailed to the Service Location address indicated on the provider's service location profile. Providers with multiple service locations must revalidate the enrollment of each service location. Providers that fail to submit revalidation paperwork in a timely manner will be disenrolled from participation in Utah Medicaid.

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

Provider Agreements

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

Billing and Compliance Issues

As part of the Provider Agreement, providers agree to disclose information on ownership and control, information related to business transactions, information on changes in ownership, and information on persons convicted of crimes. In addition to DMHF, the Utah Office of Inspector General for Medicaid Services has responsibility for overseeing the integrity of all Medicaid payments issued by the State for services on behalf of all Medicaid-eligible beneficiaries as well as referring cases of suspected fraud to the Utah Office of the Attorney General, Medicaid Fraud Control Unit. Additionally, each of Utah Medicaid MCEs are contractually obligated to have administrative procedures that detail the manner in which each will detect fraud and abuse, including

the operation of special investigation units (SIUs). The MCE SIUs meet regularly with the OIG and MFCU address program integrity issues. The MCEs are also contractually obligated to provide reports to Utah Medicaid on their activities.

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

Benefit Management

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

Future State:

No changes are expected.

Summary of Actions Needed:

None

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

Level of Care: OTS (Opioid Treatment Services)

Current State:

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

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

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

ii. Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. Educate the client about MAT options; when clinically indicated and the client is amenable:

a. Include the use of MAT in the treatment plan, and

b. Either provide MAT as part of the treatment, or

c. Refer the individual for MAT.

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

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

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

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

- Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.

- The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.
- Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

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

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

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

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

Buprenorphine is the first medication to treat opioid dependency that is permitted to be

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

Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

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

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

Prior Authorization Criteria

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

Prescribing Guidelines

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

ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence

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

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

Naloxone (Narcan®) is a life-saving prescription medication used as an antidote to opioid overdose. Naloxone has mainly been used in the past in the hospital or by emergency medical personnel. However, Naloxone kits are now available for patients to use for emergency treatment of overdoses at home. In 2016, the executive director of the Utah Department of Health signed a statewide standing order allowing to dispense Naloxone, without a prior prescription, to anyone at increased risk of experiencing or witnessing an overdose. Through this standing order, anyone can purchase Naloxone without a prescription. DSAMH has worked to provide Naloxone kits and training to first responders, as well as all Adult Probation & Parole agents, and individuals in the community.

Drug Courts

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

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

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

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline

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

Milestone 6 Improved Care Coordination and Transitions between Levels of Care

Transitions of Care

Current State

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

Future State:

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

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

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

Summary of Actions Needed:

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

Action Implementation Timeline

- Utah will amend provider manuals and the PMHP contracts by July 1, 2018

- Providers will be notified of this change in the May, June and July 2018 Medicaid information Bulletin.

ADDITIONAL INFORMATION

Case Management

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

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

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

Crisis Intervention Team (CIT)

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

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

Certified Peer Support Specialists (CPSS)

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

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

Trauma-informed Approach

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

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

1. Ongoing Organizational Evaluation,
Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.

2. Utah Trauma Academy: October 31, November 4, 2016 for 110 public and provide providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.

3. Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in their practices.

Future State:

No changes are expected.

Summary of Actions Needed:

None

Grievances and Appeals

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

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline

- Utah Medicaid will conduct a review of current administrative code and federal regulations to determine any needed updates by November 30, 2017.

- Utah Medicaid will implement any necessary changes to administrative code and internal procedures by March 31, 2018

Attachment D: SUD Monitoring Protocol

[To be incorporated after CMS approval]

Attachment E: Implementation Plan

[To be incorporated after CMS approval]

Attachment F:

UTAH 1115 PRIMARY CARE NETWORK DEMONSTRATION WAIVER

SUBSTANCE USE DISORDER REVISED EVALUATION DESIGN

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INTRODUCTION

The original SUD evaluation design was approved by CMS on October 16, 2019 (see Appendix 1).

The initial evaluation design proposed for the 1115 SUD waiver relied on a differences-in differences (DiD) approach where substance abuse treatment in implementation counties would be compared to non-implementing comparison counties. However, due to the rapid and unexpected growth of SUD treatment services in newly established IMD's within the comparison counties, the anticipated window of data collection had to be decreased. Thus, the ability to establish an appropriate comparison group was compromised. As a result, a revised evaluation design for the SUD waiver will be required moving forward.

As noted in the interim report "although lacking statistical significance thus far for the five primary research hypotheses, most of the outcome measures are trending positively in the hypothesized direction, suggesting that additional time for policy and program implementation may be required to detect the impact of the demonstration on the outcomes. *Key to this will be the need to change the research design from a DiD analysis to a longitudinal time series design*." The Utah Department of Health (UDOH), included in its Waiver renewal application a request to revise the SUD evaluation design.

Additionally, a technical assistance call was held with CMS staff on May 21, 2021 to discuss potential approaches to a new evaluation design. During that call the recommendation was made to submit the revised design with a table listing the proposed changes. The proposed revisions to the 1115 SUD Evaluation Design are included in Table 1 below with the changes highlighted in red. These changes include replacing the differences-in-differences (DiD) design with an interrupted time series (ITS) design, modifying some metrics from annual to monthly, and also linking the Medicaid data with Treatment Episode Data Set (TEDS) which will provide additional variables to strengthen the design. Another change, utilizing propensity score matching (PSM), may lead to the creation of a comparison group among patients in TEDS. This technique may help identify a group of matched patients with similar characteristics to the target (Medicaid patient) population. If the PSM approach is not feasible, then the analysis will be to create monthly metrics where ITS will be used, or simple pre/post analysis with logistic regression.

The TEDS is a standardized client-level compilation of demographic, substance use, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. Specifically, TEDS provide data on drug use patterns among admissions to treatment, including primary drug use, age at first use, mode of administration, and frequency of use, which are useful in tracking changing patterns of drug use and treatment need. Client discharge data in TEDS has allowed the analysis of treatment length of stay and treatment completion, potentially important factors in treatment outcomes. Further, data are used by states to compare their experience with the rest of the country.

The interrupted time series (ITS) analysis proposed here is a quantitative, statistical method in which multiple repeated observations are made at regular intervals before and after the waiver policy implementation. By collecting data at regular intervals over time, a pre-post comparison can be made while accounting for underlying trends in the outcome. One of the important advantages ITS holds is that it can detect changes that are delayed or intermittent. It can also determine if the change is permanent or temporary.

Propensity score matching (PSM) is a statistical matching technique that attempts to reduce the bias due to confounding variables that could be found in an estimate of the treatment effect obtained from simply comparing outcomes among units that received the treatment versus those that did not. PSM may allow the creation of a control population with similar values on the propensity score, and possibly other covariates, which will strengthen the overall design.

Table 1: Revised Summary of Demonstration Populations, Hypotheses, Evaluation Questions, Data Sources, and Analytic Approaches.

Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?						
Demonstration Goal: Increased rates of identification, initiation, and engagement in treatment for SUDs. **Evaluation Hypothesis: The demonstration will increase the percentage of members who are referred and engage in treatment for SUDs.**						
Driver	Measure Description	Steward	Numerator	Denominator	Evaluation Period	Analytic Approach /Target or Comparison Population
Primary Driver *(Increase the rates of initiation and engagement in treatment for SUDs)*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NQF #0004	Initiation: number of patients who began initiation of treatment through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date Engagement: Initiation of treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post) Retrospectively changing the metric to monthly (from annually)	**Descriptive statistics** (frequencies and percentages); Linear regression. Interrupted time series (ITS) design will be used

Secondary Drivers *(Enhance provider and plan capabilities to screen/identify patients for engagement and intervention; Improve community knowledge of available treatment and services)*	Community knowledge of available treatment and services	University of Utah / SRI	Beneficiary survey Adult SUD consumer satisfaction questions	NA	State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population**: SUD members. **Comparison population**. Annual survey of Medicaid members receiving SUD services. Survey findings are compared between respondents in 2020, 2021, and 2022 survey.
Demonstration Goal: Increased adherence to and retention in treatment for SUDs. **Evaluation Hypothesis: The demonstration will increase the percentage of members who adhere to treatment of SUDs.**						
Primary Drivers *(Increase the rates of initiation and engagement in treatment for OUD and SUDs; Improve adherence to treatment for SUDs)*	Continuity of Pharmacotherapy for OUD Percentage of members with a SUD diagnosis including those with OUD who used services per month	NQF #3175 N/A	Number of members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days Number of members who receive a service during the measurement period by service type	Members who had a diagnosis of OUD and at least one claim for an OUD medication Number of members	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post) First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Descriptive statistics** (Frequencies and percentages); Pre-post waiver analysis with logistic regression **Target population:** SUD members receiving MAT

Secondary Drivers *(Increase access to outpatient, intensive outpatient, and residential treatment for SUD; Improve care coordination and transitions between levels of care)*	Length of engagement in treatment	NBHQF Goal 1	Number of members completing 4th treatment session within 30 days	Number of members receiving treatment	First year of waiver is baseline compared to years 2 through 5 of the waiver. Retrospectively changing the metric to monthly (from annually)	Interrupted time series (ITS) design will be used
Secondary Driver *(Ensure patients are satisfied with services*	Patient experience of care	University of Utah / SRI	Beneficiary survey Adult SUD consumer satisfaction questions	N/A	State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population**: SUD members. **Comparison population**. Annual survey of Medicaid members receiving SUD services. Survey findings are compared between respondents in 2020, 2021, and 2022 survey.
Increase the rates of successfully completing treatment for SUDs	Treatment completion	TEDS	Number of patients completing treatment	Total number of patients treated	Yearly	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison

						group (matched) population of others receiving treatment through publicly funded SUD systems.
Increase the rates of successfully completing treatment for SUDs	Returning to treatment	TEDS	Number of patients re-admitting to treatment after completing or dropping out	Total number of patients treated	Yearly	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison group (matched) population of others receiving treatment through publicly funded SUD systems.
Demonstration Goal: Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. **Evaluation Hypothesis: The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.**						
Primary Drivers *(Reduced utilization of emergency department and inpatient hospital settings for SUD treatment)*	Follow-up after emergency department visit for alcohol and other drug abuse or dependence Inpatient admissions for SUD	NQF 2605	An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7/30 days after emergency department discharge Number of members with and inpatient admission for SUD and specifically OUD	Members treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence in the measurement year/1000-member months	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. Interrupted time series (ITS) design will be used

	and specifically OUD			Total number of members/1000-member months		

Evaluation Question: Do members receiving SUD services experience improved health outcomes?						
Demonstration Goal: Improved access to care for co-morbid physical health conditions commonly associated with SUD among members. **Evaluation Hypothesis: The demonstration will increase the percentage of members with SUD who experience care for comorbid conditions.**						
Improve access to care for co-morbid physical health conditions among beneficiaries with SUD	Number of routine office visits by people with SUD	N/A	Number of members with a SUD diagnosis, and specifically those with OUD, who access physical health care.	Total number of members	First year of waiver is baseline compared to years 2 through 5 of the waiver	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. Interrupted time series (ITS) design will be used
Increased initiation and engagement for treatment	Alcohol use by patients	TEDS	Patients with alcohol use Abstinence (Percent Increase): (Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission	Total number of patients	Admission to discharge	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison group (matched) population of others receiving treatment through publicly funded SUD systems.
Increased initiation and engagement for treatment	Drug use by patients	TEDS	Abstinence (Percent increase): (Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission	N/A	Admission to discharge	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison

						group (matched) population of others receiving treatment through publicly funded SUD systems.
Increased initiation and engagement for treatment	Opioid use by patients	TEDS	Abstinence (Percent increase): (Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission	N/A	Admission to discharge	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison group (matched) population of others receiving treatment through publicly funded SUD systems.
Improved screening and integration of physical health care	Tobacco use by patients	TEDS	Abstinence (Percent increase): (Percent abstinent at discharge minus percent abstinent at admission) divided by percent abstinent at admission	N/A	Admission to discharge	Descriptive statistics Pre-post waiver analysis with logistic regression **Comparison population** Propensity score matching (PSM) to create comparison group (matched) population of others receiving treatment through publicly funded SUD systems.

Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?						
Demonstration Goal: Reduction in overdose deaths, particularly those due to opioids. **Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.**						
Reduce opioid-related opioid overdose deaths	Rate of overdose deaths, specifically overdose deaths due to any opioid	UDOH SUD Monitoring Workbook Metric 27	Number of overdose deaths per month and per year	Number of members/1000	First year of waiver is baseline compared to years 2 through 5.	Descriptive statistics (Frequencies and percentages); t-test.

Waiver Introduction from Initial Evaluation Design

In October 2017, the Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF) received a five-year extension to its 1115 Primary Care Network (PCN) Demonstration Waiver. This extension adds covered benefits and continues providing health coverage to eight vulnerable population groups, some of whom are not eligible for Medicaid under the state plan.

This proposal will both track the general performance of the 1115 waiver and evaluate demonstration impacts and outcomes. Results of the evaluation will be presented in a series of annual reports, as well as interim and final evaluation reports. This draft proposal identifies the general design and approach of the evaluation in response to the required Special Terms and Conditions (STC's).

A. GENERAL BACKGROUND INFORMATION

Utah's 1115 PCN Demonstration Waiver (hereinafter referred to as "Demonstration") is a statewide waiver that was originally approved on February 8, 2002 and implemented on July 1, 2002. Since that time, the Demonstration has been extended and amended several times to add additional benefits and Medical programs. Most recently, the Demonstration was amended and approved on October 31, 2017 with an approval period through June 30, 2022. The evaluation will cover the Demonstration approval period.

Waiver Population Groups
The Demonstration authorizes the State of Utah to administer the following medical programs and benefits:

- PCN Program (Demonstration Population I) - Provides a limited package of preventive and primary care benefits to adults age 19-64.
- Current Eligibles - Provides a slightly reduced benefit package for adults receiving Parent/Caretaker Relative (PCR) Medicaid.
- Utah's Premium Partnership Program (UPP) (Demonstration Populations III, V & VI) - Provides premium assistance to pay the individual's or family's share of monthly premium costs of employer sponsored insurance or COBRA.
- Targeted Adult Medicaid- Provides state plan Medicaid benefits to a targeted group of adults without dependent children.
- Former Foster Care Youth from Another State- Provides state plan Medicaid benefits to former foster care youth from another state up to age 26.
- Dental Benefits for Individuals who are Blind or Disabled- Provides dental benefits to individuals age 18 and older with blindness or disabilities.
- Substance Use Disorder (SUD) Residential Treatment- Allows the State to provide a broad continuum of care which includes SUD residential treatment in an Institution for Mental Disease (IMD) for all Medicaid eligible individuals.

This Evaluation Design will focus on the SUD component of the Demonstration, which provides a broad continuum of care for all Medicaid eligible individuals. This is an important Medicaid addition due to the significant impact substance use disorders have on the health and well-being of Utahans.

Prior to the approval of this demonstration, individuals who were receiving SUD residential treatment in an IMD were not eligible to receive Medicaid. SUD services provided in residential and inpatient treatment settings that qualified as an IMD, were not otherwise matchable expenditures under section 1903 of the Act. Individuals needing treatment waited months to receive residential treatment due to the low number of treatment beds available in smaller facilities. Prior to implementation of the demonstration, there were approximately 50 treatment beds available. Since implementation, approximately 490 additional treatment beds have been added Statewide. The State currently has seven SUD treatment facilities that meet the definition of a SUD IMD facility.

Substance Use Disorders in the United States

Behavioral health disorders, which include substance use and mental health disorders, affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[1,2,3] Illicit drug use, including the misuse of prescription medications, affects the health and well-being of millions of Americans. Cardiovascular disease, stroke, cancer, infection with the human immunodeficiency virus (HIV), hepatitis, and lung disease can all be affected by drug use. Some of these effects occur when drugs are used at high doses or after prolonged use. However, other adverse effects can occur after only one or a few occasions of use.[4] Addressing the impact of substance use alone is estimated to cost Americans more than $600 billion each year.[5]

Reducing SUD and related problems is critical to Americans' mental and physical health, safety, and quality of life. SUDs occur when the recurrent use of alcohol or other drugs (or both) causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. These disorders contribute heavily to the burden of disease in the United States. Excessive substance use and SUDs are costly to our nation due to lost productivity, health care, and crime. [6, 7, 8] Approximately 23.3 million people aged 12 or older in 2016 had SUDs in the past year, including 15.6 million people with an alcohol use disorder and 7.4 million people with an illicit drug use disorder. [9]

Among those dealing with SUDs, opioid misuse, overdose and addiction, occurs in only a subset of individuals prescribed opioid medications for pain relief. However, because many individuals take opioids, the number of Americans affected is significant. According to the Centers for Disease Control and Prevention (CDC), deaths due to prescription opioid pain medication overdose in the US have more than quadrupled from 1999 to 2011. [10] In addition to the increase in drug-related deaths, the rise in opioid prescribing has led to increases in the prevalence of opioid use disorder. [11] Other research has

demonstrated that the so-called opioid epidemic has a disproportionate impact on Medicaid beneficiaries. Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times the risk of prescription painkillers overdose.[12], [13] North Carolina found that while the Medicaid population represented approximately 20 percent of the overall state population, it accounted for one-third of drug overdose deaths, the majority of which were caused by prescription opioids. [14] One study from the state of Washington found that 45 percent of people who died from prescription opioid overdoses were Medicaid enrollees. [15]

Substance Use Disorders in Utah

According to the 2016 National Survey of Drug Use and Health, in Utah there were an estimated 134,764 adults in need of treatment for alcohol and/or drug dependence or abuse.[16] For youth in grades 6 through 12 in 2017 there were 11,804 in need of treatment. However, only 13,780 adults and 1,179 youth received SUD treatment services in FY 2017. [17] Of those in treatment, 46% received outpatient, 21% received intensive outpatient, 21% participated in detox, and 12% participated in residential treatment. Seventy-one percent of those in treatment were retained for 60 or more days. In 2017, Opioids were the top drug of choice at admission (32%). [18]

Utah has experienced a sharp increase in opioid related deaths since 2000. Recent data suggests that the number of deaths due to opioids peaked initially in 2007, then showed a promising decreasing trend through 2010, before increasing dramatically once more from 2011 through 2015. Emergency department encounters data over the same timeframe shows a steady increase through 2012, with a small decrease observed from 2012 to 2014. Males accounted for approximately 60% of opioid deaths in 2013, but the gap between males and females has shrunk so that by 2015 males accounted for only 54% of deaths. For emergency department encounters, the opposite has been true. In the past, females have traditionally accounted for more visits than males. However, similar to the death data, the gap between females and males has been closing. In 2014, the percentage of emergency department encounters for males and females was essentially even (50.3% vs. 49.7% for females and males, respectively). [19]

However, SUDs are preventable and treatable. The Utah State Division of Substance Abuse and Mental Health (DSAMH) has statutory oversight of substance abuse and mental health treatment services statewide through local county authority programs. SUD services are available to all Medicaid members statewide. A full continuum of SUD services becomes even more critical in an effort to address the needs of Medicaid members. [20]

B. EVALUATION QUESTIONS & HYPOTHESES

The primary goals of the waiver are to increase access, improve quality, and expand coverage to eligible Utahans. To accomplish these goals, the Demonstration includes several key activities including enrollment of new populations, quality improvement, and benefit additions or changes. This evaluation plan will describe how the University of Utah's Social Research Institute (SRI) will document the

implementation of the key goals of the Demonstration, the changes associated with the waiver including the service outputs, and most importantly, the outcomes achieved over the course of the Demonstration.

Evaluation Purpose

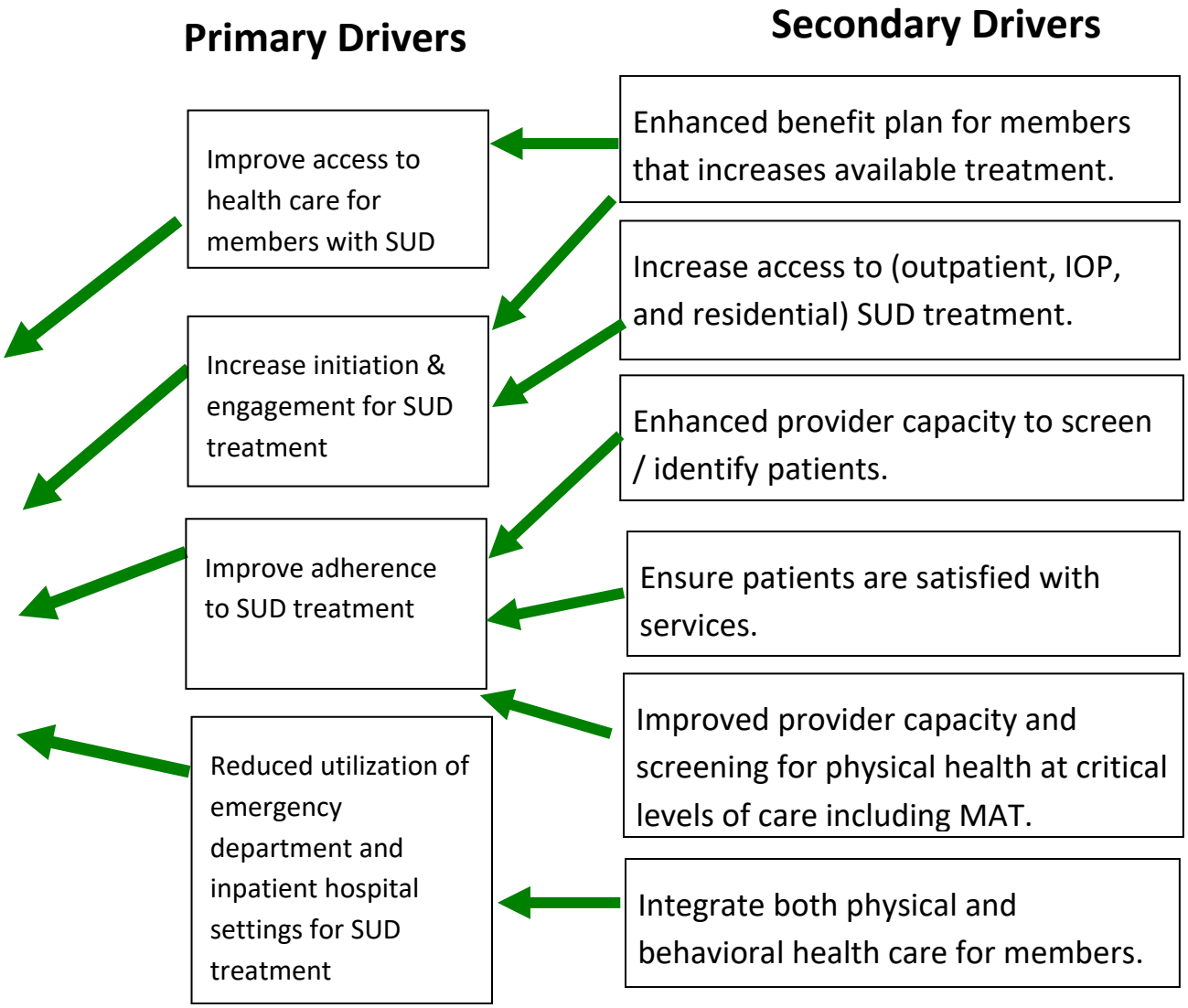
SRI will conduct an evaluation of the Utah 1115 PCN Demonstration Waiver by establishing research questions and a study design that is responsive to the hypotheses identified by UDOH. SRI will collaborate with UDOH and DSAMH to obtain the appropriate data to conduct the analysis needed to complete the required evaluation reports on an annual basis, and at each subsequent renewal or extension of the demonstration waiver. This includes an evaluation of the overall waiver and the SUD component. The SUD evaluation is addressed in this document.

Driver Diagram

Aim: 1115 Demonstration Waiver SUD treatment will improve access, utilization, and health for members

Outcome Measures:

1. Increased access to SUD treatment
2. Increased utilization of SUD treatment
3. Improved health outcomes in SUD members
4. Reduce opioid-related overdose deaths
5. Slow the rate of growth of total cost of care for SUD members

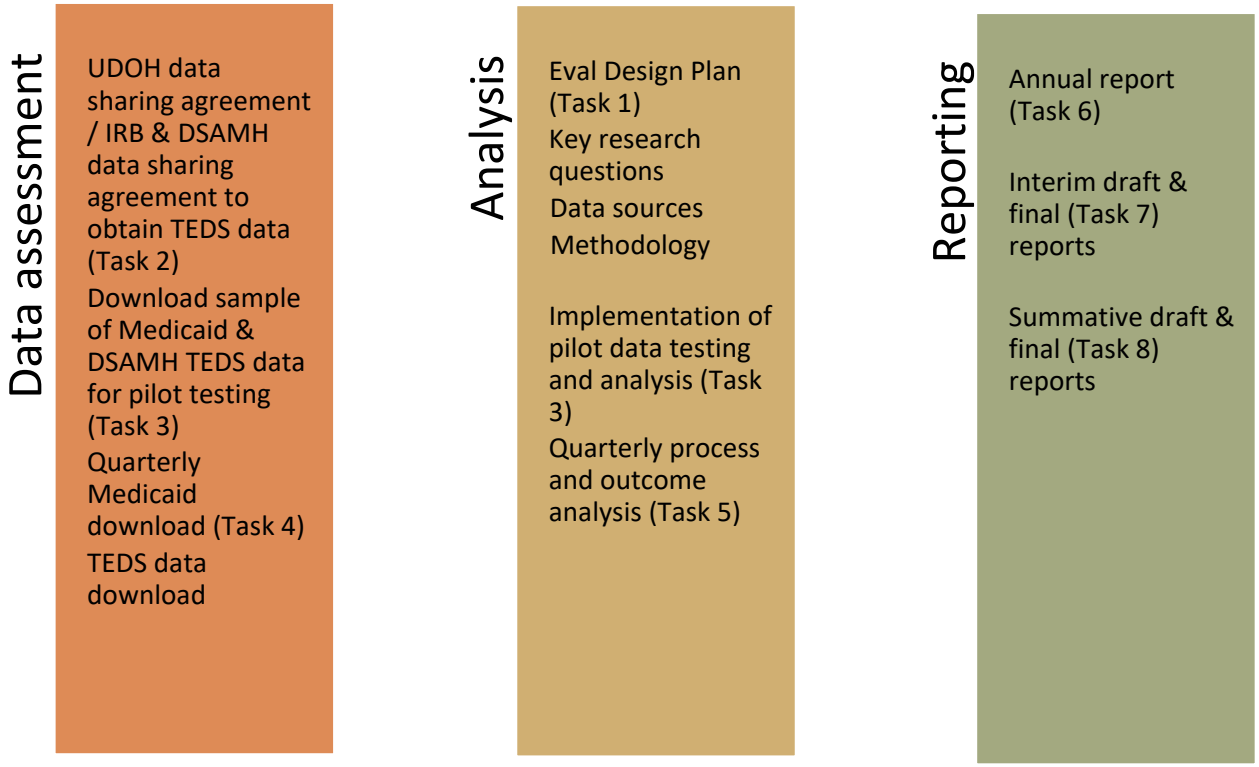


C. METHODOLOGY

Evaluation Approach

To evaluate the different components of the waiver demonstration, we envision three main phases of work: (1) data assessment and collection, (2) analysis, and (3) reporting. The last phase will include both reporting of waiver findings to UDOH in response to the STC's and also providing written summary reports for submission to the Centers for Medicare and Medicaid Services (CMS). The first key task—development of the evaluation design plan—appears at the top of Figure 1. This plan will specify the key research questions the evaluation will address for each demonstration component, as well as the primary data sources and methodologies that will be used. This plan will guide decision making at all levels of the study and drive the content of the reporting tasks.

Figure 1. Project vision



1. Evaluation Design

Due to the unique target population groups included in the Demonstration evaluation, a combination of design approaches will be implemented. First, for several of the SUD hypotheses demonstration components pre / post comparison will be conducted. Second, other SUD hypotheses will consist of a pre / post comparison where the target population will serve as its own control group. A time series design will be employed for most of the individual analysis using pre-Demonstration as a baseline and then using the first year as baseline where no pre-Demonstration data are available due to the nature of the individual target population. A quasi-experimental design (difference-in-difference, DiD) approach will be used to estimate the effect by comparing the SUD (IMD) residential treatment service expansion in Salt Lake and Utah Counties with other counties (Davis, Weber, and Washington). The use of both quantitative and qualitative data will be important to this design. Quantitative data will come from Utah Medicaid claims. Qualitative data will come from a SUD beneficiary survey.

The specific evaluation questions to be addressed are based on the following criteria:
1) Potential for improvement, consistent with the key goals of the Demonstration;
2) Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time; and
3) Potential to coordinate with the UDOH's ongoing performance evaluation and monitoring efforts.
Once research questions are selected to address the Demonstration's major program goals and activities, specific variables and measures will then be identified to correspond to each research question. Finally, a process for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions will be identified. The evaluation team will use all available data sources. The timing of data collection periods will vary depending on the data source, and on the specific Demonstration activity.

2. Target and Comparison Populations

The target population includes any Medicaid beneficiary with a substance abuse disorder (SUD) diagnosis. Several comparison population groups will be used in this evaluation. The first will be comprised of the target population, which will serve as its own comparison group longitudinally, where the research question will compare service utilization differences across the demonstration period. The second group that will be used as a comparison population for some of the SUD components will be members who previously received SUD treatment services in counties without access to an IMD. A difference-in-difference (DiD) approach will be used to estimate the effect by comparing the SUD (IMD) residential treatment service expansion in Salt Lake and Utah Counties with counties (Davis, Weber, and Washington) where there was no residential expansion. At the present time, these three counties have elected not to establish an IMD residential facility. Table 2 below summarizes the residential population and those that have received SUD treatment in the counties through publicly funded treatment programs.

The source of these data is DSAMH Treatment Episode Data Set (TEDS). These five counties will be included in the DiD design comparison.

Table 2: Summary of target populations in SUD DiD design counties in Utah.

Counties w / IMD Expansion	County Population	# of clients served	Percent of Admissions in Outpatient / IOP/ Residential / Detox		
			2016	2017	2018
Salt Lake	1,152,633	7,497	36/21/10/33	35/19/13/33	30/17/17/36
Utah	622,213	1,229	29/29/27/15	29/29/28/14	33/27/21/18
Counties w / No Expansion					
Davis	351,713	1,548	55/31/14/0	58/29/13/0	75/19/6/0
Washington	171,700	596	44/35/21/0	48/31/21/0	53/28/19/0
Weber	256,359	1,757	81/14/5/0	77/18/5/0	73/22/5/0

The third comparison population will include patients in publicly funded treatment programs receiving substance services who complete annual MSHIP survey which will serve as a comparison group for the consumer survey that will be administered to SUD beneficiaries.

3. Evaluation Period

The SUD waiver evaluation components will use pre-demonstration data from January 2016 to October 2017 to understand trends in treatment services and for state-level benchmarking of treatment outcomes. The State is aware that many measures with an established measure steward require reporting according to calendar year. This includes:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
- Continuity of Pharmacotherapy for OUD; and
- Follow-up after Emergency department visit for alcohol and other drug abuse or dependence

For these measures, the State will use a pre-post approach. Calendar year 2016 will serve as the pre-demonstration year. Calendar year 2017 will be reported and observed for trend, however it will be a partial-demonstration year due to the demonstration begin date of November 1, 2017. Calendar year 2018 will serve as the first full post-demonstration year.

The 1st year of the waiver will serve as the baseline using a post-only approach for some State-created measures as noted in Table 3 below. The post-only approach will be used due to the lack of a national benchmark in these measures that may inform the State on relevant performance. Data to be used for the evaluation will span the entire Demonstration period (11/1/2017 – 6/30/2022) for the targeted population groups and for the comparison groups identified.

4. Evaluation Measures

The measures to be used in the SUD evaluation include nationally standardized data collection protocols such as NFQ #0004, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Continuity of Pharmacotherapy for OUD (NQF #3175), and qualitative data from a beneficiary survey that focuses on health care satisfaction, access, and quality. The specific measures are listed in Table 3 below.

5. Data Sources

The State will use four data sources to conduct the evaluation plan. First, UDOH's Medicaid HIPAA transaction set consisting of all Utah claims and encounters data. Data from this source is available prior to the November 2017 waiver approval and throughout the demonstration. Second, the DSAMH TEDS Admission and Discharge record is an electronic client data file that includes data from all publicly funded SUD treatment service providers in Utah. This data file includes required standardized variables that are submitted to the Substance Abuse and Mental Health Administration (SAMHSA) for its State Outcomes Measurement and Management System (SOMMS) as well as variables that are required for the National Outcome Measures (NOMS). The file includes more than 100 variables ranging from most current diagnosis (ASAM levels), Drug Court Submissions, referral sources, waiting time to enter treatment, to criminogenic risk level. TEDS data is also available prior to the waiver and annually moving forward. Third, the State will conduct a SUD beneficiary survey annually. Fourth, the State's Vital Records dataset will be used to identify overdose deaths.

6. Analytic Methods

A combination of quantitative statistical methods will be used for the analysis. Specific measures will be utilized for each demonstration as detailed in Table 3 (retained without changes for historical purposes). While the Demonstration seeks to increase service provision and promote quality care, observed changes may be attributed to the Demonstration itself and/or external factors, including other State- or national-level policy or market changes or trends. For each Demonstration activity, a conceptual framework will be developed depicting how specific Demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis for the evaluation methodology. Methods chosen will attempt to account for any known or possible external influences and their potential interactions with the Demonstration's goals and activities. The evaluation will seek to isolate the effects of the Demonstration on the observed outcomes in several ways:

First, the evaluation will incorporate baseline measures and account for trends for each of the selected variables included in the evaluation. Medicaid data for each of the targeted variables and measures will be analyzed annually so that outcome measures and variables can be monitored on a regular basis. The hypotheses in Table 3 involving the DiD design compare SUD residential expansion counties with SUD residential services in non-expansion counties.

Second, the evaluation will use known state benchmarks for publicly funded SUD treatment annually to measure Demonstration outcomes related to domains of consumer experience with treatment services. Specifically, those seven domains are: Satisfaction, Access, Quality, Participation, Outcomes, Social Connectedness, and Functioning. [21] These variables are collected by the DSAMH annually among publicly funded SUD service providers. This DSAMH data cannot be linked to specific Medicaid enrollees, therefore, the waiver evaluation will conduct its own SUD beneficiary survey. The Utah MHSIP data collected during State fiscal year 2020-2022 will be used as a state benchmark for comparison to the SUD beneficiary survey results. Since the MHSIP survey has demonstrated modest correlations in magnitude in the predicted directions, with greater patient satisfaction being associated with lower symptoms and more positive outcomes,[22] the same questions will be used in the Demonstration survey. This data will be analyzed with descriptive statistics such as frequencies, percentages, and t-tests.

Table 3: Summary of Demonstration Populations, Hypotheses, Evaluation Questions, Data Sources, and Analytic Approaches.

Note: This table, was included in the original CMS-approved Evaluation Design labeled 'Table 2'. It has been relabeled Table 3 here and is being retailed for historical purposes.

Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?						
Demonstration Goal: Increased rates of identification, initiation, and engagement in treatment for SUDs. **Evaluation Hypothesis: The demonstration will increase the percentage of members who are referred and engage in treatment for SUDs.**						
Driver	Measure Description	Steward	Numerator	Denominator	Evaluation Period	Analytic Approach /Target or Comparison Population
Primary Driver *(Increase the rates of initiation and engagement in treatment for SUDs)*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NQF #0004	Initiation: number of patients who began initiation of treatment through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (frequencies and percentages); Linear regression. **Comparison population**. SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
			Engagement: Initiation of treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year		

Secondary Drivers *(Enhance provider and plan capabilities to screen/identify patients for engagement and intervention; Improve community knowledge of available treatment and services)*	Community knowledge of available treatment and services	University of Utah / SRI	Beneficiary survey Adult SUD consumer satisfaction survey		State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population**: SUD members. **Comparison population**. Patients in publicly funded programs receiving SUD services who complete annual MSHIP survey.
Demonstration Goal: Increased adherence to and retention in treatment for SUDs. **Evaluation Hypothesis: The demonstration will increase the percentage of members who adhere to treatment of SUDs.**						
Primary Drivers *(Increase the rates of initiation and engagement in treatment for OUD and SUDs; Improve adherence to treatment for SUDs)*	Continuity of Pharmacotherapy for OUD	NQF #3175	Number of members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Members who had a diagnosis of OUD and at least one claim for an OUD medication	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (Frequencies and percentages); Linear regression. **Target population:** SUD members receiving MAT
	Percentage of members with a SUD diagnosis including those with OUD who used services per month	N/A	Number of members who receive a service during the measurement period by service type	Number of members	First year of waiver is baseline compared to years 2 through 5 of the waiver.	

Secondary Drivers *(Increase access to outpatient, intensive outpatient, and residential treatment for SUD; Improve care coordination and transitions between levels of care)*	Length of engagement in treatment	NBHQF Goal 1	Number of members completing 4th treatment session within 30 days	Number of members receiving treatment	First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Comparison population**. SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
Secondary Driver *(Ensure patients are satisfied with services)*	Patient experience of care	University of Utah / SRI	Adult SUD beneficiary satisfaction survey		State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population:** SUD members. **Comparison population**. Patients in publicly funded programs receiving SUD services who complete annual MSHIP survey.

Demonstration Goal: Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. **Evaluation Hypothesis: The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.**						
Primary Drivers *(Reduced utilization of emergency department and inpatient hospital settings for SUD treatment)*	Follow-up after emergency department visit for alcohol and other drug abuse or dependence	NQF 2605	An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7/30 days after emergency department discharge	Members treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence in the measurement year/1000-member months	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. **Comparison population** SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
	Inpatient admissions for SUD and specifically OUD	N/A	Number of members with an inpatient admission for SUD and specifically for OUD	Total number of members/1000-member months	First year of waiver is baseline compared to years 2 through 5 of the waiver.	

Evaluation Question: Do members receiving SUD services experience improved health outcomes?						
Demonstration Goal: Improved access to care for co-morbid physical health conditions commonly associated with SUD among members. **Evaluation Hypothesis: The demonstration will increase the percentage of members with SUD who experience care for comorbid conditions.**						
Primary Drivers *(Improve access to care for co-morbid physical health conditions among beneficiaries with SUD)*	Number of routine office visits by people with SUD	N/A	Number of members with a SUD diagnosis, and specifically those with OUD, who access physical health care.	Total number of members	First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. **Comparison population** SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?						
Demonstration Goal: Reduction in overdose deaths, particularly those due to opioids. **Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.**						
Primary Driver *(Reduce opioid-related opioid overdose deaths)*	Rate of overdose deaths, specifically overdose deaths due to any opioid	UDOH	Number of overdose deaths per month and per year	Number of members/1000	First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population:** SUD members. **Comparison population**. State General Population.

D. METHODOLOGICAL LIMITATIONS

The first potential limitation is ensuring each individual analysis is based on unduplicated data. SRI staff will work closely with Utah Medicaid data personnel and DSAMH to ensure the data used for final analysis is as accurate as possible and that error in matching the TEDS Admission and Discharge data set to Medicaid claims data has been minimized to avoid duplication. There are also limitations of conducting a time series analysis without a comparison group. For example, data collected at different times are not mutually independent, which means a single chance event may affect all later data points. As a result, the true pattern or trend underlying time series data can be difficult to discern.

E. ATTACHMENTS

A. Independent Evaluator

The Social Research Institute (SRI) will conduct all activities related to this proposal to fulfill the evaluation requirements of Utah's 1115 PCN Waiver with specific emphasis on conducting data analysis to ensure timely reporting. SRI was established in 1982 as the research arm of the College of Social Work. Its goal is to be responsive to the needs of community, state, national and international service systems and the people these systems serve. Through collaborative efforts, SRI facilitates innovative research, training and demonstration projects. SRI provides technical assistance and research services in the following functional areas: conducting quantitative and qualitative research; designing and administering surveys; analyzing and reporting data analysis; designing and conducting needs assessments of public health and social service problems and service systems; planning and implementing service delivery programs; evaluating program and policy impacts; training in research methods and data analysis; providing technical assistance.

SRI staff are experienced in complying with state and federal laws regarding protecting human subjects and assuring confidentiality of data. SRI will complete the required IRB applications for this project including any data sharing agreements that may be necessary. SRI staff comply with generally accepted procedures to safeguard data by ensuring all data is stored on password protected and encrypted computers. Specifically, we use two-factor authentication (2FA) verification as an extra layer of security. All data collection and analysis SRI is responsible for will be based on the agreed upon data collection plan and in accordance with HIPAA-compliant data management systems available to University of Utah researchers.

Data Security and Storage

SRI will store UDOH's Medicaid (HIPPA transaction set) in the University's REDCap application. REDCap is a secure database with the ability to create web-accessible forms, continuous auditing, and a flexible reporting system. Controls within REDCap allow researchers to specify differential levels of data

access to individuals involved with a REDCap project, including restrictions to HIPAA-sensitive identifiers. REDCap is located on a secure, 21 CFR Part11 compliant server farm within the Center for High Performance Computing (CHPC) at University of Utah. Data are backed up every hour with the hourly backups being incorporated into the regular backup-recovery data process (nightly, weekly, and monthly), which includes off-site storage. Routine data recovery and disaster recovery plans are in place for all research data. During analysis, de - identified data may be maintained on University of Utah-encrypted computers or hard-drives in compliance with University policy.

Independent Evaluator Selection Process

SRI staff have contracted with the Utah Department of Human Services, Division of Child and Family Services (DCFS) to evaluation their IV-E waiver demonstration project for the past 4 years. Simultaneously, SRI also served as the independent evaluator for the State of Idaho's IV-E waiver demonstration for two years. Within the past year, key research staff from DCFS who were familiar with the work performed by SRI staff changed jobs and now work for UDOH Office of Health Care Statistics. As result, when UDOH was trying to locate an independent evaluator a referral was provided and several preliminary meetings and discussions were held. This led to SRI developing a proposal for UDOH to conduct the Demonstration evaluation.

The research team will consist of Rodney W. Hopkins, M.S., Research Assistant Professor, Kristen West, MPA., Senior Research Analyst, and Jennifer Zenger, BA, Project Administrator.

Mr. Hopkins in an Assistant Research Professor and has 25 years' experience in conducting program evaluations for local, state, and federal agencies. He has an M.S. and will be the project lead, with responsibility for evaluation design and implementation, data collection, and reporting. He will be .45 FTE.

Kristen West, MPA (.25 FTE) is a Senior Research Analyst with experience conducting multi-year program evaluations for DCFS and JJS. She has expertise with a variety of statistical software programs to analyze data including multi-level regression models, linear regression, and descriptive statistics (SPSS and R). She also has experience developing and data visualization dashboards. Jennifer Zenger (.05 FTE) is SRI's Project Administrator and has 25 years' experience in budgeting, accounts payable, and working with state and federal agencies. She will be responsible for contract setup, monitoring, and accounting services.

An interdepartmental consortium has been established between SRI and the University of Utah's Department of Economics and the Department of Family and Consumer Studies. The Department of Economics, Economic Evaluation Unit led by Department Chair, Norm Waitzman, Ph.D., (.03 FTE) a Health Economist who has extensive health care utilization and cost analysis experience will lead this effort. The other principal researcher is Jaewhan Kim, Ph.D. (.21 FTE) a Health Economist and Statistician with a broad background in health care utilization and cost analysis, statistical design and data analysis including cohort studies and cross-sectional studies. He currently co-directs the Health Economics Core, Center for Clinical & Transitional Science (CCTS) at the University of Utah School of

Medicine. He has expertise in analyzing claims databases for health care utilization and costs and has worked on multiple federal studies of health care utilization using diverse claims data such as Medicare, Medicare-SEER, Medicaid, MarketScan, PHARMetrics, University of Utah Health Plan's claims data and Utah's All Payers Claims Database (APCD). He was one of the original l developers of the APCD, published the first paper with Utah's APCD data, and has worked collaboratively with other researchers to successfully conduct more than 20 studies using the APCD. They will also be supported by a to-be-named Graduate Research Assistant (1.0 FTE).

Conflict of interest document attached.

B. Evaluation Budget

The initially proposed budget (3/2018) of projected costs for the 1115 Demonstration evaluation are detailed below. Costs include all personnel (salary + benefits), study related costs (mileage), and university indirect (reduced from 49.9% to 14.8% state rate). Year 1 budget begins April 1, 2018 and ends June 30, 2018. Year 2-5 are based on the state fiscal year. An additional 90-day period has also been included, during which SRI will complete the Year 5 Annual Report, Waiver Final Report, and SUD Final Report.

Table 1. Proposed budget

Salaries	ABA	FTE	SALARY	BENEFITS	YEAR I	YEAR II	YEAR III	YEAR IV	YEAR V	90-DAY	
Faculty											
Matt Davis	$102,000	5%	$ 5,100	$ 2,059	$ 1,785	$ 7,283	$ 7,428	$ 7,577	$ 7,729	$ 1,971	
Rod Hopkins	$ 91,997	15%	$ 13,800	$ 5,877	$ 4,919	$ 20,170	$ 20,471	$ 20,880	$ 21,298	$ 5,431	
			$ 18,900	$ 7,936	$ 6,704	$ 27,453	$ 27,899	$ 28,457	$ 29,027	$ 7,402	
Staff											
Kristen West	$ 57,222	15%	$ 8,583	$ 3,433	$ 3,004	$ 12,257	$ 12,502	$ 12,752	$ 13,007	$ 3,318	
Jennifer Zenger	$ 85,435	5%	$ 4,272	$ 1,709	$ 1,495	$ 6,100	$ 6,222	$ 6,347	$ 6,473	$ 1,650	
			$ 12,855	$ 5,142	$ 4,499	$ 18,357	$ 18,724	$ 19,099	$ 19,481	$ 4,968	
Total Staff					$4,499	$18,357	$ 18,724	$ 19,099	$ 19,481	$ 4,968	
Total Faculty Salaries					$6,704	$27,453	$ 27,899	$ 28,457	$ 29,027	$ 7,402	
Total Fringe Benefits					added in abov	added in above	added in above	added in above	added in above		
Travel (1 trip per month to UDOH & DSAMH)					$65	$250	$250	$250	$ 250	$ 65	
Total Direct					**$11,268**	**$46,060**	**$ 46,874**	**$ 47,806**	**$ 48,757**	**$ 12,435**	
Indirect (F&A) Cost				*14.80%*	**$1,668**	**$ 6,817**	**$ 6,937**	**$ 7,075**	**$ 7,216**	**$ 1,840**	
Grand Total					**$12,936**	**$52,877**	**$ 53,811**	**$ 54,881**	**$ 55,973**	**$ 14,275**	**$244,754**

Budget Narrative

Rodney Hopkins, M.S., Assistant Research Professor will be the lead on this project and will be responsible for day-to-day activities. He will work (.15 FTE) closely with UDOH and DSAMH staff to ensure appropriate data is available to answer the research questions and execute the data analysis and reporting. Dr. Davis (.05 FTE) will bring his considerable experience with quantitative analysis to this project. Kristen West, MPA, Senior Research Analyst (.15 FTE) will assist with data analysis and reporting, including data visualization. Jennifer Zenger (.05 FT) is SRI's Project Administrator. She oversees contract monitoring and the budget.

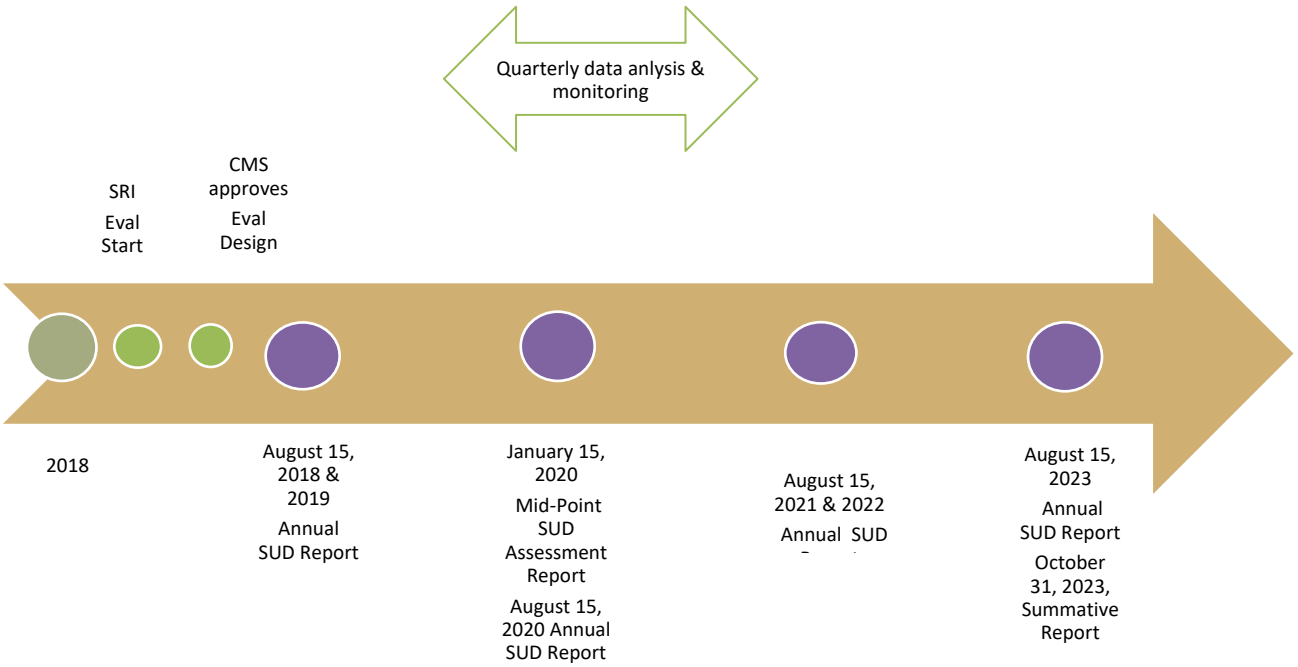
A strength this team brings to the project will be its ability to conduct a thorough and accurate data analysis and provide a professional report that will address each component of the waiver demonstration. Salaries calculated include a 2% increase as of July 1 of each year. University of Utah benefits are calculated at 40%. Year 1 is only a 6-month budget (April 1, 2018 – Sept. 30, 2018).

Local travel will be needed for SRI faculty and staff to attend meetings with UDOH and DSAMH staff. We anticipate one meeting per month.

UDOH state agency to state agency indirect costs calculated at 14.8%.

C. Timeline and Major Milestones

Figure 2. Waiver Evaluation Timeline



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Attachment H: Intensive Stabilization Services (ISS) for Children/Youth Claiming Methodology Protocol

Introduction

The Special Terms and Conditions (STCs) of Utah's Section 1115(a) Demonstration #11-W-00145/8 approved by the Centers for Medicare and Medicaid Services (CMS) on November 25, 2019, include expenditure authority for Utah's ISS Medicaid Eligible Children/Youth Program. The ISS Program is a specific set of state plan and home and community based services provided during the first eight-weeks of the intensive program to support a customized service approach to keep families together while effectively helping children with emotional and/or behavioral needs thrive in their homes, schools, and communities resulting in reduced visits to the emergency room, psychiatric hospitalizations, and residential treatment services. These services are provided on a FFS basis using a daily bundled rate. Accordingly, Utah Medicaid established the protocols herein to define the claimable expenditures.

Intensive Stabilization Services (ISS) for Children/Youth Bundled Rate

Only those providers that meet the criteria set forth in STC 74 may be reimbursed for ISS. A description of the services included in the bundled rate is located at Table 2c. A provider may not receive separate reimbursement for ISS for the same individual for which the bundled rate was claimed. Medicaid providers delivering other Medicaid-covered services outside of the service bundle may bill in accordance with the state's Medicaid billing procedures. A provider must provide at least one of the services included in the bundle within the service payment unit in order to bill the daily bundled rate. The following provides a description of how the rate methodology was developed.

The ISS bundled rate is based on a similar Department of Human Services program, Families First, which is an intensive in-home services program. The Families First rate is $100 per hour. The Department of Human Services conducted an in depth review of the Family First Rate in 2015. The cost inputs included: number of families served; average number of hours of services provided per family; actual face to face time, and indirect staff time. Families First had calculated the anticipated number of hours of service per week per family and then adjusted the number of service hours based on the percentage of families anticipated to complete the program. A sample of 20 cases from the Division of Child and Family Services, Juvenile Court and the Division of Juvenile Justice Services was used. Based on the sampling, the state calculated the average number of hours provided per family per week. The assumption was that a family would receive 48-52 face-to-face hours to complete the Families First program. The state then reviewed the billable hours per family and took the total costs divided by billable hours to calculate the cost of providing services, which was $80 per hour in 2015 and $90 per hour in 2016. Given the single year projected jump of $10, the state felt a rate of $100 was reasonable. The general breakdown of calculations:

For FYE 2015, $80 per hour ($1,802,045 in total costs divided by 22,454 hours) Hours were calculated at 436 families served x 51.5 billable hours per family = 22,454 hours.
For FYE 2016, $90 per hour ($2,374,701 in total program costs divided by 26,368 hours) Hours were calculated at 512 families served x 51.5 billable hours per family = 26,368 hours.

Since ISS are also intensive in-home services, the Families First rate is being used as a proxy for $100 per hour. The ISS bundle rate was based on the assumption that a family would receive an average of 42 face-to-face hours to complete the Stabilization Services program. The state examined and considered provider costs, which included: employee's level of education, training and experience; fringe benefits; administrative costs; and on-

going training. The eight weeks of the ISS program include:

Week 1: 7.5 hours @$100
Week 2: 7.5 hours @$100
Week 3: 6 hours @$100
Week 4: 6 hours @$100
Week 5: 4.5 hours @$100
Week 6: 4.5 hours @$100
Week 7: 3 hours @$100
Week 8: 3 hours @$100
Grand Total $4,200

Providers will submit an invoice to SMR Administrator for services provided. The SMR administrator will make appropriate payment to the provider. Any discrepancies will be resolved before payment is issued to the provider and payment is received from the Medicaid agency to the sister agency, Department of Human Services. The SMR administrator will audit the service provider(s) quarterly to ensure compliance with all stabilization service requirements and reconcile billings with documentation of services. States can only report expenditures for which all supporting documentation is available (i.e. date of service, name of recipient, Medicaid identification number), in readily reviewable form, which has been compiled and is immediately available when the claim for expenditures is filed on the CMS-64.

The state will conduct an annual review of the actual provision of services paid under the bundled rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and ensure the rates remains economic and efficient based on the services that are actually provided as part of the bundle. The rate does not include costs related to room and board or any other unallowable facility cost, or other non-covered Medicaid services.

Attachment I: Non-Traditional Benefit Package

State Name: Utah Attachment 3.1-L- OMB Control Number: 0938-1148 Transmittal Number:
- -

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

PEHP Utah Basic Plus
Adult Medicaid Expansion

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved 1115 Waiver

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Remove

Benefit Provided: Outpatient Hospital Services

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization

Remove

Benefit Provided: Clinic Services

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes ambulatory surgical centers and dialysis

Remove

Benefit Provided: Family Planning Services

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Physician Services

Source:
Secretary-Approved Other

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Medical and Surgical Services by a Dentist

Source:
Secretary-Approved Other

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Podiatry

Source:
Secretary-Approved Other

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Varies

Duration Limit:
Varies

Scope Limit:

For residents of long term care facilities: footcare performed by an employee of the facility is not covered, visits are limited to one visit every 60 days, debridement of mycotic toenails is limited to one every 60 days

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Optometry Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 exam

Duration Limit:

12 months

Scope Limit:

Eyeglasses are not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Services Provided by Licensed Nurse Practitioners

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Hospice

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Audiology

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Hearing evaluations or assessments for hearing aids are covered, hearing aids covered only if hearing loss is congenital.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Personal Care Services

Source:
Secretary-Approved Other

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 hours

Duration Limit:

30 days

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Add

■ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Hospital Services

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Ambulance Transportation

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:
□ Life of the member is in immediate danger
□ Life support equipment or medical care is required during travel
□ Other means of transportation would endanger the member's health or be medically contraindicated

Add

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Remove

Benefit Provided:
Inpatient Hospital Services

Source:
Secretary-Approved Other

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.
2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.
4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.
5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.
6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.
7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).
8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.

Add

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Remove

Benefit Provided: Extended Services to Pregnant Women

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Inpatient Hospital Services as defined in EHB3; Outpatient Hospital Services, Family Planning Services, Physician Services, Home Health Services, Services provided by a Pediatric and Family Nurse Practitioners as defined in EHB3; Medical Supplies and Equipment as defined in EHB7.

Remove

Benefit Provided: Perinatal Care Coordination

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Remove

Benefit Provided: Prenatal and Postnatal Home Visits

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 Visits

Duration Limit: 12-month period

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Remove

Benefit Provided:
Group Prenatal/Postnatal Education

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
8 Units

Duration Limit:
12-month period

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Remove

Benefit Provided:
Prenatal and Postnatal Psychosocial Counseling

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
12 Visits

Duration Limit:
12-month period

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Remove

Benefit Provided:
Nutritional Assessment Counseling

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
14 Visits

Duration Limit:
12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Remove

Benefit Provided:

Freestanding Birthing Clinics

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

Remove

Benefit Provided:

Extended Services for Pregnant Women-Other Service

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

In accordance with 42 CFR 440.250, pregnant women may receive pregnancy related services and services for other conditions that might complicate the pregnancy.

Add

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Remove

Benefit Provided: Psychiatric Diagnostic Evaluation

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Mental Health Assessment

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Psychological Testing

Source: Secretary-Approved Other

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Psychotherapy

Source:
Secretary-Approved Other

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Pharmacologic Management-Rehabilitative Mental Hea

Source:
Secretary-Approved Other

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Nurse Medication Management

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Therapeutic Behavioral Services

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Psychosocial Rehabilitative Services

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Peer Support Services

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Inpatient Hospital-Mental Health

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:
Residential and Inpatient Treatment for SUD

Source:
Secretary-Approved Other

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
60 days

Duration Limit:
12 months

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.
SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD.

These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.

Add

☑ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Remove

Benefit Provided: Physical Therapy and Occupational Therapy

Source: Secretary-Approved Other

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 16

Duration Limit: 12 months

Scope Limit: Limitations are combined for physical therapy and occupational therapy visits

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Prior authorization may be obtained if the limit of 16 visits combined needs to be exceeded due to medical necessity .

Remove

Benefit Provided: Prosthetic Devices

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Durable Medical Equipment and Supplies

Source: Secretary-Approved Other

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Varies

Duration Limit: Varies

Scope Limit: Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The following items are excluded from coverage as benefits of the Medicaid program:
1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.
9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.
a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.

Add

8. Essential Health Benefit: Laboratory services

Collapse All

Remove

Benefit Provided:
Other Laboratory and X-Ray Services

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided:
Diabetes Self-Management Training

Source:
Secretary-Approved Other

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
10 hours

Duration Limit:
12-month period

Scope Limit:
Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.

Remove

Benefit Provided:
Tobacco Cessation

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
7

Duration Limit:
12 months

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Within the State Plan this benefit is entitled 'Face-to-face Tobacco Cessation Counseling Services for Pregnant Women." Tobacco cessation services are not only covered for pregnant women. The State provides tobacco cessation services under the State Plan benefits including Physician Services, Outpatient Hospital Services, Prescribed Drugs, and Clinic Services. Utah Medicaid offers a total of 7 sessions in a 12-month period.

Add

10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Through age 20

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

11. Other Covered Benefits from Base Benchmark — Collapse All

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All

Base Benchmark Benefit that was Substituted: Adoption: Substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Adoption was removed and replaced in EHB 1 by substitution with the actuarial value of personal care services which are not covered in the Base Benchmark.

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat an Injury: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Specialist Visit: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services (for Physician Assistants working under supervision) and Services Provided by Licensed Nurse Practitioners, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Outpatient Facility Fee: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services: Du

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Outpatient Hospital Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Hospice Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Hospice Services, under EHB 1. Base Benchmark Plan: Limitation of 6 months per 3 years

Base Benchmark Benefit that was Substituted: Urgent Care Centers: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations.

Base Benchmark Benefit that was Substituted: Home Health Care: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Home Health Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Skilled Nursing Facility Services, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period

Base Benchmark Benefit that was Substituted: Dialysis: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Chemotherapy and Radiation: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Infusion Therapy: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Outpatient Hospital Services, Clinic Services, and Home Health Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Reconstructive Surgery: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Medicaid Limits: Covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention. Base Benchmark Plan: Covered when performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Base Benchmark Benefit that was Substituted: Emergency Room Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Emergency Hospital Services , under EHB 2. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Ambulance Transportation, under EHB 2. Medicaid Limitation: Medical emergencies only as defined by Utah Medicaid. Base Benchmark Plan: Limitation medical emergencies only, as determined by PEHP

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physical Therapy and Occupational Therapy under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 16 visits each per 12 months. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted: Habilitation Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physical Therapy and Occupational Therapy under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 16 visits each per 12 months. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: Substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Cardiac rehabilitation was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Cardiac Rehabilitation, Phase 2, following heart attack, cardiac surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment/Supply: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Durable Medical Equipment and Medical Supplies in EHB7. Medicaid Limitations: The following items are excluded from coverage as benefits of the Medicaid program:
1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.

9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.
a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.
Base Benchmark: Except for oxygen, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require preauthorization. Maximum limits apply on many items. Sleep Disorder equipment is not covered. TENS units, Neuromuscular stimulator, H-Wave electronic devices, Sympathetic therapy stimulators are not covered.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility/Rehabilitation:See Notes

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year. Requires preauthorization. This services is not detailed as a covered service for this benefit package.

Base Benchmark Benefit that was Substituted: Inpatient Hospitalization: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Medicaid Limitations: 1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State
of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.
2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.
4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.
5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.
6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.
7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment#5a).
8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.
Base Benchmark: The following are Exclusions of the policy:
1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community

reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications., unless legally required and approved by PEHP.
12. Mastectomy for gynecomastia.
13. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
14. Breast reduction.
15. Tests and treatment for infertility.
16. Blepharoplasty (or other eyelid Surgery).
17. All facility claims related to a Hospital stay when the Member is discharged against medical advice.
18. Sclerotherapy of varicose veins.
19. Microphlebectomy (stab phlebectomy).
20. Blood clotting factor.
21. Inpatient or outpatient dental hospitalization.

Base Benchmark Benefit that was Substituted: MH-Substance Facility and Hospital Services-Duplic

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Preauthorization required for many services. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed. Day treatment or intensive outpatient programs require Preauthorization. If approved, Benefit applied is the same as inpatient.

Base Benchmark Benefit that was Substituted: MH-Substance Inpatient Provider Visits-Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Only one visit per Provider of the same specialty per day is payable.
1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.

5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
13. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted: MH-Substance Outpatient Provider Visits-Duplicatio

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. Only one visit per Provider of the same specialty per day is payable.
1. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
2. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Wilderness programs.
4. Inpatient treatment for behavior modification, enuresis, or encopresis.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or Recreational Therapy.
7. Sodium amobarbital interviews.
8. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
9. Tobacco abuse.

Base Benchmark Benefit that was Substituted: Lab, X-Ray, and Diagnostic Imaging: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Other Laboratory and X-Ray Services in EHB8. Base Benchmark:
1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to

the potential diagnosis.
2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.
3. Drug screening, up to 2 times in a 30-day period.
4. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.
The following are Exclusions of the policy:
1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.
2. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological counseling and testing.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
11. Sleep Studies for sleep disorders.
12. Services in conjunction with diagnosing infertility.
13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.
14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.
15. Whole exome and whole genome sequencing for the diagnosis of genetic disorders.
16. Chromosomal Microarray Analysis (CMA) for Autism Spectrum Disorder.

Base Benchmark Benefit that was Substituted: Preventive Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Extended Services for Pregnant Women and Prenatal and Postnatal Home Visits in EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient for Maternity: Duplicat

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Allergy Testing: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Diabetes Education-Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Diabetes Self-Management Education in EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Transplant-Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Speech Language Pathology-Substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Speech Language Pathology Services was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Physical, Occupational, and Speech Therapy limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Add

13. Other Base Benchmark Benefits Not Covered Collapse All

14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All

Other 1937 Benefit Provided:
Optometry Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

Other:
Prior authorization is not required.

Other 1937 Benefit Provided:	Source:	Remove
Targeted Case Management for Tuberculosis	Section 1937 Coverage Option Benchmark Benefit Package	
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		

Other:

Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

Add

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Attachment J: Traditional Benefit Package

State Name: Utah Attachment 3.1-L- OMB Control Number: 0938-1148 Transmittal Number: -

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

PEHP Utah Basic Plus
Adult Medicaid Expansion

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary - Approved

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Benefit Provided:
Outpatient Hospital Services

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Some services require prior authorization

Benefit Provided:
Clinic Services

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Includes ambulatory surgical centers and dialysis

Benefit Provided:
Family Planning Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Physician Services

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Medical and Surgical Services by a Dentist

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Podiatry

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Optometry Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Services Provided by Licensed Nurse Practitioners

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health Nursing

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Hospice-Ambulatory

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Audiology

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Home Health Aide

Source:
State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

■ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided:
Emergency Hospital Services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Ambulance Transportation

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:
1. Life of the member is in immediate danger
2. Life support equipment or medical care is required during travel
3. Other means of transportation would endanger the member's health or be medically contraindicated

Add

3. Essential Health Benefit: Hospitalization

Collapse All

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.

Benefit Provided:

Inpatient Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Transplant

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Benefit Provided:

Extended Services to Pregnant Women

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Inpatient Hospital Services as defined in EHB3; Outpatient Hospital Services, Family Planning Services, Physician Services, Home Health Services, Services provided by a Pediatric and Family Nurse Practitioners as defined in EHB3; Medical Supplies and Equipment as defined in EHB7.

Benefit Provided:

Freestanding Birthing Clinics

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

Benefit Provided:

Inpatient Care for Maternity and Newborn

Source:

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Physician Services for Maternity and Newborn

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided:
Psychiatric Diagnostic Evaluation

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Mental Health Assessment

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Psychological Testing

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Psychotherapy

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Pharmacologic Management-Rehabilitative Mental Hea

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Nurse Medication Management

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Therapeutic Behavioral Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychosocial Rehabilitative Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Peer Support Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Inpatient Hospital-Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are not provided for members in Institutions for Mental Disease for those ages 21-64.

Benefit Provided:

Residential and Inpatient Treatment for SUD

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.
SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD.

These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.

Add

☑ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Utah ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Benefit Provided:
Skilled Nursing Facility Services-Acute

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Long Term Acute Care-Rehabilitative

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Physical Therapy-Rehabilitative and Habilitative

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization may be obtained if the limit of 20 visits needs to be exceeded due to medical necessity .

Benefit Provided:
Prosthetic Devices

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Durable Medical Equipment and Supplies

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Occupational Therapy-Rehabilitative and Habilitati

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization may be obtained if the limit of 20 visits needs to be exceeded due to medical necessity.

Benefit Provided:

Speech Language Pathology-Rehab and Habilitative

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

Varies

Scope Limit:

Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

8. Essential Health Benefit: Laboratory services

Collapse All

Benefit Provided:

Other Laboratory and X-Ray Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided:
Diabetes Self-Management Training

Source:
State Plan 1905(a)

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
10 hours

Duration Limit:
12-month period

Scope Limit:
Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.

Remove

Benefit Provided:
Tobacco Cessation

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Through age 20

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

11. Other Covered Benefits from Base Benchmark — Collapse All

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All

Base Benchmark Benefit that was Substituted:	Source:	
Inpatient Physician and Surgical Services: Duplica	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services in EHB3 and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Primary Care Visit to Treat an Injury: Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Specialist Visit: Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Other Practitioner Office Visit: Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services (for Physician Assistants working under supervision) and Services Provided by Licensed Nurse Practitioners, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Facility Fee: Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Surgery Physician/Surgical Services: Du	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Hospice Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Hospice Services, under EHB 1. Base Benchmark Plan: Limitation of 6 months per 3 years

Base Benchmark Benefit that was Substituted: Urgent Care Centers: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations.

Base Benchmark Benefit that was Substituted: Home Health Care: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Home Health Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Skilled Nursing Facility Services, under EHB 1. Base Benchmark Plan: Limitation 30 days per plan year

Base Benchmark Benefit that was Substituted: Dialysis: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Chemotherapy and Radiation: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Infusion Therapy: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, Clinic Services, and Home Health Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Reconstructive Surgery: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Medicaid Limits: Covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention. Base Benchmark Plan: Covered when performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Base Benchmark Benefit that was Substituted: Emergency Room Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Emergency Hospital Services , under EHB 2. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Ambulance Transportation, under EHB 2. Medicaid Limitation: Medical emergencies only as defined by Utah Medicaid. Base Benchmark Plan: Limitation medical emergencies only, as determined by PEHP

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 20 visits each per 12 months, Speech Therapy limited based on diagnoses. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted: Habilitation Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 20 visits each per 12 months, Speech Therapy limited based on diagnoses. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: Substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Cardiac rehabilitation was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Cardiac Rehabilitation, Phase 2, following heart attack, cardiac surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment/Supply: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Durable Medical Equipment and Medical Supplies in EHB7. Base Benchmark: Exclusions include
1. Training and testing in conjunction with Durable Medical Equipment or prosthetics;
2. More than one lens for each affected eye following Surgery for corneal transplant;
3. Durable Medical Equipment that is inappropriate for the patient's medical condition;
4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit;
5. Equipment purchased from non-licensed Providers;
6. Used Durable Medical Equipment;
7. TENS Unit;
8. Neuromuscular Stimulator;
9. H-wave Electronic Device;
10. Sympathetic Therapy Stimulator (STS);
11. Limb prosthetics;

12. Machine rental or purchase for the treatment of sleep disorders;
13. Support hose for phlebitis or other diagnosis.

Base Benchmark Benefit that was Substituted: Source:

Skilled Nursing Facility and Rehabilitation: Dupli | Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Skilled Nursing Facility Services in EHB7. Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year. Requires preauthorization.

Base Benchmark Benefit that was Substituted: Source:

Inpatient Hospitalization: Duplication | Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Inpatient Hospital Services in EHB3. Medicaid Limitations: Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
Base Benchmark: The following are Exclusions of the policy:
When an inpatient hospital stay can be shortened or charges reduced by transfer to a transitional care unit or Skilled Nursing Facility, PEHP may require the patient to be transferred for Coverage to continue. This benefit is only available through concurrent Medical Case Management and approval by PEHP; Inpatient benefits for Mental Health require Preauthorization; Only acute Emergency Care for Life-threatening injury or illness is covered in conjunction with attempted suicide or anorexia/bulimia. Other services require Pre-authorization through the inpatient Mental Health benefits; Inpatient Rehabilitation and Skilled Nursing Facility stays are limited to 30 days per plan year combined.

Base Benchmark Benefit that was Substituted: Source:

Substance Abuse Disorder Oupatient-Duplication | Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: 8 visits per plan year combined with mental health outpatient services.

Base Benchmark Benefit that was Substituted: Source:

Mental Health Inpatient Services-Duplication | Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management,

Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: 30 days per plan year combined with Substance Abuse outpatient

Base Benchmark Benefit that was Substituted: Mental Health Outpatient Services-Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: 8 visits per plan year combined with Substance Abuse outpatient

Base Benchmark Benefit that was Substituted: Diagnostic Test (X-Ray and Lab): Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Other Laboratory and X-Ray Services in EHB8. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Preventive Services: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Extended Services for Pregnant Women and Prenatal and Postnatal Home Visits in EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient for Maternity: Duplicat

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services in EHB3 and Inpatient Care for Maternity and Newborn in EHB4. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Source:

Allergy Testing: Duplication | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Source:

Diabetes Education-Duplication | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Diabetes Self-Management Education in EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Source:

Transplant-Duplication | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Transplant Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Source:

Substance Abuse Disorder Inpatient-Duplication | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Residential and Inpatient Treatment for SUD in EHB5. Base Benchmark: 30 days per plan year combined with mental health inpatient services.

Base Benchmark Benefit that was Substituted: Source:

Outpatient Rehabilitation Services-Duplication | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 20 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted: Source:

Imaging (CT/PET Scans, MRIs) | Base Benchmark | Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Other Laboratory and X-Ray Services in EHB8. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Nutritional Counseling: Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Physician Services and Services Provided by Licensed Nurse Practitioners in EHB1. Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted: Inherited Metabolic Disorder-Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Physician Services and Outpatient Hospital Services in EHB1 and Inpatient Hospital Services in EHB3. Base Benchmark: No limitations.

Add

☐ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided: Personal Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Other 1937 Benefit Provided: Targeted Case Mgmt - Chronically Mentally Il

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Specialized services for mentally ill individuals means the services from an individualized plan of care that:
a. Are prescribed only for persons experiencing an acute episode of serious mental illness, which necessitates supervision of trained mental health personnel;
b. Are developed and supervised by an interdisciplinary team, which includes a physician and qualified mental health professionals;
c. Are directed toward reducing behavioral symptoms and improving his or her level of independent functioning level that permits reduction in the intensity of mental health services; and
d. Are usually limited to inpatient psychiatric hospital care and care in an institution for mental diseases. Certain individuals, as applicable, are not precluded from receiving such services in a nursing facility

Other 1937 Benefit Provided: Nursing Facility Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Duration Limit:

Scope Limit:

Long term custodial care

Other:

Must meet institutional level of care

Other 1937 Benefit Provided:

Targeted Case Management for Tuberculosis

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

Other 1937 Benefit Provided:

Optometry Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:	Provider Qualifications:
Other	Medicaid State Plan
Amount Limit:	Duration Limit:
None	None
Scope Limit:	
Other:	
Prior authorization is not required.	

Add

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Attachment K: Modified Adjusted Gross Income (MAGI) Conversion Table

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*		Converted Standard
	A	B	C	D	E	F		G
		Conversions for FMAP Claiming						
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state)	**NO**	**Converted in Part 1 and described there.**	**NO**	% FPL _____ **or** Fixed dollar standards Family size 1_ $382_____ 2_ $468___ 3_ $583_____ 4_ $682_____ 5_ $777___ 6__$857__ 7__$897__ 8 $938 9 $982 10 $1023 11 $1066 12 $1108 13 $1150 14 $1192 15 $1236 16 $1277 Add-on for additional family members if relevant__$42_	% FPL **or** FPL% by family size (Fixed dollar standards) 1 – 16.0-41.0% 2 – 12.1-37.1% 3 – 11.6-36.6% 4 – 10.5-35.5% 5 – 9.5-34.5% 6 – 8.2-33.2% 7 – 5.8-30.8% 8 – 3.9-28.9% 9 – 2.5-27.5% 10 – 1.2-26.2% 11 – 0.2-25.2% 12 – 0-24.3% 13 – 0-23.5% 14 - 0-22.8% 15 - 0-22.3% 16 - 0-21.7% Add-on for additional family members if relevant_____		% FPL _____ **or** Fixed dollar standards Family size 1_ $438_____ 2_ $544___ 3_ $678_____ 4_ $797_____ 5_ $912___ 6__$1012__ 7__$1072_ 8 $1132 9 $1196 10 $1257 11 $1320 12 $1382 13 $1443 14 $1505 15 $1569 16 $1630 Add-on for additional family members if relevant__$62_

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*		Converted Standard
	A	B	C	D	E	F		G
2	Non-institutionalized disabled adults	**YES**	**N/A**	**N/A**	% FPL __100%__ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____	%FPL _____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____		% FPL __102%____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____ Conversion based on: __ Average disregard __ Median disregard
3	Institutionalized disabled adults (This is a gross income category: fill in column G **only**)							% FPL _____ % SSI FBR _300%____ **or** Dollar Standards Single_____ Couple_____

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*		Converted Standard
	A	B	C	D	E	F		G
4	Children age 19 and/or 20 **Specify age limit as of 12/1/09 (19 or 20):** _____	**N/A**			% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____		% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____
5	Childless Adults	**N/A**			% FPL _____	% FPL _____		% FPL _____

Attachment L: Claiming Methodologies
[To be incorporated after approval]

ATTACHMENT M: SMI Evaluation Design

[To be incorporated after CMS approval]

Attachment N: SMI Implementation Plan
[To be incorporated after CMS approval]

Attachment O: PCN Evaluation Designs
Targeted Adult Medicaid Program for Dental Services
Adult Expansion
Employer Sponsored Insurance

Attachment P: UMIC Evaluation Design

Evaluation Design: Utah Medicaid Integrated Care (UMIC) Demonstration

Report prepared by the Public Consulting Group: April 30, 2021
Revised by Public Consulting Group: September 14, 2021

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

A. GENERAL BACKGROUND INFORMATION

1.DEMONSTRATION NAME AND TIMING

On December 23, 2019, CMS approved the "Utah Medicaid Integrated Care Plan" (UMIC) Amendment to Utah's Primary Care Network Demonstration for implementation in the two-and-a-half-year period starting January 1, 2020, under the authority of Social Security Act section 1115(a)(2). The evaluation will cover the time period from UMIC launch on January 1, 2020, through June 30, 2022. The Utah Department of Health (UDOH) Division of Medicaid and Health Financing (DMHF) administers the Utah Medicaid program and is responsible for the implementation of adult Medicaid expansion.

2.DEMONSTRATION GOALS

The aim of the UMIC demonstration is to improve access and health outcomes by enrolling beneficiaries in integrated MCOs for delivery of their physical and behavioral health services in the five most populous counties in the state.

Managed care, with increasing levels of care coordination and integration, is the central approach of Utah's Primary Care Network (PCN) Demonstration. The UMIC amendment advances the goals of the demonstration by providing integrated physical and behavioral health services to participants through a managed care delivery model in five urban counties. This demonstration created four integrated care plans that are responsible for providing physical, mental health, and substance use disorder services for the Adult Expansion members in Weber, Davis, Salt Lake, Utah, and Washington counties. In addition, UDOH received authority to enroll Adult Expansion Medicaid members in existing ACOs in nine additional counties for physical health (see Table 1). Beneficiaries in most counties[1] not covered by UMIC are enrolled in a Prepaid Mental Health Plan (PMHP) covering mental health and SUD services.

The goals of the UMIC waiver amendment are to:

1)Increase enrollment in managed care

2)Improve access to health care

3)Improve health outcomes and appropriate use of the ED for beneficiaries

4) Support the fiscal stability of the Medicaid program

3.DESCRIPTION

The UMIC amendment enrolls beneficiaries in managed care plans and creates an integrated managed care model, to combine the delivery of physical health and behavioral health services for the Adult Expansion Population in five of Utah's most populous counties. The new authorities provided by the UMIC waiver amendment are:

1. To enroll beneficiaries authorized under Utah's 1115 Primary Care Network Demonstration Waiver in managed care plans;

[1] All BH services in Wasatch County, and SUD services in Box Elder, Cache, and Rich Counties, are reimbursed on a FFS basis.

2. To create and operate an integrated managed care model combining the delivery of physical health and behavioral health services in five Utah counties for the Medicaid expansion groups authorized by this waiver;

3. To enroll those beneficiaries not enrolled in Utah Medicaid Integrated Care (UMIC) in Utah's Accountable Care Organizations (ACO) for their physical health service delivery system and in Prepaid Mental Health Plans (PMHP) for their behavioral health services delivery system.

UDOH has introduced managed care on a county-by-county basis. Beneficiaries in some counties have the option to receive physical health services through traditional fee-for-service arrangements or through an ACO and also have access to behavioral health services through a prepaid mental health plan (PMHP). Beneficiaries in other counties are required to enroll in ACOs for physical health, and also have access to behavioral health services through a PHMP. UMIC adds a third level to the managed care plans in place for some beneficiaries, combining behavioral health and physical health into a single integrated plan. The four integrated plans are known as Health Choice Utah, Healthy U, Molina Healthcare of Utah, and SelectHealth Community Care.

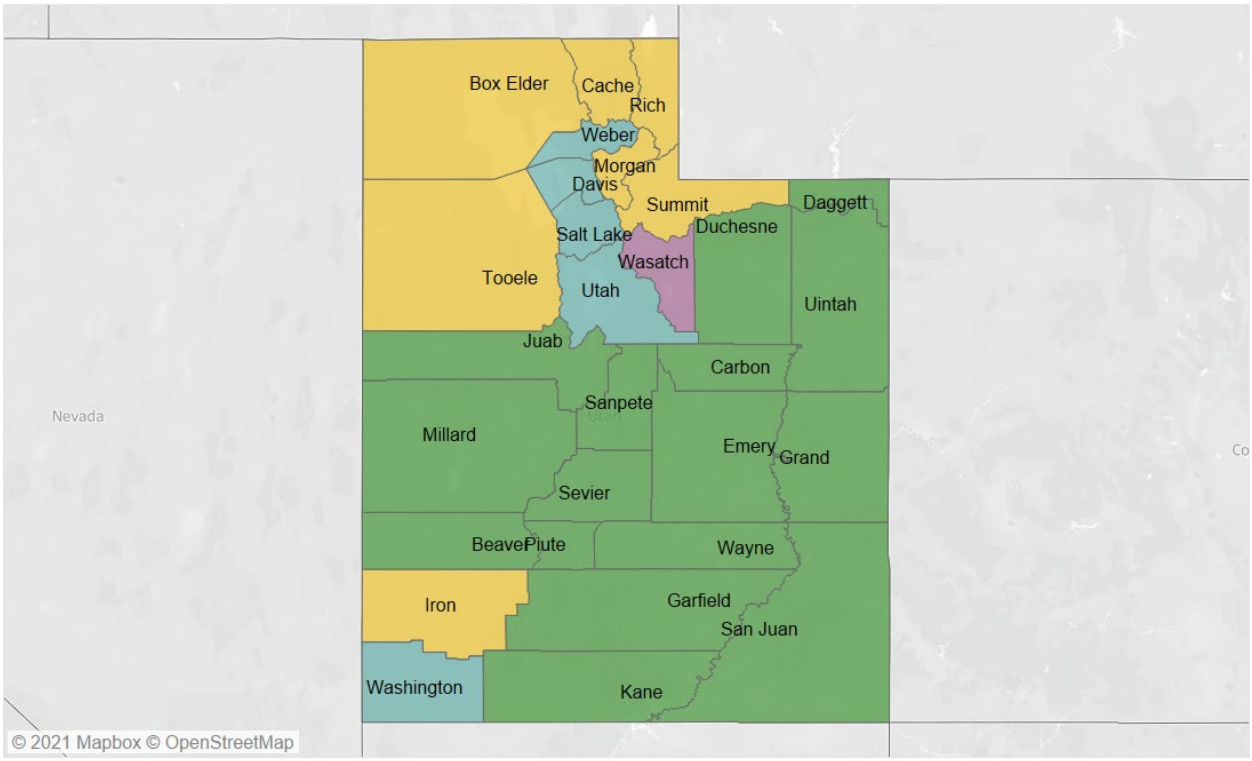
TABLE 1: UTAH 1115 HEALTHCARE DELIVERY PLANS BY COUNTY

Healthcare Delivery Plan		Counties
Physical Health	**Behavioral Health**	
Choose between Fee for Service Network or ACO	Prepaid Mental Health Plan 1915(b)	Beaver Carbon Daggett Duchesne Emery Garfield Grand Juab Kane Millard Piute San Juan Sanpete Sevier Uintah Wayne
Must have Accountable Care Organization 1915(b)	Fee for Service	Wasatch
	Prepaid Mental Health Plan 1915(b)	Box elder[2] Cache Iron Morgan Rich Summit Tooele
Utah Medicaid Integrated Care 1115		Davis Salt Lake Utah Washington Weber

[2] All SUD services in Box Elder, Cache, and Rich Counties, are reimbursed on a FFS basis.

FIGURE 1

UT Adult Expansion Integrated Managed Care



Plan Name
- UMIC
- Mandatory ACO (for physical health) and PMHP
- Wasatch County: Mandatory ACO (for physical health) and FFS Network (for behavioral health)
- FFS Network or Voluntary ACO enrollment (for physical health) and PMHP

4.POPULATION

The population studied will be the Adult Expansion members enrolled in the Utah Medicaid Integrated Care program, which is anticipated to include approximately 60,000 individuals each year (Table 2). Adult expansion includes both parents and non-parents, aged 19-64, with household incomes up to 133% of the FPL (with a 5% income disregard), who are not otherwise eligible for Medicaid. The following individuals are exempt from UMIC and will be excluded from the evaluation: Utah Medicaid beneficiaries residing in the Utah State Hospital or the Utah State Developmental Center; individuals enrolled in the Health Outcomes Medical Excellence (HOME) program; Medicaid beneficiaries enrolled in Utah's Buyout Program; and Adult Expansion Medicaid beneficiaries who have access to ESI, who will be required to enrolled in a qualified ESI plan.

Because no true comparison population is available for this demonstration, comparisons will be made up of post-waiver trends to pre-waiver trends, and among subgroups within the Utah Medicaid population, adjusted for demographic and other traits where possible.

TABLE 2: UMIC PROJECTED ENROLLMENT

	DY18 (SFY 20) *	DY19 (SFY 21)	DY20 (SFY 22)
Projected Member Months			
Expansion Parents-Integrated Care	196,306	268,285	274,992
Expansion Adults without Dependent Children-Integrated Care	309,454	422,920	433,493
Total	505,760	691,205	708,485
Projected Enrollment			
Average number of beneficiaries	56,196	57,600	59,040
*Projections were based on a start date of 10/1/2019. Actual launch was 1/1/2020.			

5.CONTEXT

The UMIC waiver amendment took the next step in UDOH's long-term strategy of using managed care to increase healthcare access and quality while containing cost. The transition to managed care plans for beneficiaries began in 1982 under Utah's 1915(b) waiver program. Utah's Primary Care Network Section 1115 demonstration waiver was first approved in 2002 and included a pre-ACA coverage expansion (called the Primary Care Network) to certain non-disabled adults. Since 2013, four full-risk ACOs have managed physical health care for all residents of designated counties and for other beneficiaries who opt in to ACO plans. Utah has also operated a 1915(b)-waiver program called the Prepaid Mental Health Plan (PMHP) since July 1, 1991. The PMHP was designed to maximize the contractors' flexibility to effectively and responsibly use Medicaid funds to ensure Medicaid beneficiaries have access to behavioral health services and to improve behavioral health outcomes for Medicaid beneficiaries. Under the PMHP, Medicaid beneficiaries have access to a spectrum of inpatient and outpatient mental health care and outpatient substance use disorder care.

In November of 2018, Utah voters supported a ballot initiative to adopt the full Medicaid expansion as set out in the Affordable Care Act, which would include coverage for childless adults with income up to 138% of the federal poverty level (FPL) and parents/caretakers with incomes from 60% to 138% of the FPL. State legislation introduced in the 2018 General session of the Utah State Legislature as well as in the 2019 General session was passed to amend the ballot measure. Senate Bill 96 "Medicaid Expansion Adjustments," which was signed into law on February 11, 2019, required the Department of Health to seek approval of a waiver request to the federal government for partial expansion for eligible individuals below 100% of the FPL.

On March 29, 2019, CMS approved an amendment to Utah's existing Primary Care Network Section 1115 demonstration waiver to expand Medicaid to a capped number of adults with income up to 100% FPL beginning on April 1, 2019. The state requested authority through the UMIC amendment to cover additional services authorized under Utah's 1915(b) PMHP waiver. These services include

Psychoeducational services[3], Personal services[4], Respite Care[5], and Supportive Living[6]. The Bridge Plan expansion was approved at the state's traditional Medicaid matching rate of 68%, not the enhanced ACA matching rate of 90%. In accordance with SB 96, Utah then submitted its Per Capita Cap waiver application with a request to receive 90/10 ACA enhanced matching rate for partial expansion and its Fallback Plan waiver seeking authority for a coverage expansion up to 133% FPL with a 90/10 ACA enhanced match.

On December 23, 2019, CMS approved expansion of Medicaid coverage for adults up to 133% of the FPL as well as a number of amendments. Approved amendments to the waiver have included targeted SUD and dental services,[7] Clinically Managed Residential Withdrawal Management, community engagement requirements,[8] and support through ESI reimbursement in April 2019 (amendment was approved in March 2019). The new waiver amendments are approved through June 1, 2022.

The UMIC amendment will provide Utahns with more coordinated care and improved access to behavioral health services with the goal of supporting improved health and well-being. As of 3/05/2021, 52,812 beneficiaries are enrolled in the UMIC plan, 8,504 are enrolled in an ACO plan, 16,327 are enrolled in a PMHP, and 15733 are enrolled in FFS. The number of Utah residents with incomes below 133% FPL is likely to increase due to income loss related to the COVID-19 pandemic. Enrollment numbers may also increase for the duration of the PHE, and decrease when the PHE ends, due to the postponement of eligibility review and terminations.

TABLE 3: NUMBER OF ENROLLEES

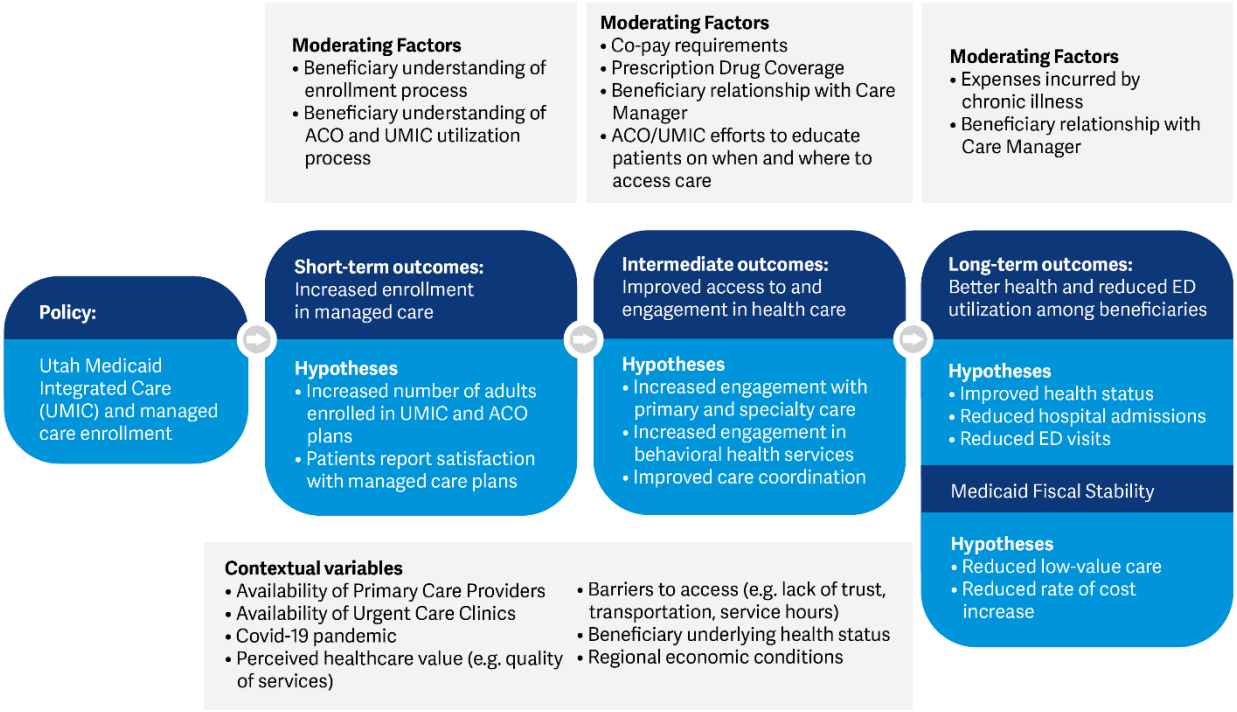
Care Delivery	Utah Medicaid Current Enrollment
FFS (physical and behavioral health)	15,733
ACO (physical health)	8,504
UMIC Fully Integrated Care Plan (physical and behavioral)	52,812

[3] Services recommended by a physician or licensed mental health practitioner that are furnished for the primary purpose of assisting in the rehabilitation of enrollees with serious mental illness (SMI) or serious emotional disturbance (SED)
[4] Assistance with instrumental activities of daily living (IADLs) that are necessary for SMI or SED individuals to live successfully and independently in the community and avoid hospitalization.
[5] Services furnished for the primary purpose of giving parents/guardians temporary relief from the stresses of care for a child with SED.
[6] Costs incurred in residential treatment/support programs when managed care plan enrollees are placed in these programs to reduce risk for inpatient hospitalization.
[7] CMS also approved expanded criteria for the Targeted Adults, state plan dental benefits for Medicaid eligible individuals over the age of 65, porcelain or porcelain-to-metal crowns for Adults receiving SUD treatment, and the UMIC Integrated Care Amendment.
[8] In 2020, community engagement requirements were suspended due to the Public Health Emergency.

B. EVALUATION QUESTIONS AND HYPOTHESES

1.LOGIC MODEL

FIGURE 2



2.HYPOTHESES AND RESEARCH QUESTIONS

The objectives of the UMIC amendment are to improve access to integrated care, to improve health outcomes, especially behavioral health outcomes, and to support the fiscal sustainability of the Utah Medicaid program, through greater participation in the Medicaid managed care delivery system. Accordingly, the overarching evaluation questions are:

TABLE 4: DEMONSTRATION GOALS AND RESEARCH QUESTIONS MATRIX

Demonstration Goal	Research Question
1. Increased enrollment in managed care	Did the Demonstration increase enrollment in managed care among Medicaid beneficiaries?

2. Improved Access to health care	Did beneficiaries enrolled in managed care have increased access to and engagement in health care?
3. Improved Health outcomes and appropriate use of the ED	Did beneficiaries enrolled in managed care have improved health outcomes, including behavioral health, and reduced ED utilization?
4.Support the fiscal sustainability of the Medicaid program	Did managed care contain costs of care?

The logic model above illustrates how the amendment's objective is expected to be achieved by program activities, following a natural progression from proximate to distal outcomes as the demonstration goes on. Each outcome is represented by a testable hypothesis, listed below, about the impact of the demonstration activities, and a corresponding research question. Table 10 specifies the measures that will be used to assess each hypothesis.

The first UMIC objective, greater participation in managed care, is the direct outcome of beneficiary enrollment in the UMIC program in five urban counties, and enrollment of adult expansion beneficiaries in ACOs in an additional nine counties. Adult expansion Medicaid beneficiaries in Davis, Salt Lake, Utah, Washington, and Weber counties will be required to receive their physical and behavioral health services through one of Utah's four integrated care plan MCOs. The first evaluation hypothesis is that implementation of the waiver amendment will increase the number of adult beneficiaries receiving benefits through managed care, both in ACOs and fully integrated plans.

The second hypothesis is that enrollment in the UMIC program will improve access to health care, including behavioral health, through greater coordination in the delivery system. Utahns who are part of the Adult Expansion population will be able to take advantage of consumer-facing features of Utah's four managed care plans including appointment scheduling assistance, telehealth services, 24-hour nurse triage lines, and virtual prenatal visits. In addition, Utah's Bureau of Managed Care (BHMC) has stated Quality Strategy Goals, overseen by the Quality Improvement Council (formerly the State Quality Committee), that incorporate care coordination into managed care contracts. ACOs and PMHPs are required to hold semi-annual meetings, develop rate setting methodologies that support coordinated care, and solidify expected outcomes for members in order to participate in the state's managed care delivery system. ACOs and PMHPs are also required to develop collaborative relationships with state bureaus, agencies, and other external partners to achieve better outcomes for their members. The evaluator will assess demonstration participants' access to primary care, behavioral health services, and improved care coordination as a result of UMIC.

The long-term UMIC objective, improved health outcomes, especially for behavioral health, is the anticipated result of more coordinated care and greater access to BH services. Integrated care delivery is expected to facilitate consistent and timely referrals to the appropriate care setting. Additionally, the state anticipates that access to a suite of mental health services will lead to better treatment compliance and improvements to overall quality of life for beneficiaries. The evaluation hypothesis is that the

demonstration will improve the health of beneficiaries enrolled in managed care, reflected in reduced rates of hospitalization and ED visits. In particular, the state hypothesizes that integrated care for beneficiaries with BH diagnoses will reduce the incidence of ED visits for BH conditions. In addition to acute care utilization, measures to assess this hypothesis will include self-reported health status, mental health outcomes, and engagement in SUD treatment.

Fiscal sustainability, the final UMIC objective, is targeted by this demonstration through greater participation in the Medicaid managed care delivery system. The evaluation hypothesis is that the UMIC amendment will improve the fiscal sustainability of the Medicaid Program both by reducing the rate of hospitalizations and ED visits, as described above, and by decreasing the rate of low-value care among adult expansion beneficiaries, thereby containing growth in the total cost of care for beneficiaries in the adult expansion population.

Hypothesis 1: **The demonstration will increase the number of adult beneficiaries receiving benefits through managed care.**

Primary research question 1.1: Did the demonstration increase the number of adult beneficiaries receiving benefits through managed care?

Subsidiary research question 1.1.1: Did enrollment in either form of managed care (ACOs or UMIC) differ among beneficiaries by demographic factors, such as by age, gender, race/ethnicity, or language?

Primary research question 1.2 Was the demonstration implemented effectively?

Subsidiary research question 1.2.1: Did the Public Health Emergency/Covid-19 pandemic impact implementation?

Primary research question 1.3 Is patient satisfaction associated with enrollment in any managed care, or type of managed care?

Subsidiary research question 1.3.1: Was patient satisfaction associated with receiving care in person or by telehealth, including audio-only?

Hypothesis 2: **The demonstration will improve access to and engagement in health care.**

Primary research question 2.1: Did beneficiaries enrolled in managed care have increased access to and engagement in health care?

Primary research question 2.2: Did beneficiaries enrolled in managed care have increased access to and engagement in behavioral health care?

Primary research question 2.3: Did beneficiaries enrolled in managed care have increased access to care coordination?

Hypothesis 3: **The demonstration will improve the health of beneficiaries enrolled in managed care.**

Primary research question 3.1: Did beneficiaries enrolled in managed care have improved health outcomes, including behavioral health?

Subsidiary research question 3.1.1 Did the outcome of either form of managed care differ among subgroups of beneficiaries by demographic factors?

Primary research question 3.2: Did the rate of ED visits decrease for beneficiaries in managed care?

Subsidiary research question 3.2.1 Did the rate of ED visits for BH conditions decrease for beneficiaries in managed care?

Subsidiary research question 3.2.2 Did any change in the rate of ED visits differ among subgroups by demographic factors?

Primary research question 3.3: Did the demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?

Hypothesis 4: **The demonstration will improve the fiscal sustainability of the Utah Medicaid program.**

Primary research question 4.1: Did the total cost of care decrease for beneficiaries in managed care?

Primary research question 4.2: Did the rate of hospitalization decrease for beneficiaries in managed care?
Primary research question 4.3: Did the rate of utilization of low-value care decrease for beneficiaries in managed care?

C. METHODOLOGY

1. EVALUATION DESIGN SUMMARY

The Independent Evaluator (IE) will use a mixed-methods evaluation approach that will combine administrative and survey data as well as APCD claims data to address the goals and hypotheses presented in the UMIC waiver amendment application and answer all research questions listed above.[9] The UMIC evaluation design leverages the state's incremental adoption of managed care to compare three groups of beneficiaries. Beneficiaries covered by fee-for-service will serve as a reference population. Those who are covered by ACOs and by integrated care MCOs will be distinct intervention groups. Table 1 shows the counties that comprise each group. The fully integrated UMIC plans are treated as a higher "dose" of managed care, and physical-health ACO plans as a lower dose. While the dosage analogy is imperfect, this framework is a useful representation of the state's concept of physical-health ACOs as a first step in managed care, and UMIC integrated plans as a further step. Comparison of the three groups may identify outcomes where one or both forms of managed care achieve results. Further, a stepwise progression may be seen from FFS to ACO to UMIC, which would suggest a "dose-response" type relationship between managed care and the outcome. Outcomes related to behavioral health are of particular interest, because the integration of BH services in UMIC plans represents the next step in integrated managed care.

These are non-equivalent groups, particularly since the demonstration will target the most populous and urban counties for integrated care. In order to account for differences among the groups as much as possible, regression analysis will adjust for demographics and health status at baseline and will employ propensity score matching to further mitigate the dissimilarities.

For testing the evaluation hypotheses, the IE will analyze the trend over time in outcome variables, using truncated regression to follow individuals through time while accounting for individuals who enter and leave the demonstration at different times. Change over time (slope) will be compared for the three evaluation groups.

Additionally, stratification by demographic subgroups and other populations of interest will be used to investigate whether UMIC engages some regions or populations more effectively, whether these are the same regions or populations with the highest rates of utilization, poor mental health outcomes, etc., and whether these patterns change over time.

Comparisons to Medicaid beneficiaries in other states also provide valuable context. A difference-in-difference (DID) comparison of the aggregate Medicaid population to Medicaid beneficiaries in states without Medicaid integrated care delivery will address the research question "Did the demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?" The DID approach accounts for large historic trends that affect outcomes for all beneficiaries, and in that sense is

[9] This evaluation design report describes the evaluation of the UMIC component specifically. The IE will separately evaluate the Adult Expansion and Employer Sponsored Insurance (ESI) components of the waiver.

more rigorous, but must be interpreted carefully since populations are non-equivalent, and identification of UMIC participants from national survey data will be imprecise.

2. TARGET AND COMPARISON POPULATIONS

In-State Comparison Groups

The population studied will be the members of the Adult Expansion Medicaid population. This includes parents and adults without dependent children aged 19-64 with household incomes up to 133% of the FPL (with a 5% income disregard) who are not otherwise eligible for Medicaid. The analysis of claims/administrative data will include all individuals enrolled in Medicaid for 12 consecutive months. Individuals enrolled in ESI will be excluded.

As described below, the evaluation will compare three groups of beneficiaries (Table 5), with beneficiaries covered by fee-for-service designated as a reference population. Enrollment in ACO plans and UMIC integrated plans will be treated as levels of intervention. Beneficiaries will be attributed to the three groups based on claims data.

Because the ACO and UMIC plans were deliberately introduced in Utah's more populous counties, the three groups are differently sized and clearly nonequivalent at baseline. The IE will employ a difference-in-differences (DID) approach with inverse probability of treatment weighting (IPTW) to account for baseline differences and identify the effect of the demonstration on study outcomes. The IPTW approach will consider the demographic variables that are most different among Utah counties and assign each individual a weight that accounts for the likelihood, based on demographic factors, that they are included in their group. Each individual's weight is defined as the inverse of the probability of receiving the treatment (health plan type) that the subject received. This model allows for a comparison of the overall outcomes for the three health plan types and can be stratified by age and gender to identify different outcomes for these subgroups.

Subgroup comparisons by race/ethnicity across the three health plan types are likely to be underpowered due to low numbers in the less urban counties.[10] In order to investigate possible disparities by race/ethnicity within the state, the IE will break down outcomes by race/ethnicity within each of the three groups.

TABLE 5: COMPARISON GROUPS

Group	Care Delivery	Evaluation
1	Fee-for-Service	Reference group
2	ACO	Intervention group: Lower "dose" managed care
3	Fully Integrated UMIC plan	Intervention group: Higher "dose" managed care

[10] The less populous counties have both smaller numbers of residents, and smaller proportions of minority residents. According to 2019 census data, among the counties comprising the FFS group, on average 7% of residents identified as Hispanic, and 14% as a race other than White, compared to 14% Latino and 21% non-White for the UMIC counties.

Other-State Comparison

For additional context, comparisons of statewide outcomes to national trends and a synthetic control derived from other states will be made using BRFSS data.

As described below in Analytic Methods, for each outcome of interest, the IE will use BRFSS data for other states for each quarter of the three years prior to launch to construct a synthetic control[11] representing Utah's outcomes during the baseline period. The weights derived empirically during this stage will allow the IE to generate a predicted outcome value for "synthetic Utah" for each quarter during the demonstration period. This model will be used to find mean differences between actual Utah outcomes and predicted outcome of the synthetic control during the demonstration period.

The population served by the demonstration cannot be directly identified in BRFSS data. Therefore, the intervention (Utah) and comparison (other states) groups will be constructed by identifying individuals within the age and income bands served by Adult Expansion. The comparison will be of the estimated adult expansion population in Utah, to the synthetic control composed of equivalent individuals in control states. States that newly implemented Medicaid expansion during this time period will be excluded, but all states that expanded before 2017 or did not expand Medicaid will be included.[12] Non-expansion states are included because they are likely to represent the closest match to pre-demonstration Utah.

[11] CMS White Paper, October 2020, "Selection of Out-of-State Control Groups and the Synthetic Control Method.

[12] Based on dates of Medicaid expansion, Virginia, Maine, Idaho, Nebraska, Oklahoma, and Missouri will be excluded from the control pool. Other states may be excluded if they expand before 6/30/2022.

3. EVALUATION PERIOD

The evaluation will include the time period from January 1st, 2020, through June 30th, 2022. The evaluation population is new to Medicaid, so pre-demonstration claims are not available. The evaluation design relies on FFS beneficiaries as a contemporaneous reference group. For out-of-state comparisons based on national survey data, the three years prior to demonstration launch will serve as the baseline.

4. DATA SOURCES

The evaluation will use the following quantitative and qualitative data sources:

- National Survey Data: Behavioral Risk Factor Surveillance System (BRFSS)
- Medicaid Administrative Data
- CAHPS Survey Data
- Key Informant Interviews (KIIs)

The measures used for evaluation are listed in Table 10. Most are derived from claims and administrative data and will be reported to CMS as part of the approved UT Primary Care Network waiver monitoring protocol. Wherever possible, the evaluation design aligns measures with CMS monitoring metrics to ease administrative burden, but also includes additional measures to support robust econometric methods.

National Survey Data

The IE will use the Behavioral Risk Factor Surveillance System (BRFFS) data to answer research questions about changes in access to preventive care and health status of low-income residents (Table 6). The data will be leveraged to compare against national averages, and a nationally derived synthetic control.

BRFSS collects data on over 400,000 adult U.S residents' health-related risk behaviors and events, chronic health conditions, and use of preventive services across all 50 states, the District of Columbia and three U.S territories. The IE anticipates leveraging the BRFSS data for Health-Related Quality of Life estimates. Specifically, the IE will use BRFSS to understand the eligible population's general health status, physical health status, mental health status, and impact of health status on quality of life. These estimates for Utah will then be compared against national averages, and a synthetic control derived from other states.

Measures employing national survey data for an out-of-state comparison will use a three-year pre-demonstration baseline. The measurement period for national surveys does not align with the demonstration years or benefit periods, so the annual survey datasets will not perfectly represent the demonstration timeline. For the years prior to demonstration launch, and for each demonstration year, the closest available datasets will be used.

TABLE 6: APPLICATION OF NATIONAL SURVEY DATA

Survey Name	Topic	Survey Questions
BRFSS	Health status	• Healthy days • Anxiety/depression symptoms • Having a PCP • Primary care engagement • Delayed or avoided care

Medicaid Administrative Data

The IE anticipates receiving claims and other Medicaid administrative data, such as eligibility files, from the state on an annual basis. Administrative data is expected to be of high quality, in terms of completeness and accuracy.

The IE anticipates having access to aggregate CAHPS data collected by the health plans and reported to UDOH. Health plans are able to distinguish between ACO and UMIC plan enrollment in CAHPS data and report this information to the state These data will allow for comparisons between lower "dose" managed care and higher "dose" managed care and will be used to answer primary research questions 1.3 "Is patient satisfaction associated with enrollment in any managed care, or type of managed care?" and 2.3. "Did beneficiaries enrolled in managed care have increased access to care coordination?"

CAHPS data will also be used to analyze differences in access to care coordination and patient satisfaction between subgroups. Because CAHPS data will be available only in aggregate, subgroup analysis will be limited to the available demographic stratifications: age, race (White and Other), ethnicity (Hispanic/ Not Hispanic), and gender.

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews (KIIs) with providers and state administrators. A total of 20-24 KIIs are planned; three at each of the four health plans, five state employees participating in implementation, and at least three community-based providers. For each health plan participating in the UMIC demonstration,[13] the IE will interview individuals from multiple different perspectives: a clinician that serves Medicaid patients, someone in a managerial role who is familiar with the UMIC program, and another employee involved in implementing the UMIC demonstration who can provide the member perspective. For example, from one of the managed care organizations, the IE will interview the following individuals: a physician, the Chief Medical Officer of the health plan, the Vice President of Government Contracts, the Assistant Vice President of Health Plan Operations, and the Manager of Government Contracts.

In addition to the administrative contacts from the ACOs and MCOs, the IE will interview at least three community-based providers, such as primary care providers and behavioral health clinicians, who directly

[13] The four health plans are Healthy U, Health Choice Utah, Molina Healthcare, and SelectHealth Community Care. All four provide both ACO and UMIC plans.

serve Medicaid patients at sites such as community health centers, in order to capture the perspective of front-line clinicians working through the UMIC demonstration. These providers will be asked about topics including integration of behavioral health care, barriers to access, and their perceptions of patients' engagement in care.

Semi-structured key informant interviews lasting 30-45 minutes per contact will be conducted by phone or videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. Interview guides will be developed by the IE in collaboration with UDOH for providers, health plans, and for state administrators involved in implementation of the waiver demonstration. Based on the interviewee's role, the interview guide and questions asked will be tailored accordingly. For example, state administrators will be invited to discuss the program rollout and feedback received from plans, health plan representatives will be asked about the plan's approach to integrating BH services, and questions regarding telehealth experiences will be directed towards clinicians.

As appropriate, interviews will explore successes and challenges with regard to program implementation, especially in light of the PHE, and other topics drawn from the logic model; examples are shown in Table7.[14] Interview guides will include questions that address disparities and health equity as appropriate for the interviewee's role. This may include population health analysis strategies, language services, and targeted outreach programs.

TABLE7: TOPICS FOR KEY INFORMANT INTERVIEWS

Research Question	Example topics

Was the demonstration implemented effectively?	• Perceived successes and challenges in implementation
	  ○ Care integration with behavioral health
	• Perceived steps towards integrating behavioral health with physical health services, e.g., screening and referrals
	• Perceived impact of the PHE/pandemic on member engagement
	• Perceptions about the role of telehealth in achieving demonstration goals
	  ○ Member experience
	  ▪ Q: How did members experience the transition to telehealth?

Did enrollment or outcomes differ by demographic factors?	• Perceptions of barriers to access and participation in care • Steps health plans/providers are taking to identify, understand, and address disparities in access and engagement

[14] KIIs will cover topics relevant to the evaluation of the Adult Expansion and ESI components of the demonstration as well; these are covered in separate evaluation designs.

5. ANALYTIC METHODS

Quantitative Analyses

In order to provide robust conclusions, the IE will employ multiple analytic strategies to answer the research questions. The IE will utilize statistical software packages including SAS, SQL, and Stata to analyze the data, generating descriptive statistics and assessing significant differences in comparisons of interest. Multivariate regression will be used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the demonstration population as members enter and leave the Adult Expansion Population.

TABLE 8: SUMMARY OF ANALYTIC METHODS TO BE USED FOR EVALUATION

Method	Comparison	Data sources
Subgroup comparison	Demonstration participants stratified by demographic and health factors	Encounter data, administrative data
Event study/ time series	Trend during demonstration for beneficiaries enrolled in ACO or UMIC plans, vs FFS	Encounter data Administrative data
Difference in difference	Pre/Post change in Utah vs Pre/Post change in neighboring states	National survey data

Descriptive statistics

The IE will use descriptive statistical methods to generate summary tables of population size and characteristics, and outcomes for the three groups of demonstration participants. Data will be analyzed using standard tests as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Prior to performing regression analysis, the composition of the beneficiary population in the three groups (FFS, ACO, and UMIC) will be compared to identify differences in demographic or clinical characteristics. ANOVA/MANOVA tests will be used as a first pass comparison of mean outcomes for the three groups. For metrics derived from BRFSS survey data, results for Utah will be compared to national averages for each year.

Trend over time and linear regression modeling

Outcomes of interest will be plotted over time for the duration of the demonstration. The trend for each evaluation group will be modeled using multivariate linear regression and compared. The null hypothesis will be that the three groups have identical trends. In order to account for demographic characteristics such as age and gender that may differ among the three groups, the IE will use inverse probability of treatment weighting. Individuals in the two intervention groups will be assigned weights based on the

composition of the reference group, producing three groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[15]

The analysis will use multiple techniques to account for the impact of the Covid-19 pandemic on health care utilization. Patterns of utilization were impacted everywhere, but the effects may have been different in timing or degree among counties, particularly between urban and rural areas. First, trends for each evaluation group will be modeled with and without the most affected months in 2020 and 2021. This sensitivity analysis will help to identify whether the three groups have been impacted differentially. If the pattern changes observed in the first quarter of the Public Health Emergency are similar for all three evaluation groups, then confounding of the results by pandemic impacts is less likely. Second, because the effects of the pandemic may have been felt later in some areas, and may continue past the official end of the PHE, modeling of trends needs to incorporate the altered patterns over time. Two useful dynamic variables that can be included in the modeling are county-level Covid-19 caseloads[16], and county-level community mobility.[17] Publicly available mobility data is a useful proxy for the pandemic's impact on consumer behavior including attending medical appointments. The IE will explore using both caseloads and community mobility as covariates to minimize confounding by differential effects of the PHE.

Synthetic control methods

In order to examine the impact of the demonstration as a whole, the IE will use synthetic control methods (SCM) to estimate the association between implementation of Utah's Medicaid expansion and study outcomes. SCM have been employed to evaluate state-level policy impacts because they are particularly useful when estimating the impact of a policy change that affects a small number of treatment groups (i.e., a state).[18,19,20,21] These methods are a quasi-experimental approach similar to traditional difference-in-difference (DID) estimation but require fewer assumptions to obtain estimates of association. DID assumes that any differential changes in outcomes between treated and control groups are attributable to the policy change. Yet treated and control groups are often nonequivalent in terms of pre-treatment outcome levels, trends in outcomes, and other important covariates. To mitigate this limitation, researchers typically attempt to control for observed variables that may be associated with both treatment

[15] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.
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[18] Abadie, A., 2012. *Synthetic control methods for comparative case studies: estimating the effect of California's tobacco control program. J Am Stat Assoc* 105(490):493-505. https://www.tandfonline.com/doi/abs/10.1198/jasa.2009.ap08746
[19] Rudolph, K.E., *et al.*, 2015. *Association between Connecticut's Permit-ti-Purchase handgun law and homicides. Am J Public Health* 105(8):e49-e54. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302703
[20] Santella-Tenorio, J. *et al*., 2020. *Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities. JAMA* 180 (8):1061-1068. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2767647
[21] Bhatt, A. *et al.* 2020. *Association of changes in Missouri firearm laws with adolescent and young adult suicides by firearms. JAMA Netw Open* 3(11). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772526

likelihood and the outcome of interest. However, treatment and control groups may still differ in terms of outcome pre-trends and levels due to unobserved factors. This introduces potential selection issues, which may bias any estimates of association.

In contrast, SCM constructs a synthetic control from a pool of groups not exposed to the treatment of interest – in this case other states. The synthetic control is constructed using a weighted average of the control groups, with weights chosen through a fully empirical process; weights for individual control units may range from 0 to 1 and are selected so the synthetic control is as similar as possible to the treated group in terms of outcome pre-trends. Unlike traditional regression, inclusion of covariates is not required to achieve equivalence between treated and control groups.

The full adult expansion Medicaid population (approximated based on age and income) will be the intervention group for this analysis. The IE will use data from the BRFSS for health outcomes. A three-year, pre-demonstration baseline will be used to determine the weights for the control states. The post-demonstration trend for Utah will be compared to the calculated values for synthetic Utah using linear regression.

Subgroup Analyses

The evaluation will use the aforementioned data sources to understand how different subgroups of Adult expansion participants are impacted by the demonstration. Analyses will partition participants by age, race/ethnicity and gender. Where possible, race will include White, Black, Asian, Latinx, and Native American populations for stratification. Due to the low prevalence of some subgroups, it may be necessary to combine non-white racial groups into an "Other" category. Ethnicity will be characterized as Hispanic/Not Hispanic. Geographic patterns will also be investigated, using zip codes of residence to map beneficiaries to the three intervention types.

Qualitative analysis

Qualitative analysis will be used for key informant interview transcripts. The research questions to be addressed, with corresponding example topics, are listed in Table 10 (Attachment 4). Interviews will address these questions by probing for perspectives from providers and from administrators involved in implementing the demonstration. Thematic analysis using a coding tree derived from the demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results of provider interviews will be used to add context to the quantitative findings regarding experience of care, beneficiary engagement, and barriers to engagement. Results of provider and administrator interviews will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

D. METHODOLOGICAL LIMITATIONS

1. **Lack of a true comparison group.** The UT Adult Expansion Population includes individuals aged 19-64 with household incomes up to 138% of the FPL who are not otherwise eligible for Medicaid. As such, no true comparison group for this population exists. Other Medicaid beneficiaries are not comparable due to income and groups covered by traditional Medicaid which may have incomes up to 138% of the FPL. To mitigate this limitation, the IE plans to use both in-state comparison among the three benefit groups, and out-of-state BRFSS data.

2. **Lack of historic data for newly eligible individuals.** As all Utah adult expansion enrollees are newly eligible, no pre-demonstration data is available for these individuals through Medicaid. The use of FFS beneficiaries as a contemporaneous reference group provides a comparison without a pre-demonstration baseline.

3. **Sample size.** Full UMIC participation is projected to be around 60,000 individuals. However, the data set for specific outcomes may not have sufficient size statistical analysis on all subgroups of interest. In particular, the lower number of residents in the FFS counties may not support analysis by race/ethnicity. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient, most likely the ACO and UMIC groups. To further investigate health equity, KII interview guides will include questions about health plan efforts to identify and remediate disparities in access, such as population health analyses and targeted outreach.

4. **Health Plan Reporting.** The independent evaluator will receive aggregate CAHPS data reported in aggregate by the health plans, stratified by gender, age, and race/ethnicity. Patient-level data is not available for privacy reasons. Data aggregation will limit the available subgroup analyses that can be performed. The current age and race/ethnicity reporting buckets for CAHPS data are limited and are not standardized across health plans. In order to aggregate data across the population, the IE will combine categories as needed, creating wider age bands, and characterizing race as White/Other.

5. **Out-of-state comparisons.** The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the demonstration. An approximation will be achieved by using income and Medicaid enrollment to define a sample representing demonstration participants as closely as possible.

6. **Historic effects.** The impacts of the Covid-19 pandemic/PHE expand beyond the expected increase in enrollment numbers. Participants' ability and willingness to make and keep appointments could impact demonstration goals to improve healthcare access. Analytic techniques described above will be used to minimize confounding.

E. ATTACHMENTS

1.INDEPENDENT EVALUATOR

As required by the Centers for Medicare & Medicaid Services (CMS) and the Section 1115 waiver's Special Terms and Conditions (STCs), the Utah Department of Health (UDOH) conducted an open solicitation process to secure a third-party evaluator to conduct an evaluation of the State of Utah's Section 1115 Waiver Demonstration.

The State issued one contract for all evaluation activities and the production of required CMS reports.[22] As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

- Experience conducting program evaluations for programs administered by the federal department of Health and Human Services.
- Ability to provide at least two examples of program evaluations conducted meeting the above criterion.
- Experience with Medicaid claims data.
- Experience complying with human subjects' protection and data confidentiality laws (state and federal)
- Experience with quantitative and qualitative evaluation design, implementation, analysis, and reporting, and impact evaluations in public health and social services settings.

Consistent with the requirements of the State of Utah Division of Purchasing, UDOH selected and retained PCG as an independent evaluator to complete the independent evaluation of the demonstration. UDOH contracted with the evaluator, PCG, to promote an independent evaluation, following the general requirements for each state contractor as well as project-specific standards.

The third-party evaluator, PCG, will conduct an evaluation following guidelines set forth by UDOH and CMS. The Department retains responsibility for monitoring the demonstration activities and providing oversight of the evaluation design and overall approach for the contractor. To ensure a fair and impartial evaluation and mitigate any potential conflict of interest, the independent evaluator, PCG, will:

- Conduct an evaluation of the waiver hypotheses for the Adult Expansion population, to include the community engagement and employer-sponsored insurance requirements, as well as the UMIC hypotheses, to determine if the goals and objectives of the demonstration have been achieved.
- Meet the evaluation requirements of the waiver STCs.
- Follow the CMS approved evaluation design.

[22] This procurement sought an Independent Evaluator for the Adult Expansion, ESI, Community Engagement, and UMIC components of the waiver. PCG was awarded a five-year contract covering these components.

- Provide UDOH with the required annual interim evaluation report and summative evaluation report at the end of the waiver approval period, by the due dates outlined in the contract.
- Provide future evaluations as required by the contract, at the option of the Department, and develop the evaluation design and implement the design upon CMS approval.
- Complete any required IRB applications, data sharing agreements, or other documents needed to protect human subjects and data confidentiality.
- Appropriately safeguard evaluation data in compliance with HIPAA requirements, protection of human subjects, data sharing agreements, state or federal laws, and other applicable regulations.

The waiver evaluation conducted by PCG will determine if the goals and objectives of the Adult Expansion program, community engagement requirement, employer-sponsored insurance requirement, and UMIC have been achieved. The evaluation will meet the requirement of the waiver STCs, follow the CMS approved evaluation design, and provide required deliverables.

UDOH staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, UDOH is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation

PUBLIC CONSULTING GROUP

Solutions that Matter

PCG always strives to uphold the highest standards of ethical conduct for its employees and business partners, and we are proud of our excellent track record in this regard. PCG maintains a Code of Conduct and detailed policies and procedures that reflect our strong expectations for ethical conduct, a comprehensive risk assessment and management process, and a robust compliance monitoring and training program that is overseen by PCG's Governance, Risk and Compliance Department (GRC) in conjunction with the firm's Legal, Human Resources (HR), and Finance Departments. PCG's Legal, HR, and GRC functions work together to identify and monitor adherence to cooling periods and related disclosure and compliance requirements, which are designed to avoid even the appearance of conflicts of interest that may vary widely across states and contracts.

Before responding to any RFP or other opportunity, PCG conducts a conflict check. The check matches the potential services in the RFP against a database of all current and recent consulting and operations contracts performed by PCG and its employees, both in the RFP subject state and nationally. This conflict check includes determining if any employees associated with the potential project are former employees of the client or other stakeholder groups. Any circumstance presenting a potential conflict, real or perceived, is independently reviewed by GRC and Legal. If risk mitigation steps are deemed necessary, PCG will work with the client to implement all appropriate safeguards to ensure a common comfort level with the actions taken. Mitigation strategies may include, but not be limited to, reassigning employees to other projects, or constructing a compliance "wall" to prohibit interaction between the relevant employees. PCG does not submit proposals in cases where, in its judgment, the potential for conflict is beyond the limits of reasonable accommodations, which would otherwise not impair our ability to perform services to the satisfaction of a prospective client.

PCG applied this same protocol to the Utah 1115 Waiver Evaluation procurement, with the resulting conclusion that the operation of this project will not create a conflict of interest with any other work being performed by PCG.

Aaron Holman,
Associate Manager
PCG Health

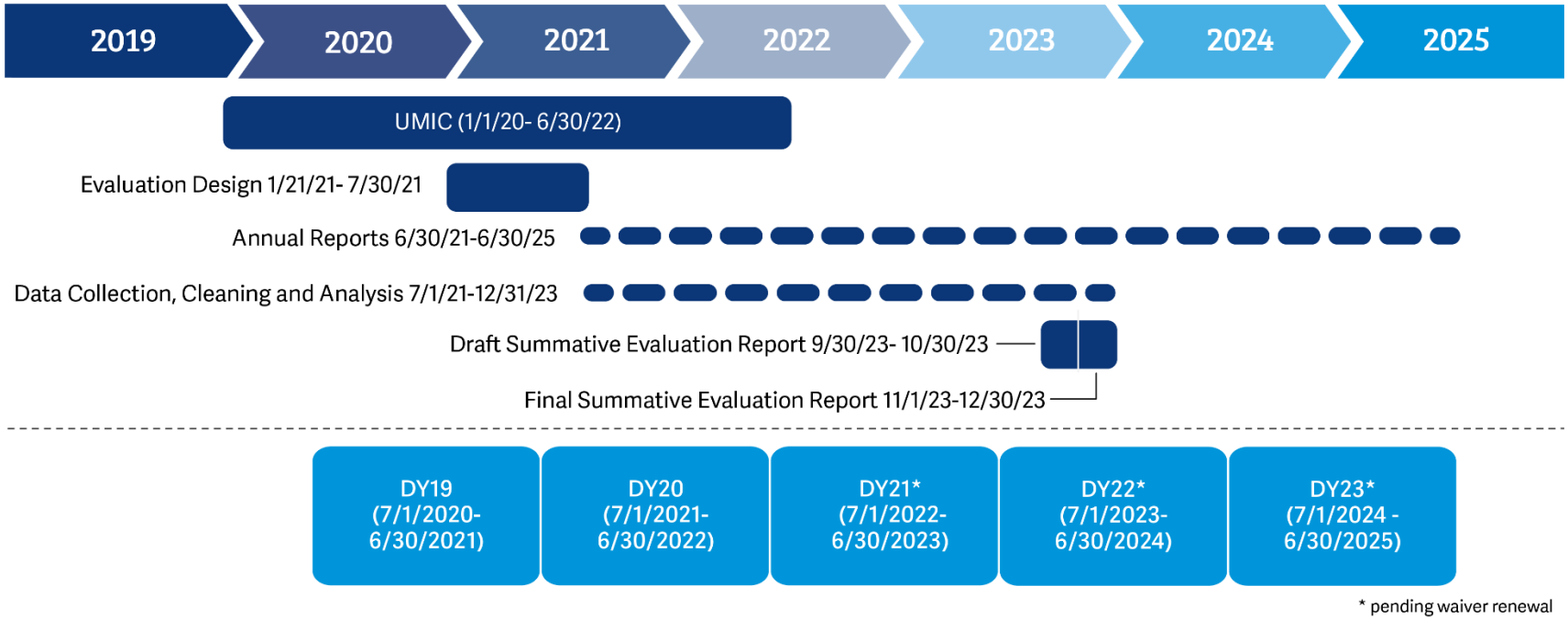
2.EVALUATION BUDGET

TABLE 9: BUDGET

Evaluation Activity	Total Estimated Cost					
	DY19 *(7/1/2020 - 6/30/2021)*	**DY20** *(7/1/2021 - 6/30/2022)*	**DY21** *(7/1/2022 - 6/30/2023)*	**DY22** *(7/1/2023 - 6/30/2024)*	**DY23** *(7/1/2024 - 6/30/2025)*	**Total**
Project Management (e.g., regular project meetings, status updates and ad hoc discussions)	$3,225	$5,375	$4,300	$4,300	$4,300	**$ 21,500.00**
Evaluation Design	$16,254	$6,966	$0	$0	$0	**$ 23,220.00**
Key Informant Interviews, Data Collection, Cleaning and Analysis	$0	$26,445	$26,445	$0	$0	**$ 52,890.00**
Quantitative Data-Collection, Cleaning and Analysis	$9,901	$29,702	$24,752	$24,752	$9,901	**$ 99,007.50**
Annual Reports	$0	$255	$255	$255	$255	**$ 1,021.25**
Summative Evaluation Report Generation	$0	$0	$5,208	$12,153	$0	**$ 17,361.25**
Total	**$29,380**	**$68,744**	**$60,961**	**$41,460**	**$14,456**	**$215,000**

3.TIMELINE AND MAJOR MILESTONES

FIGURE 3



4. EVALUATION TABLE

TABLE 10: UMIC EVALUATION TABLE

Comparison Strategy	Measure Name	Measure Description	Data Source	Analytic Approach
Hypothesis 1: The demonstration will increase the number of adult beneficiaries receiving benefits through managed care.				
Primary research question 1.1: Did the demonstration increase the number of adult beneficiaries receiving benefits through managed care?				
▪ *Subsidiary research question 1.1.1: Did enrollment in either form of managed care (ACOs or UMIC) differ among beneficiaries by demographic factors, such as by age, gender, race/ethnicity, or language?*				
Change over time in adult beneficiary population	Delivery system enrollment	Number of beneficiaries receiving care through each delivery model: 1) Physical health through FFS and BH through PMHP 2) Care for physical health through ACOs and BH through PMHP 3) Integrated care through UMIC	UDOH Administrative data	Descriptive statistics; ANOVA
Primary research question 1.2: Was the demonstration implemented effectively?				
▪ *Subsidiary research question 1.2.1: Did the Public Health Emergency/Covid-19 pandemic impact implementation?*				
N/A	Implementation	Implementation challenges and successes	Key Informant Interviews; Document review	Qualitative Analysis
Primary research question 1.3: Is patient satisfaction associated with enrollment in any managed care, or type of managed care				
▪ *Subsidiary research question 1.3.1: Was patient satisfaction associated with receiving care in person or by telehealth, including audio-only?*				

Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Patient satisfaction	CAHPS patient satisfaction measures (Q26) - Respondent rating of their health plan, overall (Q16) - Respondent rating of their 'personal doctor' (Q20) - Respondent rating of specialist they saw most	CAHPS aggregate data reported by plans	Descriptive statistics; ANOVA
Hypothesis 2: The demonstration will improve access to and engagement in health care.				
Primary research question 2.1: Did beneficiaries enrolled in managed care have increased access to and engagement in health care?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year.	Claims data	Multiple linear regression; ANOVA
	Comprehensive Diabetes Care (CDC) (modified)	Assesses adults 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: • two A1C tests per year (CPT 83036) and one albumin lab test (CPT 80243) per year	Claims data	Multiple linear regression; ANOVA
Primary research question 2.2: Did beneficiaries enrolled in managed care have increased access to and engagement in behavioral health care?				

Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. 2) had two or more additional AOD services or MAT within 34 days of the initiation visit.	Claims data	Multiple linear regression; ANOVA
Primary research question 2.3: Did beneficiaries enrolled in managed care have increased access to care coordination?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Getting Needed Care (Adult CAHPS)	**(Q9)**- Easy for respondent to get necessary care, tests, or treatment **(Q18)**- Respondent got appointment with specialists as soon as needed	Administrative data	ANOVA
	Getting Care Quickly (Adult CAHPS)	**(Q4)**- Respondent got care for illness/injury as soon as needed **(Q6)**- Respondent got non-urgent appointment as soon as needed	Administrative data	
	Follow-Up After Hospitalization for Mental Illness (HEDIS-FUH/NQF 0576)	Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner.	Claims data	
Hypothesis 3: The demonstration will improve the health of beneficiaries enrolled in managed care.				
Primary research question 3.1: Did beneficiaries enrolled in managed care have improved health outcomes, including behavioral health?				

▪ *Subsidiary research question 3.1.1 Did* the outcome of either form of managed care differ among subgroups of beneficiaries by demographic factors?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Annual Monitoring for Patients on Persistent Medications (MPM)	Assesses adults 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims data	Multiple linear regression; ANOVA
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Antidepressant Medication Management (AMM)	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims data	
Primary research question 3.2: Did the rate of ED visits decrease for beneficiaries in managed care?				
▪ *Subsidiary research question 3.2.1 Did the rate of ED visits for BH conditions decrease for beneficiaries in managed care?*				
▪ *Subsidiary research question 3.2.2 Did any change in the rate of ED visits differ among subgroups by demographic factors?*				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries	Emergency Department Utilization (EDU)	Rate of ED visits without a qualifying diagnosis (non-emergent).	Claims data	Multiple linear regression; ANOVA

receiving integrated care through UMIC				
Primary research question 3.3: Did the demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?				
Comparison of Utah population in eligible income range to national average, and to a synthetic control derived from other states	Personal care provider	Fraction who says they have one person they think of as their person doctor or provider	BRFSS	Difference-in Difference, Synthetic Control Method (SCM)
	Primary care engagement	Time since last routine check up	BRFSS	
	Delayed or avoided care	Fraction who have delayed or avoided needed care because of cost	BRFSS	
	Health Related Quality of Life	Healthy Days Measures (covers physical and mental health)	BRFSS	
Hypothesis 4: The demonstration will improve the fiscal sustainability of the Utah Medicaid program.				
Primary research question 4.1: Did the total cost of care decrease for beneficiaries in managed care?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Cost of care	PMPM cost of acute care PMPM cost of primary/ambulatory care PMPM total cost of care	Claims data	Multiple linear regression; ANOVA
Primary research question 4.2: Did the rate of hospitalization decrease for beneficiaries in managed care?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP	Inpatient Utilization (IPU)	All Cause Hospital Readmission Overall inpatient hospitalization per thousand	Claims/Administrative data	Multiple linear regression; ANOVA

Group 2: Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC		Inpatient days per year		
Primary research question 4.3: Did the rate of utilization of low-value care decrease for beneficiaries in managed care?				
Group 1: Beneficiaries receiving care for physical health through FFS and BH through PMHP **Group 2:** Beneficiaries receiving care for physical health through ACOs and BH through PMHP **Group 3:** Beneficiaries receiving integrated care through UMIC	Rates of services identified as low value by the American Board of Internal Medicine (ABIM)	Head imaging for headache, without additional indicators Pre-operative testing for cataract surgery Inappropriate antibiotic prescriptions	Claims data	Multiple linear regression; ANOVA

Measure Specifications
for
UT UMIC

Prepared by Public Consulting Group

A. Table: Claims-based data performance measures

Population	Measure Name	Data Source	Data Steward(s)	Steward Version	NQF
Quantitative Measures					
AE	Adults' Access to Preventative/Ambulatory Health Services (AAP)	MMIS, APCD	NCQA	HEDIS MY 2020 & MY 2021	N/A
AE	Annual Monitoring for Patients on Persistent Medications (MPM)	MMIS	NCQA	HEDIS 2019	2371
AE	Antidepressant Medication Management (AMM)	MMIS	NCQA	HEDIS MY 2020 & MY 2021	0105
AE	Comprehensive Diabetes Care (CDC) (modified) 1 indicator	MMIS	NCQA	HEDIS MY 2020 & MY 2021	0731
AE	Emergency Department Utilization (EDU)	MMIS	NCQA	HEDIS MY 2020 & MY 2021	Based on 9999
AE	PMPM Cost of Care	MMIS	N/A	N/A	N/A
AE	Delayed or Avoided Care	BRFSS	CDC	N/A	N/A
AE	Delivery System Enrollment	MMIS, APCD	N/A	N/A	N/A
AE	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	MMIS	NCQA	HEDIS MY 2020 & MY 2021	0576
AE	Getting Care Quickly (Adult CAHPS)	CAHPS	AHRQ	5.0	N/A
AE	Getting Needed Care (Adult CAHPS)	CAHPS	AHRQ	5.0	N/A
AE	Health Related Quality of Life	BRFSS	CDC	N/A	N/A

AE	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	MMIS	NCQA	HEDIS MY 2020 & MY 2021	0004
AE	Inpatient Admissions (IPU)	MMIS/Administrative	NCQA	HEDIS MY 2020 & MY 2021	Based on 9999
AE	Low-Value Care 1: Head imaging for headache	MMIS, APCD	MA Health Policy Commission	N/A	N/A
AE	Low-Value Care 2: Pre-operative testing for cardiac stress test	MMIS, APCD	MA Health Policy Commission	N/A	N/A
AE	Low-Value Care 3: Inappropriate antibiotic prescriptions	MMIS, APCD	MA Health Policy Commission	N/A	N/A
AE	Patient Satisfaction	CAHPS	AHRQ	5.0	N/A
AE	Personal care provider	BRFSS	CDC	N/A	N/A
AE	Primary Care Engagement	BRFSS	CDC	N/A	N/A
Qualitative Measures					
AE	Implementation/Implementation PHE impact	KIIs	N/A	N/A	N/A

B. Performance Measures Specifications

Summative Report	
Time period	January 1st, 2017 – December 31st, 2020 (Baseline Period for BRFSS and APCD measures); January 1st, 2020 - June 30th, 2022 (Intervention Period)

Data sources / Definitions	Medicaid Claims (MMIS) Member definition: ● DEMONSTRATION_POPULATION = “Adult Expansion” ● UMIC= “Utah Medicaid Integrated Care Plan” ● Both Genders ● Age 19 – 64 years at the time of starting last eligibility enrollment segment Claim definition ● PLAN = Payer Plan Type (FFS, ACO, UMIC, Mental Health Plan, Substance Use Disorder plan) All Payer Claim Database (APCD) Behavioral Health Risk Factor Survey (BRFSS) Adult Consumer Assessment of Healthcare Providers & Systems (Adult CAHPS)
Analyses	● Multiple Linear Regression ● ANOVA ● Difference-in-Difference ● Synthetic Control Method (SCM)
Approach	Inferential
Measures	Not Included in UMIC version of Databook: ● Some Adult Expansion and ESI measures
Findings	Trends within Medicaid population during the Demonstration Period.

QUANTITATIVE MEASURES

ADULTS' ACCESS TO PREVENTATIVE/AMBULATORY HEALTH SERVICES (AAP)

Measure Description:

The percentage of members 19 years and older who had an ambulatory or preventive care visit.

- Medicaid members who had an (AT LEAST ONE) ambulatory or preventive care visit during the measurement year.

Data Source(s): **APCD, MMIS**	NQF #: **N/A**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, BH diagnosis, chronic health conditions, race/ethnicity, language, county of residence

Numerator:

Medicaid: One or more ambulatory or preventive care visits during the measurement year. 7/1/19 – 6/30/20

Use the following value sets to identify ambulatory or preventive care visits:

Ambulatory:

1. Ambulatory Visits Value Set.
2. Other Ambulatory Visits Value Set
3. Other: PLACEOFSERVICE NOT IN ('04', '21', '23', '31', '33', '34',' 41', '42')
4. BILLTYPE <> '11X' (inpatient)

Non-Ambulatory

1. Telephone Visits Value Set.
2. Online Assessments Value Set.

Denominator:
The eligible population.

Exclusions:
Exclude members receiving Hospice Care (Hospice Encounter, Hospice Intervention Value Set) during the measurement year.

Result:
The result is expressed as a percentage.

ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS (MPM)

Measure Description:

The percentage of members 19 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. For each product line, report each of the two rates separately and as a total rate.

- Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB).
- Annual monitoring for members on diuretics.
- Total rate (the sum of the two numerators divided by the sum of the two denominators).

Data Source: **MMIS**	NQF #: **2371**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS 2019 (retired)**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

Numerator:

At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. Any of the following during the measurement year meet criteria:

- A lab panel test (Lab Panel Value Set).
- A serum potassium test (Serum Potassium Value Set) ***or*** a serum creatinine test (Serum Creatinine Value Set) on the same date of service or on different dates of service.
    - LOINC codes were unavailable as our analysis did not have access to nonclaims based data.

Additional eligible population criteria

Members who received at least 180 treatment days of a diuretic (Diuretic Medications List) during the measurement year.

Note: *Members may switch therapy with any medication on the Diuretic Medications List during the measurement year and have the days supply for those medications count toward the total 180 treatment days.*

Diuretic Medications

Description	Prescription	
Antihypertensive combinations	• Aliskiren-hydrochlorothiazide	• Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan

	• Aliskiren-hydrochlorothiazide-amlodipine • Amiloride-hydrochlorothiazide • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-hydrochlorothiazide-valsartan • Atenolol-chlorthalidone • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Bendroflumethiazide-nadolol • Bisoprolol-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Chlorthalidone-clonidine • Enalapril-hydrochlorothiazide • Eprosartan-hydrochlorothiazide	• Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-methyldopa • Hydrochlorothiazide-metoprolol • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-propranolol • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-spironolactone • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-triamterene • Hydrochlorothiazide-valsartan
Loop diuretics	• Bumetanide • Ethacrynic acid	• Furosemide • Torsemide
Potassium-sparing diuretics	• Amiloride • Eplerenone	• Spironolactone • Triamterene
Thiazide diuretics	• Chlorothiazide • Chlorthalidone	• Hydrochlorothiazide • Indapamide • Methyclothiazide • Metolazone

Denominator:
19 years and older as of June 30 of the measurement year.

Event/ diagnosis

Members on persistent medications (i.e., members who received at least 180 treatment days of ambulatory medication in the measurement year). Refer to *Additional Eligible Population Criteria* for each rate.

Treatment days are the actual number of calendar days covered with prescriptions within the measurement year (i.e., a prescription of 90 days supply dispensed on June 1 of the measurement year counts as 30 treatment days). Sum the days supply for all medications and subtract any days supply that extends beyond June 30 of the measurement year.

Administrative Specification

For each product line, report each of the two rates separately and as a combined rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

Rate 1: Annual Monitoring for Members on ACE Inhibitors or ARBs

Additional eligible population criteria

Members who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year (ACE Inhibitor/ARB Medications List).

Note: *Members may switch therapy with any medication on the ACE Inhibitor/ARB Medications List during the measurement year and have the days supply for those medications count toward the total 180 treatment days (i.e., a member who received 90 days of ACE inhibitors and 90 days of ARBs meets the denominator definition for rate 1).*

ACE Inhibitor/ARB Medications[23]

Description	Prescription
Angiotensin converting enzyme inhibitors	● Benazepril ● Enalapril ● Lisinopril ● Perindopril ● Ramipril ● Captopril ● Fosinopril ● Moexipril ● Quinapril ● Trandolapril
Angiotensin II inhibitors	● Azilsartan ● Eprosartan ● Losartan ● Telmisartan ● Candesartan ● Irbesartan ● Olmesartan ● Valsartan
Antihypertensive combinations	● Aliskiren-valsartan ● Amlodipine-benazepril ● Amlodipine-hydrochlorothiazide-valsartan ● Amlodipine-hydrochlorothiazide-olmesartan ● Amlodipine-olmesartan ● Amlodipine-perindopril ● Amlodipine-telmisartan ● Amlodipine-valsartan ● Azilsartan-chlorthalidone ● Benazepril-hydrochlorothiazide ● Candesartan-hydrochlorothiazide ● Captopril-hydrochlorothiazide ● Enalapril-hydrochlorothiazide ● Eprosartan-hydrochlorothiazide ● Fosinopril-hydrochlorothiazide ● Hydrochlorothiazide-irbesartan ● Hydrochlorothiazide-lisinopril ● Hydrochlorothiazide-losartan ● Hydrochlorothiazide-moexipril ● Hydrochlorothiazide-olmesartan ● Hydrochlorothiazide-quinapril ● Hydrochlorothiazide-telmisartan ● Hydrochlorothiazide-valsartan ● Sacubitril-valsartan ● Trandolapril-verapamil

Exclusions:

Members in hospice are excluded from this measure.

Optional: Exclude members from each eligible population who had an acute inpatient encounter (Acute Inpatient Value Set) or nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year.

Result:
The result is expressed as a percentage.

ANTIDEPRESSANT MEDICATION MANAGEMENT (AMM)

Measure Description:

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

1. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Data Source: **MMIS**	NQF #: **2732**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

SUMMARY OF CHANGES TO HEDIS MY 2020 & MY 2021

- Added e-visits and virtual check-ins to the event/diagnosis (step 2 required exclusion).

Description

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported.

2. *Effective Acute Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
3. *Effective Continuation Phase Treatment.* The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Definitions

Intake Period	The 12-month window starting on May 1 of the year prior to the measurement year and ending on April 30 of the measurement year.
IPSD	Index Prescription Start Date. The earliest prescription dispensing date for an antidepressant medication where the date is in the Intake Period and there is a Negative Medication History.
Negative Medication History	A period of 105 days prior to the IPSD when the member had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified 180-day (6-month) measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 80 days counted in the 231-day interval.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. Refer to General Guideline 17: Members in Hospice.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18 years and older as of April 30 of the measurement year.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.

Allowable gap One gap in enrollment of up to 45 days. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (e.g., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled.

Anchor date IPSD.

Benefits Medical and pharmacy.

Event/diagnosis Follow the steps below to identify the eligible population, which is used for both rates.

Step 1 Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List) during the Intake Period.

Step 2: Required exclusion Exclude members who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Members who meet any of the following criteria remain in the eligible population:

- An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria.
- An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set ***with*** Major Depression Value Set.
- A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set ***with*** Major Depression Value Set.
- An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Partial Hospitalization POS Value Set ***with*** Major Depression Value Set.
- An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set ***with*** Major Depression Value Set.
- A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Community Mental Health Center POS Value Set ***with*** Major Depression Value Set.
- Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set ***with*** Major Depression Value Set.
- Transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set ***with*** Major Depression Value Set.

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- A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set ***with*** Major Depression Value Set.
- An observation visit (Observation Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit (ED Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set ***with*** ED POS Value Set ***with*** Major Depression Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** any diagnosis of major depression (Major Depression Value Set).

Step 3 Test for Negative Medication History. Exclude members who filled a prescription for an antidepressant medication 105 days prior to the IPSD.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.

Administrative Specification

Denominator The eligible population.

Numerators

Effective Acute Phase Treatment At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

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Antidepressant Medications

Description	Prescription		
Miscellaneous antidepressants	● Bupropion ● Vilazodone ● Vortioxetine		
Monoamine oxidase inhibitors	● Isocarboxazid ● Phenelzine ● Selegiline ● Tranylcypromine		
Phenylpiperazine antidepressants	● Nefazodone ● Trazodone		
Psychotherapeutic combinations	● Amitriptyline-chlordiazepoxide ● Amitriptyline-perphenazine ● Fluoxetine-olanzapine		
SNRI antidepressants	● Desvenlafaxine ● Duloxetine ● Levomilnacipran ● Venlafaxine		
SSRI antidepressants	● Citalopram ● Escitalopram ● Fluoxetine ● Fluvoxamine ● Paroxetine ● Sertraline		
Tetracyclic antidepressants	● Maprotiline ● Mirtazapine		

Tricyclic antidepressants	● Amitriptyline ● Amoxapine ● Clomipramine	● Desipramine ● Doxepin (>6 mg) ● Imipramine	● Nortriptyline ● Protriptyline ● Trimipramine		

Effective Continuation Phase Treatment At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period specified.*

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Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AMM-1/2/3: Data Elements for Antidepressant Medication Management

	Administrative
Measurement year	✔▪
Eligible population	✔▪
Number of required exclusions	✔▪
Numerator events by administrative data	*Each of the 2 rates*
Numerator events by supplemental data	*Each of the 2 rates*
Reported rate	*Each of the 2 rates*

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Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Antidepressant Medication Management

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range below age 18 is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.

		Note: *Changes to these criteria can impact how the event/diagnosis would be calculated using the Intake Period, IPSD, Negative Diagnosis History and Treatment Days.*
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	Yes, with limits	Only events or diagnoses that contain (or map to) codes in the medication lists and value sets may be used to identify visits. Medication lists, value sets and logic may not be changed. ***Note:*** *This measure uses treatment with antidepressant medication; modifying the measurement period can affect other dates; however, the order and relationship of the events may not be changed.*
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Required Exclusions	No	Apply required exclusions according to specified value sets.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
● Effective Acute Phase treatment ● Effective Continuation Phase treatment	No	Medication lists, value sets and logic may not be changed.

COMPREHENSIVE DIABETES CARE (CDC)

Measure Description:

The percentage of members 19–64 years of age with diabetes (type 1 and type 2) who had Hemoglobin A1c (HbA1c) testing.

Data Source: **APCD, MMIS**	NQF #: **0731**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

Numerator:

HbA1c Testing An HbA1c test (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) performed during the measurement year. 7/1/19 – 6/30/20

Denominator:

Members 19–64 years as of June 30 of the measurement year 2020, with a diabetes diagnosis.

Event/diagnosis A member only needs to be identified by claim/encounter data or by pharmacy data to be included in the measure. Members may be identified as having diabetes during the measurement year.

Claim/encounter data. Members who met any of the following criteria during the measurement year :

- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).
- At least one acute inpatient discharge with a diagnosis of diabetes (Diabetes Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), telephone visits (Telephone Visits Value Set),e-visits or virtual check-ins (Online Assessments Value Set), ED visits (ED Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim), on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters. To identify a nonacute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the discharge date for the stay.

Only include nonacute inpatient encounters (Nonacute Inpatient Value Set) ***without*** telehealth (Telehealth Modifier Value Set; Telehealth POS Value Set).

Pharmacy data. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year (Diabetes Medications List).

Diabetes Medications

Description	Prescription		
Alpha-glucosidase inhibitors	● Acarbose	● Miglitol	
Amylin analogs	● Pramlintide		
Antidiabetic combinations	● Alogliptin-metformin ● Alogliptin-pioglitazone ● Canagliflozin-metformin ● Dapagliflozin-metformin ● Empagliflozin-linagliptin	● Empagliflozin-metformin ● Glimepiride-pioglitazone ● Glipizide-metformin ● Glyburide-metformin ● Linagliptin-metformin	● Metformin-pioglitazone ● Metformin-repaglinide ● Metformin-rosiglitazone ● Metformin-saxagliptin ● Metformin-sitagliptin
Insulin	● Insulin aspart ● Insulin aspart-insulin aspart protamine ● Insulin degludec ● Insulin detemir ● Insulin glargine ● Insulin glulisine	● Insulin isophane human ● Insulin isophane-insulin regular ● Insulin lispro ● Insulin lispro-insulin lispro protamine ● Insulin regular human ● Insulin human inhaled	
Meglitinides	● Nateglinide	● Repaglinide	
Glucagon-like peptide-1 (GLP1) agonists	● Dulaglutide ● Exenatide	● Albiglutide ● Liraglutide (excluding *Saxenda*®)	
Sodium glucose cotransporter 2 (SGLT2) inhibitor	● Canagliflozin	● Dapagliflozin	● Empagliflozin
Sulfonylureas	● Chlorpropamide ● Glimepiride	● Glipizide ● Glyburide	● Tolazamide ● Tolbutamide
Thiazolidinediones	● Pioglitazone	● Rosiglitazone	
Dipeptidyl peptidase-4 (DDP-4) inhibitors	● Alogliptin ● Linagliptin	● Saxagliptin ● Sitagliptin	

Note: *Glucophage/metformin as a solo agent is not included because it is used to treat conditions other than diabetes; members with diabetes on these medications are identified through diagnosis codes only.*

Exclusions:
Exclude members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Exclusion (Optional):

Members who do not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

Organizations that apply optional exclusions must exclude members from the denominator for all indicators. The denominator for all rates must be the same. If the member was included in the measure based on claim or encounter data, as described in the event/diagnosis criteria, the optional exclusions do not apply because the member had a diagnosis of diabetes.

Result:
The result is expressed as a percentage.

PMPM COST OF CARE

Measure Description:
The PMPM cost of acute care and primary care for Medicaid members 19 years and older within the eligible populations.

- Medicaid members within the eligible populations who had an (AT LEAST ONE of the following) acute care visit, ambulatory or preventive care visit, or outpatient or specialty care visit during the measurement year.

Data Source(s):	NQF #:
APCD, MMIS	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Medicaid:

Total Cost of Acute Care

Total cost of acute care claims for members with one or more acute care visits during the measurement year. 7/1/19—6/30/20
Use the following value sets to identify acute care visits:
Acute Inpatient Value Set

Total Cost of Primary Care

Total cost of ambulatory or preventative care claims for members with one or more ambulatory or preventive care visits during the measurement year. 7/1/19 – 6/30/20
Use the following value sets to identify ambulatory or preventive care visits:
Ambulatory:

1. Ambulatory Visits Value Set.
2. Other Ambulatory Visits Value Set
3. Other: PLACEOFSERVICE NOT IN ('04', '21', '23', '31', '33', '34',' 41', '42')
4. BILLTYPE <> '11X' (inpatient)

Non-Ambulatory

1. Telephone Visits Value Set.
2. Online Assessments Value Set.

Denominator:
The total number of member months within the eligible population.
Exclusions:
Exclude all member months for members receiving Hospice Care (Hospice Encounter, Hospice Intervention Value Set) during the measurement year.

Result:
The result is expressed as a dollar amount.

DELAYED OR AVOIDED CARE

Measure Description:
Fraction of Medicaid Beneficiaries in the eligible population who have delayed or avoided care due to cost.

Data Source(s):	NQF #:
BRFSS	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Question:

Members of the eligible population who answered yes to BRFSS Health Care Access question CHCA.03

Question CHA.03: Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Result:

The result is expressed as a percentage.

DELIVERY SYSTEM ENROLLMENT

Measure Description:
Fraction of Medicaid Beneficiaries in the eligible population receiving care through each delivery model:

1) Physical health through FFS and BH through PMHP
2) Care for physical health through ACOs and BH through PMHP
3) Integrated care through UMIC

Data Source(s):	NQF #:
UDOH Administrative	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Members of the eligible population receiving care through each delivery model:

- Physical health through FFS and BH through PMHP
- Care for physical health through ACOs and BH through PMHP
- Integrated care through UMIC

Denominator:

The total number of members within the eligible population.

Exclusions:

None.

Result:

The result is expressed as a percentage.

EMERGENCY DEPARTMENT UTILIZATION (EDU)

Measure Description:

The rate per 1,000 of members 19 years and older who had emergency department (ED) visits during the measurement year.

Data Source: **APCD, MMIS**	NQF #: **9999**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, BH diagnosis, chronic health conditions, race/ethnicity, language, county of residence

Numerator:

The number of observed ED visits within each:

- Age and gender group, and
- The overall total

Visit definition:

*A unique combination of the variables CLIENTID – TCN – SERVICEBEGINDATE
This accounts for members that may have more than one claim for the same or different diagnosis and procedure per day.

Step 1:

- Count each visit to an ED once, regardless of the intensity or duration of the visit.
- Count multiple ED visits on the same date of service as one visit.
- Identify all ED visits during the measurement year using either of the following:

*Note: measurement year has been altered from CY to fiscal year

- An ED Visit (ED Value Set). (CPT Code OR UBRev Code)
- A procedure code (ED Procedure Code Value Set) with (AND) an ED place of service code (ED POS Value Set).

1. **INPATIENT**:
   - An inpatient stay (Inpatient Stay Value Set) OR
   - An acute inpatient stay (Acute Inpatient Value Set) OR
   - Non-acute inpatient stay (NonAcute Inpatient Value Set)
   - BILLTYPE IN ('11X', '12X', '21X', '22X')

   OR

   - An observation (Observation Value Set) OR
   - An observation stay (Observation Stay Value Set)

   OR

Step 2:

- Exclude encounters with any of the following:

- A **principal diagnosis** of (see **UT BH dx Master Listing for EDU**)[24]

Step 3:

- For the remaining ED visits, calculate the:
- number of visits per member and
- remove visits for outlier members.

OUTLIER DEFINITION: Medicaid members 19–64 years of age with **four or more ED visits** during the measurement year (7/1/19 – 6/30/20).

Step 4:

- Calculate the total using all ED visits identified after completing steps 1–3.

Assign each remaining ED visit to an age and stratification category.

Denominator:
The number of members in the eligible population for each age and gender combination.

Result:

The result is expressed as a rate.

[24] Mental and Behavioral Disorders Value Set, Psychiatry Value Set, and Electroconvulsive Therapy value sets have been modified and combined into the UT BH dx Master Listing for EDU to fit needs of UT Interim Evaluation.

FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Measure Description:

The percentage of discharges for patients 19 years of age and older who were hospitalized for treatment of selected mental health disorders or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Data Source: **MMIS**	NQF #: **0576**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

Numerator:

30-Day Follow-Up A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) ***with*** (Outpatient POS Value Set) ***with*** a mental health provider.
- An outpatient visit (BH Outpatient Value Set) ***with*** a mental health provider.
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) ***with*** (Partial Hospitalization POS Value Set).
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) ***with*** (Community Mental Health Center POS Value Set).
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) ***with*** (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).
- A telehealth visit: (Visit Setting Unspecified Value Set) ***with*** (Telehealth POS Value Set) ***with*** a mental health provider.
- An observation visit (Observation Value Set) ***with*** a mental health provider.
- Transitional care management services (Transitional Care Management Services Value Set), ***with*** a mental health provider.
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).

- A telephone visit (Telephone Visits Value Set) ***with*** a mental health provider.

Denominator:

Members 18+ years who were discharged alive from an acute inpatient with a principal mental illness diagnosis or intentional self-harm.

Event/diagnosis

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between July 1, 2019 and June 30, 2020 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between July 1, 2019 and June 30, 2020 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after June 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

Nonacute readmission or direct transfer

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.

Exclusions:

- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after June 1 of the measurement year.
- Exclude both the original and the readmission/direct transfer discharge if the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim).

- Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

Result:
The result is expressed as a percentage.

GETTING CARE QUICKLY (CAHPS)

Measure Description:
The survey asked enrollees how often they got care as soon as needed when sick or injured and got non-urgent appointments as soon as needed.

Data Source(s):	NQF #:
CAHPS Health Plan Adult Survey	**N/A**
Measure Steward:	Measure Steward Version:
AHRQ	5.0
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Questions

Members of the eligible population who answered either Q4 or Q6 on the CAHPS Health Plan Adult Survey.

Q4: Respondent got care for illness/injury as soon as needed.

- Never
- Sometimes
- Usually
- Always

Q6: Respondent got non-urgent appointment as soon as needed

- Never
- Sometimes
- Usually
- Always

Result:

The result is expressed as a percentage.

GETTING NEED CARE (CAHPS)

Measure Description:
The survey asked enrollees how often it was easy for them to get appointments with specialists and get the care, tests, or treatment they needed through their health plan.

Data Source(s):	NQF #:
CAHPS Health Plan Adult Survey	**N/A**
Measure Steward:	Measure Steward Version:
AHRQ	5.0
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Questions:

Members of the eligible population who answered either Q9 or Q18 on the CAHPS Health Plan Adult Survey.

Q9: Easy for respondent to get necessary care, tests, or treatment.

- Never
- Sometimes
- Usually
- Always

Q18: Respondent got appointment with specialists as soon as needed

- Never
- Sometimes
- Usually
- Always

Result:

The result is expressed as a percentage.

HEALTH RELATED QUALITY OF LIFE

Measure Description:
Healthy Days Measures Core Module from the CDC HRQOL.

Data Source(s):	NQF #:
BRFSS	**N/A**
Measure Steward:	Measure Steward Version:
CDC	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Questions:

Members of the eligible population who answered CDC HRQOL-4.

Healthy Days Core Module (CDC HRQOL-4):

Question 1: Would you say that in general your health is:

- 1. Excellent
- 2. Very Good
- 3. Good
- 4, Fair
- 5. Poor
- 7 Don't know / Not sure
- 9 Refused

Question 2: Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

- Number of Days
- 88. None
- 77 Don't know / Not sure
- 99 Refused

Question 3: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?1. Excellent

- Number of Days
- 88. None
- 77 Don't know / Not sure
- 99 Refused

Question 4: During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

- Number of Days
- 88. None
- 77 Don’t know / Not sure
- 99 Refused

Result:

The result is expressed as a percentage.

INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG ABUSE OR DEPENDENCE TREATMENT (IET)

	Measure Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following. ● *Initiation of AOD Treatment.* The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. ● *Engagement of AOD Treatment.* The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

	Data Source: **MMIS**	NQF #: **0004**
	Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
	Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

Numerator:

Initiation of AOD Treatment

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED/observation visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index Episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission ***with*** a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set,

Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***and*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***and*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visit Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non Drug Service Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Monthly Office Based Treatment Value Set).
- If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).
- If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List), initiation on the same day as the IESD must be with different providers in order to count.

If a member is compliant for the Initiation numerator for any diagnosis cohort (alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns.

Exclude the member from the denominator for both indicators *(Initiation of AOD Treatment* and *Engagement of AOD Treatment)* if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of AOD Treatment

Step 1 Identify all members compliant for the Initiation of AOD Treatment numerator.

For members who initiated treatment via an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 2 Identify members who had an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set) or who had a visit that included medication administration (OUD Weekly Drug Treatment Service Value Set) beginning on the day after the initiation encounter through 34 days after the initiation event.

For these members, if the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), the member is numerator compliant for Engagement of AOD Treatment.

Step 3 Identify members whose initiation of AOD treatment was a medication treatment event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events, where only one can be an engagement medication treatment event, beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days).

Step 4 Identify the remaining members whose initiation of AOD treatment was *not* a medication treatment event (members not identified in step 3).

These members are numerator compliant if they meet *either* of the following:

- At least one engagement medication treatment event.
- At least two engagement visits.

Two engagement visits can be on the same date of service but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement visits Any of the following beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days) meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- IET Stand Alone Visits Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- Observation Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- A telephone visit (Telephone Visits Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- If the IESD Diagnosis cohort was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) an opioid treatment service (OUD Weekly Non-Drug Service Value Set).

Engagement medication treatment events

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was *a diagnosis of alcohol abuse or dependence* (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Alcohol Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was *a diagnosis of opioid abuse or dependence* (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Opioid Use Disorder Treatment Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total column is not the sum of the Diagnosis columns.

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	• Disulfiram (oral)
Antagonist	• Naltrexone (oral and injectable)
Other	• Acamprosate (oral; delayed-release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription
Antagonist	● Naltrexone (oral and injectable)
Partial agonist	● Buprenorphine (sublingual tablet, injection, implant) ● Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)

Note

- *Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some organizations may bill comparable to outpatient billing, with separate claims for each date of service; others may bill comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing is comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the required time frame for the rate.*
- *For members in the "other drug abuse or dependence" cohort, medication treatment does not meet numerator criteria for Initiation of AOD Treatment or Engagement of AOD Treatment.*
- *Methadone is not included in the medication lists for this measure. Methadone for opioid use disorder is only administered or dispensed by federally certified opioid treatment programs and does not show up in pharmacy claims data. A pharmacy claim for methadone would be more indicative of treatment for pain than treatment for an opioid use disorder; therefore, they are not included in the medication lists. The AOD Medication Treatment Value Set includes some codes that identify methadone treatment because these codes are used on medical claims, not pharmacy claims.*

Denominator: Members that are 19 years or older with a new episode of AOD abuse or dependence during the Intake Period.

AOD diagnosis cohorts

Report the following diagnosis cohorts for each age stratification and the total rate:

- Alcohol abuse or dependence.
- Opioid abuse or dependence.
- Other drug abuse or dependence.
- Total.

Event/diagnosis

New episode of AOD abuse or dependence during the Intake Period.

Follow the steps below to identify the eligible population, which is the denominator for both rates.

Step 1

Identify the Index Episode. Identify all members in the specified age range who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:
  - IET Stand Alone Visits Value Set ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
  - IET Visits Group 1 Value Set ***with*** IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- IET Visits Group 2 Value Set ***with*** IET POS Group 2 Value Set and ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- OUD Weekly Non Drug Service Value Set ***with*** Opioid Abuse and Dependence Value Set.
- OUD Monthly Office Based Treatment Value Set ***with*** Opioid Abuse and Dependence Value Set.
- OUD Weekly Drug Treatment Service Value Set ***with*** Opioid Abuse and Dependence Value Set.

- A detoxification visit (Detoxification Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An ED visit (ED Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An observation visit (Observation Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An acute or nonacute inpatient discharge ***with*** one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the discharge date for the stay.
- A telephone visit (Telephone Visits Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An e-visit or virtual check-in (Online Assessments Value Set) ***with*** one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set).

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Step 2 Select the Index Episode and stratify based on age and AOD diagnosis cohort.

- If the member has a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), place the member in the alcohol cohort.
- If the member has a diagnosis of opioid abuse of dependence (Opioid Abuse and Dependence Value Set), place the member in the opioid cohort.
- If the member has a drug abuse or dependence that is neither for opioid or alcohol (Other Drug Abuse and Dependence Value Set), place the member in the other drug cohort.

If the member has multiple substance use diagnosis for the visit, report the member in all AOD diagnosis stratifications for which they meet criteria.

The total is not a sum of the diagnosis cohorts. Count members in the total denominator rate if they had at least one alcohol, opioid or other drug abuse or dependence diagnosis during the measurement period. Report member with multiple diagnoses during the Index Episode only once for the total rate for the denominator.

Step 3 Test for Negative Diagnosis History. Exclude members who had a claim/ encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.

For an inpatient IESD, use the admission date to determine the 60-day Negative Diagnosis History period.

For ED or observation visits that result in an inpatient stay, use the earliest date of service (either the ED/observation date of service or the inpatient admission date) to determine the Negative Diagnosis History.

Step 4 Calculate continuous enrollment. Members must be continuously enrolled for 60 days (2 months) before the IESD through 47 days after the IESD (108 total days), with no gaps.

Exclusions:

- Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Alcohol Use Disorder Treatment Medications List; Opioid Use Disorder Treatment Medications List) during the 60 days (2 months) before the IESD.
- Exclude if used hospice during the measurement period (Hospice Encounter, Hospice Intervention Value Set).

Result:
The result is expressed as a percentage.

INPATIENT UTILIZATION—GENERAL HOSPITAL/ACUTE CARE (IPU)

Measure Description:

The rate of members 19–64 years of age who utilized acute inpatient care and services in the following categories:

- Maternity
- Surgery
- Medicine

- Total Inpatient (the sum of Maternity, Surgery, and Medicine)

Note: Final Outputs are Discharges per 1,000 Member Months, Days per 1,000 Member Months, and Average Length of Stay.

Data Source: **MMIS,**	NQF #: **N/A**
Measure Steward: **NCQA**	Measure Steward Version: **HEDIS MY 2020 & MY 2021**
Population(s): Adult Expansion	Stratifications: Plan Type, Age, Gender, Race/Ethnicity

Numerator:
The following steps identify and categorize inpatient discharges.

Step 1 Identify all acute inpatient discharges between 7/1/19 – 6/30/20 of the measurement year. To identify acute inpatient discharges: Include surgery in this step and remove in later step

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Pt 1b. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.
2.

Step 2 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) on the discharge claim.

Step 3 Report total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4 Report maternity. A delivery is not required for inclusion in the Maternity category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

3.

Step 5 Report surgery (Surgery Value Set).

Step 6 Report medicine. Categorize as medicine the discharges remaining after removing maternity (identified in step 4) and surgery (identified in step 5) from total inpatient (identified in step 3).

Denominator:

Member months For each table, report all member months for the measurement year. Refer to *Specific Instructions for Utilization Tables* for more information.

Additional calculations:

Days	Count all days associated with the identified discharges. Report days for total inpatient, maternity, surgery and medicine.
ALOS	Refer to *Specific Instructions for Utilization Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

Exclusions:

Members in hospice are excluded from this measure

Result:
The result is expressed as a percentage.

LOW-VALUE CARE: HEAD IMAGING FOR HEADACHE

Measure Description:
Rate of utilization of services identified as low value by the American Board of Internal Medicine (ABIM)/ Milliman Waste Calculator. Low value service is head imaging for headache, without additional indicators.

- Inappropriate antibiotic prescriptions

Data Source(s):	NQF #:
MMIS, APCD	**N/A**
Measure Steward:	Measure Steward Version:
MA Health Policy Commission	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Step1: Identify the low value service claims.

Brain CT/MRI with non-post-traumatic, non-thunderclap headache diagnosis. (CPT: 70450,70460, 70470, 70551-70553**)**

Step 2: Exclude diagnoses in claim warranting imaging.

Step 3: Report as a rate.

Denominator:

Patients with uncomplicated Headache or Migraine. (ICD-9: 30781 339xx 346x 7840)

Exclusions:

No diagnoses in claim warranting imaging. Exclusion diagnoses include epilepsy, giant cell arteritis, head trauma, convulsions, altered mental status, nervous system symptoms (e.g., hemiplegia), disturbances of skin sensation, speech problems, stroke/TIA, history of stroke, cancer or history of cancer. (CPT: 33920-33922 33943 14xx–208xx 230xx-239xx 3463x 3466x 4465 345xx 7803x 43xx 800xx-804xx 850xx-854xx 870xx-873xx 9590x 910xx 920xx-921xx 78097 781xx 7820 7845x 79953 V1254 V10xx)

Result:

The result is expressed as a rate.

LOW-VALUE CARE: PRE-OPERATIVE TESTING FOR CARDIAC STRESS TEST

Measure Description:
Rates of utilization of services identified as low value by the American Board of Internal Medicine (ABIM)/ Milliman Waste Calculator. Low value service is Pre-operative testing for cardiac stress test (low-risk non cardiac surgery).

Data Source(s):	NQF #:
MMIS, APCD	**N/A**
Measure Steward:	Measure Steward Version:
MA Health Policy Commission	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Step1: Identify the low value service claims.

Pre-operative testing for cardiac stress test: Stress testing CPT: 78451-78454 78460 78461 78464 78465 78472 78473 78481 78483 78491 78492 93015-93018 93350 93351

Step 2: Encounters were excluded from the initial population if the surgery claim occurred in the 30-day period following an inpatient admission or the 1-day period following an emergency department claim.

Step 3: Report as a rate.

Denominator:

Patients undergoing selected surgeries BETOS: p1x, P3D, P4A, P4B, P4C, P5C, P5D, P8A, P8G CPT: 19120 19125 47562 47563 49560 58558.

Exclusions:

Encounters were excluded from the initial population if the surgery claim occurred in the 30-day period following an inpatient admission or the 1-day period following an emergency department claim.

Result:

The result is expressed as a rate.

LOW-VALUE CARE: INAPPROPRIATE ANTIBIOTIC PRESCRIPTIONS

Measure Description:
Rate of utilization of services identified as low value by the American Board of Internal Medicine (ABIM)/ Milliman Waste Calculator. Low value service is Inappropriate antibiotic prescriptions.

Data Source(s):	NQF #:
MMIS, APCD	**N/A**
Measure Steward:	Measure Steward Version:
MA Health Policy Commission	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Step1: Identify the low value service claims.

Patients prescribed antibiotics. 2016 HEDIS Table ABX-A: Antibiotic Medications.

Step 2: Exclude patients with diagnoses of chronic bronchitis, emphysema, COPD, conditions where antibiotics are always indicated -miscellaneous bacterial infections, pneumonia, urinary tract infections (ICD-9 491 492 496 010-018 020-027 030-033 036-041 070-104 130-139 320-323 383 475 481 482 483 484 485 486 5901 5902 5908 5909 5950 5950 5990).

Step 3: Report as a rate.

Denominator:

Patients with diagnosis of acute sinusitis, pharyngitis, suppurative otitis media, bronchitis ICD-9: 461, 463, 462x, 382x, 490x, 466x.

Exclusions:

Patients with diagnoses of chronic bronchitis, emphysema, COPD, conditions where antibiotics are always indicated -miscellaneous bacterial infections, pneumonia, urinary tract infections (ICD-9 491 492 496 010-018 020-027 030-033 036-041 070-104 130-139 320-323 383 475 481 482 483 484 485 486 5901 5902 5908 5909 5950 5950 5990).

Result:

The result is expressed as a rate.

PATIENT SATISFACTION (CAHPS)

Measure Description:
CAHPS Patient Satisfaction Measures.

Data Source(s):	NQF #:
CAHPS Health Plan Adult Survey	**N/A**
Measure Steward:	Measure Steward Version:
AHRQ	5.0
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Questions:

Members of the eligible population who answered either Q26, Q16, and Q20 on the CAHPS Health Plan Adult Survey.

Q26: Respondent rating of their health plan, overall.

- 0-10

Q16: Respondent rating of their personal doctor

- 0-10

Q20: Respondent rating of specialist they saw most.

- 0-10

Result:

The result is expressed as a percentage.

PERSONAL CARE PROVIDER

Measure Description:
Fraction of Medicaid Beneficiaries who say they have one person they think of as their person doctor or provider.

Data Source(s):	NQF #:
BRFSS	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Numerator:

Members of the eligible population who answered yes to BRFSS Health Care Access question CHCA.03

Question CHA.02: Do you have one person you think of as your personal doctor or health care provider?

- 1 Yes
- 2 No
- 7 Don't know / Not sure
- 9 Refused

Denominator:

The total number of members within the eligible population.

Exclusions:

None.

Result:

The result is expressed as a percentage.

PRIMARY CARE ENGAGEMENT

Measure Description:
Time since last routine check up

Data Source(s):	NQF #:
BRFSS	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

Survey Question:

Members of the eligible population who answered yes to BRFSS Health Care Access question CHCA.03

Question CHA.04: About how long has it been since you last visited a doctor for a routine checkup?

- 1. Within the year (anytime less than 12 months ago)
- 2. Within the past 2 years (1 year but less than 2 years ago)
- 3. Within the past 5 years (2 years but less than 5 years ago)
- 4. 5 or more years ago
- 7. Don't know/Not sure
- 8. Never
- 9. Refused

Result:

The result is expressed as a percentage.

QUALITATIVE MEASURES
IMPLEMENTATION

Measure Description:
Description of implementation challenges and successes as well as the Public Health Emergency's/Covid-19 pandemic's impact on implementation.

Data Source(s):	NQF #:
Key Informant Interviews (KII)	**N/A**
Measure Steward:	Measure Steward Version:
N/A	**N/A**
Population(s):	Stratifications:
Adult Expansion	Plan Type

KII interview guide is in development.

Appendix A: Value Code Sets by Measure

Adults' Access to Preventative/Ambulatory Health Services (AAP)

Value Set Name	Value Set OID
Ambulatory Visits	2.16.840.1.113883.3.464.1004.1022
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Other Ambulatory Visits	2.16.840.1.113883.3.464.1004.1198
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

Annual Monitoring for Patients on Persistent Medications (MPM)

Value Set Name	Value Set OID
Acute Inpatient	2.16.840.1.113883.3.464.1004.1017
Lab Panel	2.16.840.1.113883.3.464.1004.1145
Nonacute Inpatient	2.16.840.1.113883.3.464.1004.1189
Serum Creatinine	2.16.840.1.113883.3.464.1004.1236
Serum Potassium	2.16.840.1.113883.3.464.1004.1237

Antidepressant Medication Management (AMM)

Value Set Name	Value Set OID
Acute Inpatient	2.16.840.1.113883.3.464.1004.1810
BH Outpatient	2.16.840.1.113883.3.464.1004.1481
Community Mental Health Center POS	2.16.840.1.113883.3.464.1004.1484
ED	2.16.840.1.113883.3.464.1004.1086
ED POS	2.16.840.1.113883.3.464.1004.1087
Electroconvulsive Therapy	2.16.840.1.113883.3.464.1004.1294
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Major Depression	2.16.840.1.113883.3.464.1004.1166
Nonacute Inpatient	2.16.840.1.113883.3.464.1004.1189
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Outpatient POS	2.16.840.1.113883.3.464.1004.1443
Partial Hospitalization or Intensive Outpatient	2.16.840.1.113883.3.464.1004.1492
Partial Hospitalization POS	2.16.840.1.113883.3.464.1004.1491
Telehealth POS	2.16.840.1.113883.3.464.1004.1460
Telephone Visits	2.16.840.1.113883.3.464.1004.1246
Transcranial Magnetic Stimulation	2.16.840.1.113883.3.464.1004.1486

Comprehensive Diabetes Care (CDC)

Value Set Name	Value Set OID
Acute Inpatient	2.16.840.1.113883.3.464.1004.1810
Advanced Illness	2.16.840.1.113883.3.464.1004.1465
Bilateral Modifier	2.16.840.1.113883.3.464.1004.1043
CKD Stage 4	2.16.840.1.113883.3.464.1004.1052
Diabetes	2.16.840.1.113883.3.464.1004.1077
Diabetes Exclusions	2.16.840.1.113883.3.464.1004.1105
Diabetes Mellitus Without Complications	2.16.840.1.113883.3.464.1004.1407
Diabetic Retinal Screening	2.16.840.1.113883.3.464.1004.1078
Diabetic Retinal Screening Negative In Prior Year	2.16.840.1.113883.3.464.1004.1079
Dialysis Procedure	2.16.840.1.113883.3.464.1004.1952
Diastolic 80-89	2.16.840.1.113883.3.464.1004.1082
Diastolic Blood Pressure	2.16.840.1.113883.3.464.1004.1965
Diastolic Greater Than or Equal To 90	2.16.840.1.113883.3.464.1004.1083
Diastolic Less Than 80	2.16.840.1.113883.3.464.1004.1084
ED	2.16.840.1.113883.3.464.1004.1086
ESRD Diagnosis	2.16.840.1.113883.3.464.1004.1747
Eye Exam With Evidence of Retinopathy	2.16.840.1.113883.3.464.1004.2229
Eye Exam Without Evidence of Retinopathy	2.16.840.1.113883.3.464.1004.2230
Frailty Device	2.16.840.1.113883.3.464.1004.1530

Frailty Diagnosis	2.16.840.1.113883.3.464.1004.1531
Frailty Encounter	2.16.840.1.113883.3.464.1004.1532
Frailty Symptom	2.16.840.1.113883.3.464.1004.1533
HbA1c Lab Test	2.16.840.1.113883.3.464.1004.1755
HbA1c Level Greater Than 9.0	2.16.840.1.113883.3.464.1004.1114
HbA1c Level Greater Than or Equal To 7.0 and Less Than 8.0	2.16.840.1.113883.3.464.1004.1976
HbA1c Level Greater Than or Equal To 8.0 and Less Than or Equal To 9.0	2.16.840.1.113883.3.464.1004.1977
HbA1c Level Less Than 7.0	2.16.840.1.113883.3.464.1004.1115
HbA1c Test Result or Finding	2.16.840.1.113883.3.464.1004.1756
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Kidney Transplant	2.16.840.1.113883.3.464.1004.1141
Nephrectomy	2.16.840.1.113883.3.464.1004.1909
Nephropathy Treatment	2.16.840.1.113883.3.464.1004.1184
Nonacute Inpatient	2.16.840.1.113883.3.464.1004.1189
Nonacute Inpatient Stay	2.16.840.1.113883.3.464.1004.1398
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Outpatient	2.16.840.1.113883.3.464.1004.1202
Palliative Care Assessment	2.16.840.1.113883.3.464.1004.2225

Palliative Care Encounter	2.16.840.1.113883.3.464.1004.1450
Palliative Care Intervention	2.16.840.1.113883.3.464.1004.2224
Remote Blood Pressure Monitoring	2.16.840.1.113883.3.464.1004.1469
Systolic Blood Pressure	2.16.840.1.113883.3.464.1004.1964
Systolic Greater Than or Equal To 140	2.16.840.1.113883.3.464.1004.1242
Systolic Less Than 140	2.16.840.1.113883.3.464.1004.1243
Telehealth Modifier	2.16.840.1.113883.3.464.1004.1445
Telehealth POS	2.16.840.1.113883.3.464.1004.1460
Telephone Visits	2.16.840.1.113883.3.464.1004.1246
Unilateral Eye Enucleation	2.16.840.1.113883.3.464.1004.1454
Unilateral Eye Enucleation Left	2.16.840.1.113883.3.464.1004.1455
Unilateral Eye Enucleation Right	2.16.840.1.113883.3.464.1004.1456
Urine Protein Tests	2.16.840.1.113883.3.464.1004.1400

PMPM Cost of Care

Value Set Name	**Value Set OID**
Acute Inpatient	2.16.840.1.113883.3.464.1004.1810
Ambulatory Visits	2.16.840.1.113883.3.464.1004.1022
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Online Assessments	2.16.840.1.113883.3.464.1004.1446

Other Ambulatory Visits	2.16.840.1.113883.3.464.1004.1198
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

Emergency Department Utilization (EDU)

Value Set Name	Value Set OID
Acute Inpatient	2.16.840.1.113883.3.464.1004.1810
ED	2.16.840.1.113883.3.464.1004.1086
ED POS	2.16.840.1.113883.3.464.1004.1087
ED Procedure Code	2.16.840.1.113883.3.464.1004.1088
Electroconvulsive Therapy	2.16.840.1.113883.3.464.1004.1294
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Mental and Behavioral Disorders	2.16.840.1.113883.3.464.1004.1300
Nonacute Inpatient	2.16.840.1.113883.3.464.1004.1189
Observation	2.16.840.1.113883.3.464.1004.1191
Observation Stay	2.16.840.1.113883.3.464.1004.1461
Outpatient	2.16.840.1.113883.3.464.1004.1202
Psychiatry	2.16.840.1.113883.3.464.1004.1272
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

Follow Up After Hospitalization for Mental Illness (FUH)

Value Set Name	Value Set OID
Ambulatory Surgical Center POS	2.16.840.1.113883.3.464.1004.1480

Behavioral Healthcare Setting	2.16.840.1.113883.3.464.1004.2214
BH Outpatient	2.16.840.1.113883.3.464.1004.1481
Community Mental Health Center POS	2.16.840.1.113883.3.464.1004.1484
Electroconvulsive Therapy	2.16.840.1.113883.3.464.1004.1294
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Intentional Self-Harm	2.16.840.1.113883.3.464.1004.1468
Mental Health Diagnosis	2.16.840.1.113883.3.464.1004.1178
Mental Illness	2.16.840.1.113883.3.464.1004.1179
Nonacute Inpatient Stay	2.16.840.1.113883.3.464.1004.1398
Observation	2.16.840.1.113883.3.464.1004.1191
Outpatient POS	2.16.840.1.113883.3.464.1004.1443
Partial Hospitalization or Intensive Outpatient	2.16.840.1.113883.3.464.1004.1492
Partial Hospitalization POS	2.16.840.1.113883.3.464.1004.1491
Telehealth POS	2.16.840.1.113883.3.464.1004.1460
Telephone Visits	2.16.840.1.113883.3.464.1004.1246
Transitional Care Management Services	2.16.840.1.113883.3.464.1004.1462
Visit Setting Unspecified	2.16.840.1.113883.3.464.1004.1493

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)

Value Set Name	**Value Set OID**
Alcohol Abuse and Dependence	2.16.840.1.113883.3.464.1004.1424
AOD Abuse and Dependence	2.16.840.1.113883.3.464.1004.1013

AOD Medication Treatment	2.16.840.1.113883.3.464.1004.2017
Detoxification	2.16.840.1.113883.3.464.1004.1076
ED	2.16.840.1.113883.3.464.1004.1086
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
IET POS Group 1	2.16.840.1.113883.3.464.1004.1129
IET POS Group 2	2.16.840.1.113883.3.464.1004.1130
IET Stand Alone Visits	2.16.840.1.113883.3.464.1004.1131
IET Visits Group 1	2.16.840.1.113883.3.464.1004.1132
IET Visits Group 2	2.16.840.1.113883.3.464.1004.1133
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Observation	2.16.840.1.113883.3.464.1004.1191
Online Assessments	2.16.840.1.113883.3.464.1004.1446
Opioid Abuse and Dependence	2.16.840.1.113883.3.464.1004.1425
Other Drug Abuse and Dependence	2.16.840.1.113883.3.464.1004.1426
OUD Monthly Office Based Treatment	2.16.840.1.113883.3.464.1004.2220
OUD Weekly Drug Treatment Service	2.16.840.1.113883.3.464.1004.2221
OUD Weekly Non-Drug Service	2.16.840.1.113883.3.464.1004.2222
Telephone Visits	2.16.840.1.113883.3.464.1004.1246

Inpatient Utilization—General Hospital/Acute Care (IPU)

Value Set Name	Value Set OID
Deliveries Infant Record	2.16.840.1.113883.3.464.1004.1073
Hospice Encounter	2.16.840.1.113883.3.464.1004.1761
Hospice Intervention	2.16.840.1.113883.3.464.1004.1762
Inpatient Stay	2.16.840.1.113883.3.464.1004.1395
Maternity	2.16.840.1.113883.3.464.1004.1169
Maternity Diagnosis	2.16.840.1.113883.3.464.1004.1170
Mental and Behavioral Disorders	2.16.840.1.113883.3.464.1004.1300
Nonacute Inpatient Stay	2.16.840.1.113883.3.464.1004.1398
Surgery	2.16.840.1.113883.3.464.1004.1241