



Office of the Governor

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

July 31, 2019

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

Dear Secretary Azar,

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

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

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

While the State of Utah has been able to allocate existing resources to accommodate current Medicaid needs and has authorized an increase in sales tax to fund this waiver request, it may not be practicable in the State of Utah for Medicaid expenditures to continue to grow as a share of available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a

reliable long-term funding source for the program absent additional budgetary flexibilities. Therefore, due to the current and potential budget conditions that may arise in the State of Utah, this waiver proposal includes a request that the State can cap enrollment based on available state appropriations.

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

On July 27, 2019, the Centers for Medicare and Medicaid Services (CMS) released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely that you will use your authority at this time to allow enhanced funding for an expansion up to 100 percent of the federal poverty level (FPL), the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

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

Second, the State believes there is value in getting a formal response from CMS on the State's waiver request. Over the last several years, the State has discussed multiple proposals with CMS and submitted a waiver request for enhanced match for partial expansion. These discussions have elicited verbal feedback from the administration which the State believed were helpful in crafting its proposals. However, a more formal response from CMS would best serve the State in knowing where this administration is positioned on key items contained in the State's waiver request.

Finally, the State's waiver request also contains many other program-features beyond the request for enhanced match for expansion up to 100 percent FPL. The State believes that obtaining a response from CMS on these other features will help the State in constructing the next waiver request envisioned by Senate Bill 96.

In summary, this waiver request includes the following new proposals for Utah's Medicaid Expansion:

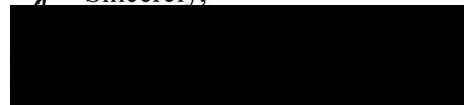
- Authority to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion demonstration group, which will include the Targeted Adult demonstration group, as well as any components approved for this population
- A per capita cap funding mechanism
- Lock out from the Medicaid expansion program for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports
- Up to 12-months continuous eligibility
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion demonstration group
- Additional flexibility for providing managed care.

The State is also requesting to administer the following components and programs under this new waiver application, which are currently authorized under the State's 1115 Primary Care Network (PCN) Demonstration Waiver:

- Adult Expansion Population, which are adults age 19-64 who have household income up to 95 percent FPL using the modified adjusted gross income (MAGI) methodology, which includes a 5 percent of FPL disregard
- Targeted Adult Medicaid Population, including state plan dental benefits provided to Targeted Adults who are receiving Substance Use Disorder (SUD) treatment
- Clinically Managed Residential Withdrawal Pilot for the populations covered under this waiver application
- Substance Use Disorder treatment provided in an Institution for Mental Disease (IMD) for the populations covered under this waiver application
- Implementing a community engagement requirement for the Adult Expansion population
- Authorizing the ability for the State to impose an enrollment cap
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20-year-old adults
- Requiring individuals with employer-sponsored insurance to enroll in the available insurance.

The State of Utah appreciates your consideration of this waiver request. If there are portions of this request that CMS is not willing to approve at this time, I ask that you provide a written response to the State in a timely manner so that the State can effectively continue its efforts to provide coverage for those in the ACA coverage gap in a way that is practicable for the State. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Expansion program.

Sincerely,



Gary R. Herbert
Governor



Utah 1115 Demonstration Waiver Application
Per Capita Cap

July 31, 2019

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Utah Section 1115 Demonstration Application

Per Capita Cap

Section I. Program Description and Objectives

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

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

- Authority to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion demonstration group, which will include the Targeted Adult demonstration group, as well as any components approved for this population
- A per capita cap funding mechanism
- Lock out from the Medicaid expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports
- Up to 12-months continuous Medicaid eligibility
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion demonstration group
- Additional flexibility for providing managed care

The State is also requesting to administer the following components and programs under this new waiver application, which are currently authorized under the State’s 1115 Primary Care Network (PCN) Demonstration Waiver:

- Adult Expansion Population, which are adults age 19-64 who have household income up to 95 percent of the federal poverty level (FPL) using the modified adjusted gross income (MAGI) methodology, which includes a five percent of FPL disregard
- Targeted Adult Medicaid Population, including state plan dental benefits provided to Targeted Adults who are receiving Substance Use Disorder (SUD) treatment
- Clinically Managed Residential Withdrawal Pilot for the populations covered under this waiver application
- Substance Use Disorder treatment provided in an Institution for Mental Disease (IMD) for the populations covered under this waiver application

- Implementing a community engagement requirement for the Adult Expansion Population
- Authorizing the ability for the State to impose an enrollment cap
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults
- Requiring individuals with employer-sponsored insurance to enroll in the available insurance.

Components and demonstration populations authorized under the State's 1115 PCN Demonstration Waiver that are not indicated above as transitioning to the new Per Capita Cap waiver will remain in the State's current 1115 PCN Demonstration Waiver.

The proposals included in this request will apply only to the Adult Expansion Population described in Section II. "Program Overview and Demonstration Eligibility" below, unless otherwise noted. With this application, the State is requesting the Targeted Adult Population be considered a subgroup of the Adult Expansion Population, thus including Targeted Adults in the Adult Expansion Population.

The table below summarizes the new requests included in this waiver application. It also includes currently approved 1115 PCN Demonstration Waiver populations and components the State is requesting to transition to this application, as well as approved populations and components remaining the 1115 PCN Demonstration Waiver.

Table 1: Summary List of Waiver Requests

New Waiver Requests	Approved 1115 PCN Waiver Populations/ Components Transitioning to this Waiver	Approved 1115 PCN Waiver Populations/ Components Remaining in the 1115 PCN Waiver	Approved 1115 PCN Waiver Populations/ Components Remaining in the 1115 PCN Waiver for other Medicaid Members
<ul style="list-style-type: none"> ● Authority to Receive Increased FMAP ● Per Capita Cap Funding Mechanism ● Lock-Out for Intentional Program Violation ● Housing-Related Supports and Services ● Up to 12-Months 	<ul style="list-style-type: none"> ● Adult Expansion Population ● Targeted Adult Population, including dental benefits for Targeted Adults who qualify for dental ● Clinically Managed Residential Withdrawal Pilot (Adult Expansion and Targeted Adults only) ● Substance Use Disorder Treatment Benefits (Adult 	<ul style="list-style-type: none"> ● Current Eligibles ● Demonstration Population III (Utah's Premium Partnership for Health Insurance - UPP) ● Demonstration Population V & VI (UPP COBRA) ● Dental Benefits for Individuals who are Blind or Disabled ● Former Foster Care 	<ul style="list-style-type: none"> ● Substance Use Disorder Treatment Benefits (Medicaid Members other than Adult Expansion and Targeted Adults) ● Clinically Managed Residential Withdrawal Pilot (Medicaid Members other than Adult Expansion and

Continuous Eligibility	Expansion and Targeted Adults only)	Youth From Another State	Targeted Adults)
<ul style="list-style-type: none"> • Not Allowing Presumptive Eligibility Determined by a Hospital • Managed Care Flexibilities 	<ul style="list-style-type: none"> • Community Engagement Requirement • Enrollment Limits • Waiver of Early and Periodic Screening, Diagnostic and Treatment • Employer Sponsored Insurance Requirement 	<ul style="list-style-type: none"> • Services for High Risk Youth (Request Pending with CMS) • Dental Benefits for Individuals Age 65 and Older (Request to be Submitted in June 2019) 	

Table 1

A. Goals and Objectives

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

- Providing health care coverage for low-income Utahns that would not otherwise have access to, or be able to afford health care coverage
- Improving participant health outcomes and quality of life
- Lowering the uninsured rate of low income Utahns
- Supporting the use of employer-sponsored insurance by encouraging community engagement and providing premium reimbursement for employer-sponsored health plans
- Providing continuity of coverage for individuals
- Providing fiscal sustainability through new financing models and state flexibility

Approval of this Demonstration will allow the State to provide coverage to uninsured adults who have limited options for affordable health coverage. These individuals fall in the coverage gap because their incomes are below 100 percent FPL and therefore are not eligible for subsidies to purchase coverage through the Marketplace.

The program components contained in this waiver application, both new and those transitioning from the State’s 1115 PCN Demonstration Waiver, will be implemented together to meet the proposed goals and objectives listed above. This demonstration will allow the State to test the effectiveness of policy that is designed to improve health outcomes of demonstration individuals, as well as promote their financial

independence. The Demonstration will provide the needed support of up to 12-months continuous Medicaid eligibility and housing supports and services, while encouraging individuals to obtain or sustain employment.

B. Operation and Proposed Timeframe

The Demonstration will operate statewide. The State intends to implement the Demonstration as soon as possible after receiving CMS approval, and is targeting an October 1, 2019 implementation. The State requests a five-year approval period for this Demonstration.

Section II. Program Overview and Demonstration Eligibility

A. Approved Demonstration Populations and Components

As stated above, the State is requesting to administer the following components and programs under this new waiver application, which are currently authorized under the State's 1115 PCN Demonstration Waiver:

1. Adult Expansion Population

The State proposes to administer the Adult Expansion Population under this waiver application. Individuals eligible for this demonstration group must meet the following criteria:

- Adults ages 19 through 64
- A U.S. Citizen or qualified alien
 - Non-qualified non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
- A resident of Utah
- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 95 percent of FPL using the MAGI methodology which includes a five percent FPL disregard
- Ineligible for other Medicaid programs that do not require a spenddown to qualify
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act

Under this demonstration application, the State does not intend to apply 42 CFR § 435.119(c)(1), which states that a State may not provide Medicaid coverage under this section to a parent or other caretaker relative living with a dependent child under the age of 19 unless the child is receiving Medicaid, the Children's Health Insurance Program (CHIP), or otherwise enrolled in minimum essential coverage. The State is seeking this exception with the goal of reducing unintentional churn for parents and caretaker relatives should their children lose coverage for administrative reasons. When a family applies for coverage, the State believes both parents and children should be considered for medical programs.

2. Targeted Adult Population

The State requests authority to administer the Targeted Adult Population under this new waiver application, including the provision to allow 12-months continuous eligibility, as approved under the State's 1115 PCN Demonstration Waiver. Individuals eligible for the Targeted Adult subgroup must meet the following criteria:

- Adults age 19-64, without a dependent child
- A U.S. Citizen or qualified alien
- A resident of Utah, and not in a public institution

- Household income at or below five percent of the FPL
- Ineligible for other Medicaid programs that do not require a spenddown
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Must also meet at least one of the following criteria:
 - Chronically homeless- this is defined as: (1) living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12- months or on at least 4 separate occasions in the last 3 years; and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability; or (2) currently living in supportive housing, but who has previously met the definition of chronically homeless defined in (1).
 - Involved in the justice system AND in need of substance use or mental health treatment- this is defined as: (1) an individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in Utah Administrative Code); (2) an individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or (3) an individual involved in a Drug Court or Mental Health Court, including Tribal courts.
 - Needing substance abuse or mental health treatment- this is defined as: (1) An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for 6 months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder; (2) an individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder. The General Assistance program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; or (3) an individual discharged from the State Hospital who was civilly committed.

3. Targeted Adult Dental Benefits

The State also requests authority under this new demonstration application to continue to administer dental benefits for individuals who are eligible for the Targeted Adult Population, and who are actively receiving substance use disorder treatment. This benefit is currently authorized under the State's 1115 PCN Demonstration Waiver. In order to be eligible for dental benefits, individuals must:

- Be eligible for the Targeted Adult demonstration group
- Be actively receiving treatment for a substance use disorder as defined in Utah State Code Section 40 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

Dental benefits for this group are delivered through a fee for service payment model, and by contracting with an entity that:

- Has demonstrated experience working with individuals who are being treated for both a substance use disorder and a major oral health disease;
- Operates a program, targeted at the individuals described in this amendment, that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals;
- Is willing to pay for an amount equal to the program's non-federal share of the cost of providing dental services to the population described.

Benefits

Individuals eligible for dental benefits under this demonstration will receive state plan dental benefits.

4. Clinically Managed Residential Withdrawal Pilot

Clinically managed residential withdrawal management services are currently approved in the State's 1115 PCN Demonstration Waiver for all Medicaid eligible adults residing in Salt Lake County. As part of this waiver request, the State proposes to provide these services for the Adult Expansion and Targeted Adult Populations residing in Salt Lake County through this new waiver. For all other eligible adults, these services will continue to be provided under the State's 1115 PCN Demonstration Waiver. The service will be provided to Medicaid eligible adults residing in Salt Lake County, through Volunteers of America's Adult Detoxification Center and Center for Women and Children (VOA).

Benefits

The specific withdrawal management services provided include:

- Assessment of substance use disorder and treatment needs
- Observation of the beneficiary's course of withdrawal
- Medication services
- Psychoeducation services
- Discharge services to prepare for reentry into the community.

5. Substance Use Disorder Treatment

The State currently has approval through its 1115 PCN Demonstration Waiver to administer a benefit package for all Medicaid recipients that includes substance use disorder treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The State is eligible to receive Federal Financial Participation (FFP) for Medicaid recipients residing in an IMD under the terms of the demonstration for coverage of medical assistance and SUD benefits, which would otherwise be matchable if the recipient were not residing in an IMD. This benefit is available to all Medicaid eligible individuals, including those in the Adult Expansion and Targeted Adult Populations.

With this application, the State is requesting to administer this benefit package under this demonstration application for the Adult Expansion and Targeted Adult Populations. The State requests to continue to administer this benefit package for all other eligible Medicaid groups, as well as all required reporting requirements, under the approved 1115 PCN Demonstration Waiver.

Benefits

Under this demonstration, beneficiaries will receive the following SUD services:

- Early intervention (Screening, Brief Intervention and Referral to Treatment)
- Outpatient therapy
- Intensive outpatient program
- Partial hospitalization treatment
- Residential treatment
- Withdrawal management
- Medication-assisted treatment (MAT)
- Peer support
- Crisis intervention
- Residential crisis stabilization.

6. Enrollment Limits

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

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

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

Enrollment Limit Exception

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

Impact to Enrollment

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

Individuals already enrolled in the Demonstration at the time enrollment is closed will remain enrolled.

7. Community Engagement through a Self Sufficiency Requirement

With this waiver application, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion Population, not to include Targeted Adults. The community engagement requirement was originally approved for this population, as part of the Medicaid expansion authorized in the March 29, 2019 amendment to the State's 1115 PCN Demonstration Waiver. The community engagement requirement applies to Adult Expansion individuals who do meet an exemption and do not show good cause, as outlined in the sections below. Participation requirements and activities are outlined in the "Community Engagement Participation" section below.

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

Community Engagement Exemptions

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

1. Age 60 or older;
2. Pregnant or up to 60 days postpartum;
3. Physically or mentally unable to meet the requirements as determined by a medical professional or documented through other data sources;
4. A parent or other member of household with the responsibility to care for a dependent child under age six;
5. Responsible for the care of a person with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act ;
6. A member of a federally recognized tribe;

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

7. Has applied for and is awaiting an eligibility determination, or is currently receiving unemployment insurance benefits, and has registered for work at DWS;
8. Participating regularly in a substance use disorder treatment program, including intensive outpatient treatment;
9. Enrolled at least half time in any school (including, but not limited to, college or university) or vocational or apprenticeship program;
10. Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;
11. State Family Employment Program (FEP) recipients who are working with an employment counselor;
12. Beneficiaries in compliance with or who are exempt from SNAP and/or TANF employment requirements; or
13. Working at least 30 hours a week, or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.

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

Community Engagement Participation

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

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

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

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

Closure Due to Non-Participation

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

The following will apply:

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

Regaining Eligibility

- Individuals who lose eligibility may become eligible again by completing all required activities OR by meeting an exemption.
- After completing all required participation activities, the individual must reapply for Medicaid. Benefits will be effective the first day of the month in which they reapply.
- As long as the individual applies for benefits in the month following the month they complete all required activities, open enrollment requirements will not apply if enrollment limits are approved under this Demonstration.
- If the individual meets the qualifications for an exemption or demonstrates good cause for the earlier non-compliance, or becomes eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement, the individual can re-enroll immediately and their eligibility will have an effective date of the first of the month of application

Good Cause Exemptions

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

1. The individual has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the individual or an immediate family member who was living in the home with the individual experiences a hospitalization or serious illness;
2. The individual experiences the birth, or death of a family member living with the individual;
3. The individual experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
4. The individual has a family emergency or other life-changing event (e.g. divorce or domestic violence);
5. The individual is not able to participate due to a lack of internet or transportation;
6. There are fewer than 48 employers in the individual's geographic area that potentially could offer employment to the individual or from whom the individual reasonably could be expected to accept an offer of employment; in this case the number of required employer contacts shall be reduced to an appropriate level so that the individual is not required to make applications for employment that would likely be futile;
7. The individual is the primary caretaker of a child age 6 or older and is unable to meet the requirement due to childcare responsibilities.

Reasonable Modifications

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

Beneficiary Supports

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

Impact to Beneficiaries

Based on the State's experience with SNAP work requirements, the State estimates approximately 70 percent of Adult Expansion beneficiaries (49,000-63,000 individuals) will meet an exemption to community engagement participation. Among individuals who do not meet an exemption or good cause reason, the State projects that approximately 75-80 percent will comply with the community engagement requirements.

8. Employer Sponsored Insurance (ESI) Reimbursement

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

ESI Benefit Package

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

Qualified Plan

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

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

Verification of Coverage

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

Impact to Beneficiaries

The State estimates that approximately 10,000 to 14,000 individuals under this demonstration will be eligible for an employer plan and will enroll in that plan.

9. Early and Periodic Screening, Diagnostic, and Treatment

Through the State's 1115 PCN Waiver Demonstration, the State currently has authority to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for adults age 19 and 20 years old in the Adult Expansion and Targeted Adult Population. The State requests to continue this authority for the Adult Expansion and Targeted Adult Population, if approved under this demonstration application.

B. New Demonstration Waiver Requests

As stated previously, with this application the State is seeking approval to implement the following proposals as directed by Senate Bill 96. These proposals apply to the Adult Expansion Population, including the Targeted Adult subgroup, unless otherwise noted:

1. Authority to Receive Increased FMAP

The State is requesting a waiver of the income level specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to allow the State to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y), which is 93 percent for 2019, and 90 percent for 2020 and each year thereafter, for this Demonstration group. The State is requesting this waiver for the Adult Expansion demonstration group, which includes adults with dependent children with household income using the 2014 Parent Caretaker Relative income standard up to 95 percent of the FPL, and adults without dependent children with household income between zero percent and 95 percent of the FPL. The State is also requesting to include the Targeted Adult Population in this request.

2. Lock-Out due to Intentional Program Violation

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

An IPV is defined as:

- Knowingly making false or misleading statements;
- Misrepresenting, concealing or withholding facts;

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

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

The determination of an IPV is different from a determination of fraud. Fraud is a conviction made by the District Court on Intentional Program Violations of specified severity that the agency refers for criminal prosecution. For the purposes of medical assistance eligibility and public assistance, the definition of fraud is found in Title 76 Chapter 8 Section 1205 of the Utah Code Annotated. The agency makes fraud referrals when evidence clearly shows an intent to fraud and the situation meets one of the following additional criteria:

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

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

Process to Determine IPV Lock-Out

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

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

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

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

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

1. Overpayment amount and time period of the overpayment
2. Evidence used in the decision
3. The date the disqualification will begin and end
4. Additional appeal rights to have the order set aside.

Lock-Out Period

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

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

Exemptions from IPV Lock-Out:

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

1. If the individual becomes eligible for another Medicaid program, the lock-out will end as of the first of the month the individual becomes eligible for that program. (Example: an individual becomes pregnant or moves to Disabled Medicaid).
2. The individual may request an undue hardship if a medical practitioner determines lack of medical care places the individual’s life in jeopardy or in danger of permanent disability.
 - a. The agency will notify the individual of the option to contact the State Medicaid agency to claim undue hardship.
 - b. The State Medicaid agency must receive verification of the reason the undue hardship exists.
 - c. The State Medicaid agency will make the determination of whether to grant a hardship exemption.

- d. If a hardship exemption is granted, the State Medicaid agency will notify DWS to not apply the lock-out.

Enrollment Limit and IPV Lock-Out

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

Impact to Beneficiaries and how this Modifies Medicaid Programs

The implementation of this proposal may cause approximately 500 individuals per year to lose eligibility for six-months as a result of committing an IPV. The State anticipates this may be a deterrent to individuals committing an IPV. Currently, the State does not impose a lock-out as a result of committing an IPV for any Medicaid program. This would allow the State to implement a new policy for a specific Medicaid population.

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

3. Housing Related Services and Supports

Background Information

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

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

For initial implementation, the State intends the Targeted Adult Population to be one of the groups that will receive these evidence-based services and supports. In addition, The State's efforts to reduce barriers that impact individuals' health will initially focus on providing housing related services and supports to eligible populations.

Housing Related Services and Supports (HRSS) will be available to identified populations, but participation is voluntary. Individuals' ongoing need for HRSS will be verified every six months.

Housing Related Services and Supports Definitions

The State intends to offer the following HRSS:

1. ***Tenancy Support Services*** – are services provided directly to eligible members that include:
 - a. Conducting a tenant screening and housing assessment to identify the member's preferences (e.g., housing type, location, living alone or with someone else, identifying a roommate, accommodations needed, etc.) and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;
 - b. In collaboration with the eligible member, developing an individualized housing support plan based on the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;
 - c. Participating in person centered planning meetings to assist the member to develop a housing support plan
 - i. Assisting the member to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers;
 - d. Assisting with the housing application process, and selection process, including filling out housing applications and obtaining and submitting appropriate documentation;
 - e. Assisting the member to complete reasonable accommodation requests as needed to obtain housing;
 - f. Assisting with the housing search process;
 - g. Identifying available resources to cover expenses such as rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;
 - h. Ensuring that the living environment is safe and ready for move-in;
 - i. Assisting in, arranging for and supporting the details of the move;
 - j. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized;

- k. Connecting the member to education and training on tenants' and landlords' role, rights, and responsibilities;
- l. Assisting in reducing risk of eviction by providing services that help the member improve conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicate with landlords and neighbors to reduce the risk of eviction; address biopsychosocial behaviors that put housing at risk; and provide ongoing support with activities related to household management;
- m. Assistance with housing voucher or subsidy applications and recertification processes.

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

2. **Community Transition Services** – are services provided to assist an eligible member to secure, establish, and maintain a safe and healthy living environment. Service includes:
 - a. One-time purchase of essential household items and services needed to establish basic living arrangements in a community setting, to include basic furnishings, kitchen, bathroom and cleaning equipment and goods;
 - b. One-time payment of a security deposit and the first and last month's rent, when a member moves to a new residence. The State will impose a maximum of two such payments per member during the pilot period. The State seeks authority to cover the first and last month's rent because expecting both the first, and last month's rent is a ubiquitous requirement in Utah's extremely competitive housing market. The services would also include payment of one-time, non-refundable fees to submit rental applications, establish utility services and other services essential to the operation of the residence.

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

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

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

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

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

- a. Health and Medical Services—Routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services;

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

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

Eligibility for Housing Related Services and Supports

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

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

Table 2

2. The following table identifies populations eligible for individual HRSS

Populations Eligible for Individual Housing Related Services and Supports		
Tenancy Support Services	Community Transition Services	Supportive Living/Supportive Housing Services
All individuals must meet at least one of the needs-based criteria identified in Table 2	All individuals must meet at least one of the needs-based criteria identified in Table 2	All individuals must meet at least one of the needs-based criteria identified in Table2
Individuals who do not have a Serious Mental Illness diagnosis <ul style="list-style-type: none"> Individuals with Serious Mental Illness currently have access to Tenancy Support Services (or component parts) through <i>Targeted Case Management for Individuals with Serious Mental Illness</i> Services available through the Medicaid State Plan 		Individuals who do not have a Serious Mental Illness diagnosis <ul style="list-style-type: none"> Individuals with Serious Mental Illness currently have access to Supported Living /Supportive Housing Services (or component parts) through 1915(b) authority through Utah’s Prepaid Mental Health Plans

Table 3

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

Impact to Beneficiaries and how this Modifies Medicaid Programs

As a growing body of evidence shows, social determinants, such as housing instability, play a significant role in individual health outcomes. *“A Primer on Using Medicaid for People Experiencing Chronic Homelessness and*

*Tenants in Permanent Supportive Housing*² published by the U.S. Department of Health & Human Services states the following:

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

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

“A pilot study conducted in Portland, Oregon, examined the effects of single-site supportive housing on health care costs, health care utilization, and health outcomes for 98 “highly medically vulnerable” individuals experiencing homelessness (Wright et al., 2016, p. 21). This study, using retrospective survey responses and Medicaid administrative claims data, showed that placing individuals experiencing homelessness and high medical costs into supportive housing significantly reduced Medicaid expenditures for inpatient hospital and emergency department services for physical health issues, with an average annual reduction of \$8,724 in the year after moving in (Syrop, 2016). The self-reported data also showed a reduction in hospital stays and emergency department visits, indicating a shift toward using primary care services rather than acute care services. Although these results are promising, the absence of a comparison group and the use of retrospective self-reported data limit interpretations of this study.”

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

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

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

The Informational Bulletin identifies 1115 Research and Demonstration Programs as a potential authority through which housing related services may be provided, including the following: *“Some section 1115*

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

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

demonstrations include housing-related services consistent with the statutory authorities described in this bulletin. For example, states can provide services to individuals already in the community, by helping the individual problem solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing. For people leaving institutions, states assist with locating housing, completing forms for subsidies, moving, and household set ups.”

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

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

Estimated Enrollment for Housing Related Supports and Services

The State estimates the following annual enrollment for each service:

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

4. Up to 12-Months Continuous Eligibility

Under the State’s 1115 PCN Demonstration Waiver, the Targeted Adult Population is currently authorized to receive continuous eligibility for a period of 12 months. Income and other changes during this continuous eligibility period do not affect the individual’s eligibility with the exception of the following:

- Turns age 65;
- Moving out of state;
- Death;
- Fails to apply for other benefits;
- Becomes institutionalized;
- Determined eligible for another Medicaid eligibility category;
- Fraud; or
- Client request

The State requests to continue providing 12-months of continuous eligibility to the Targeted Adult Population under this new demonstration application. The State estimates that approximately 240 individuals per year will continue to receive Medicaid after having increased their household income over five percent FPL, with a five percent FPL disregard.

Also with this application, the State proposes to allow up to 12-months of continuous eligibility for the Adult Expansion Population. This specific request applies to the individuals in the Adult Expansion Population who are not identified as Targeted Adults. With some exceptions, changes that occur during the certification period will not affect eligibility during the period of continuous eligibility. These exceptions include, but may not be limited to:

- Turns age 65;

- Moves out of state;
- Fails to apply for other benefits;
- Becomes institutionalized;
- Is determined eligible for another Medicaid program;
- Failure to comply with the community engagement requirement during the three-month participation period;
- Closure due to lock-out for committing an intentional program violation;
- Fraud;
- Failure to enroll in employer-sponsored insurance.

When an individual's household income exceeds 95 percent of FPL, with a five percent FPL disregard, they may continue to receive up to 12-months continuous eligibility. The State requests the ability to limit the continuous eligibility provision for the Adult Expansion Population based on income or targeted populations as defined by the State in administrative rule. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the number of continuous months, the income level, and/or targeted populations.

It is anticipated that the State would initially implement 6-month continuous eligibility, without a maximum income, across the Adult Expansion Population that is not identified as Targeted Adults.

Individuals who become eligible for another Medicaid program while enrolled in this demonstration will move to that program. For example, if an individual becomes pregnant, the individual will move to the Pregnant Woman program once the Medicaid program is made aware of that pregnancy.

In addition, if future waiver amendments to this demonstration cause an individual to become ineligible, members currently enrolled through this Demonstration will retain their existing eligibility period.

Impact to Beneficiaries and how this Modifies Medicaid Programs

The State estimates approximately 1,400-1,600 individuals per year will be eligible to receive up to 12-months continuous eligibility after having increased their household income over 95 percent FPL, with a five percent FPL disregard. This will allow eligible individuals to continue to receive Medicaid while increasing their household income.

Continuous eligibility is currently authorized under the State's 1115 PCN Demonstration waiver for the Targeted Adult population. This is a new request for the Adult Expansion population.

5. Not Allow Presumptive Eligibility Determined by a Hospital

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

Impact to Beneficiaries and how this Modifies Medicaid Programs

Presumptive eligibility determined by a hospital is currently allowed for the Adult Expansion population, but is not allowed for the Targeted Adult Population. The requested change will align the policy for both populations. The State anticipates that by no longer allowing hospitals to make presumptive eligibility determinations, approximately 300-400 individuals per month will no longer receive eligibility through presumptive eligibility. However, the State believes there will be no impact to individuals, as these individuals may still apply and have a full determination of eligibility completed for up to three months prior to the month of initial application.

6. Per Capita Cap Funding Mechanism

Information regarding this proposal can be found in “Section VII. Demonstration Financing and Budget Neutrality” below.

Section III. Demonstration Hypotheses and Evaluation

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

The evaluation budget will be included with the evaluation plan.

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

The State intends to test the following hypotheses contained in table 4 below, during the Demonstration period:

Table 4 - Waiver Hypotheses

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

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

with the employment process will improve the health outcomes of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	<ul style="list-style-type: none"> • Number of cancer screenings • Number of well-care visits 		quasi-experimental comparisons
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid	Beneficiary Surveys	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Up to 12-Months Continuous Eligibility			
The Demonstration will not discourage increases to household earned income.	Percentage of adults increasing earned income compared to a comparison group	eREP Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Per Capita Cap Funding			
Medicaid expenditures under this demonstration will grow at a slower rate than the national average of Medicaid Adult Expansion per enrollee spending which will demonstrate program sustainability.	Demonstration growth rate compared to Medicaid national growth rate in equivalent basis years of expansion (e.g. year one, year two, etc.)	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

The Demonstration will not negatively impact an individual's health.	<ul style="list-style-type: none"> • Number of prescriptions • Number of non-emergent ED visits • Number of cancer screenings • Number of well-care visits 	Claims/encounter data CMS Adult Core Measures	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Lock-Out for Intentional Program Violation			
The Demonstration will discourage individuals from committing an IPV by disqualifying individuals who commit an IPV.	Percentage of IPV's compared to a comparison group	Enrollment and IPV Lock-Out Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Housing Supports			
The demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

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

Section IV. Demonstration Benefits and Cost Sharing Requirements

Individuals eligible under this demonstration will receive benefits as listed in table 5 below. The exception to this are housing related supports and services that will be available to specific waiver populations, as outlined in the “Housing Related Supports and Services” section above.

Table 5- Eligibility Group and Benefit Package

Eligibility Group	Benefit Package
Adults with Dependent Children	<ul style="list-style-type: none">• Non-Traditional Benefits (see description below)• Up to 12-months continuous eligibility
Adults without Dependent Children	<ul style="list-style-type: none">• State Plan Benefits• Up to 12-months continuous eligibility
ESI Eligible Adults with Dependent Children	<ul style="list-style-type: none">• Premium Reimbursement with Non-Traditional Benefit Wrap-around• Up to 12-months continuous eligibility
ESI Eligible Adults without Dependent Children	<ul style="list-style-type: none">• Premium Reimbursement with State Plan Benefit Wrap-around• Up to 12-months continuous eligibility
Targeted Adults	<ul style="list-style-type: none">• State Plan Benefits, and state plan dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms & Conditions of the 1115 PCN Demonstration Waiver)• 12-months continuous eligibility
Clinically Managed Residential Withdrawal Pilot	<ul style="list-style-type: none">• Assessment of substance use disorder and treatment needs• Observation of the beneficiary's course of withdrawal• Medication services• Psychoeducation services• Discharge services to prepare for reentry into the community
Substance Use Disorder Treatment	<ul style="list-style-type: none">• Early intervention (Screening, Brief Intervention and Referral to Treatment)• Outpatient therapy• Intensive outpatient program

	<ul style="list-style-type: none"> ● Partial hospitalization treatment ● Residential treatment ● Withdrawal management ● Medication-assisted treatment (MAT) ● Peer support ● Crisis intervention ● Residential crisis stabilization
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Non-Traditional Benefit Package

Adults with dependent children will receive the State's non-traditional benefit package, authorized under the State's 1115 PCN Demonstration Waiver. This benefit package contains most of the services covered under Utah's Medicaid state plan according to the limitations specified in the state plan. This benefit package is reduced from that available under the state plan as detailed in the table 6 below.

Table 6- Benefits Different from State Plan

Service	Special Limitations for the Non-traditional Benefit
Hospital Services	Additional surgical exclusions. Refer to the Administrative Rule UT Admin Code R414-200 Non-Traditional Medicaid Health Plan Services and the Coverage and Reimbursement Code Lookup.
Vision Care	One eye examination every 12 months; No eye glasses
Physical Therapy	Visits to a licensed PT professional (limited to a combination of 16 visits per policy year for PT and OT)
Occupational Therapy	Visits to a licensed OT professional (limited to a combination of 16 visits per policy year for PT and OT)
Speech and Hearing Services	Hearing evaluations or assessments for hearing aids are covered, Hearing aids covered only if hearing loss is congenital
Private Duty Nursing	Not covered

Medical Supplies and Medical Equipment	Same as traditional Medicaid with exclusions. (See Utah Medicaid Provider Manual, Non-Traditional Medicaid Plan)
Organ Transplants	The following transplants are covered: kidney, liver, cornea, bone marrow, stem cell, heart and lung (includes organ donor)
Long Term Care	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Dental	Dental services are not covered, with exceptions.

Cost Sharing

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

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

Cost Sharing for Certain American Indian/Alaskan Native Eligibles: American Indian/Alaskan Native individuals enrolled in the Demonstration are subject to cost sharing exemptions of section 5006 of the American Recovery Reinvestment Act of 2009, and are not required to pay premiums or cost sharing for services received through the Indian health care system.

Section V. Delivery System

Services for Demonstration individuals will be provided initially through FFS. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

By January 2020, the State intends to transition populations covered by this application into managed care. In Utah's four largest counties, individuals in the Adult Expansion program will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity.

Employer Sponsored Insurance- Individuals with Access to ESI

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

Proposed Managed Care Flexibility

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

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

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

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

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

Demonstration of Actuarial Soundness of Rates

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

The State is working with its contracted actuary, Milliman, Inc. to determine actuarially sound rates for three specific populations within the waiver expansion group. The State has sufficient historical claims data for parents with dependent children. In addition, the State has more than a year of historical claims experience to establish rates for the Targeted Adult Medicaid group. For adults without dependent children, Milliman, Inc. has recommended that the state segment this group into at least two age bands 19-33 and 34-64. The actuary will use the Adults with Dependent Children, the Targeted Adult Medicaid group and expansion experience

from other states to inform the creation of a rate for Adults Without Children. In addition, initially the rates will include a risk corridor based on a medical loss ratio specified in the plan contract.

The State intends to submit plan contracts and rates to CMS as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, the State is requesting authority to make such changes effective the month following the month in which the State is notified of the change by CMS. The State is requesting that FMAP be available for any expenditures related to managed care rates paid to contractors from the date of waiver approval.

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

Flexibility in Managed Care Contract Review

The State is requesting authority to have more flexibility in the administration of our managed care contracts for the populations covered under this waiver. The State will submit its initial contract to CMS for review and approval as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by the Center for Medicaid and CHIP Services (CMCS) and the Office of the Actuary.

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

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

Demonstration of Directed Payment Compliance

The State is requesting authority to implement directed payments which are included in the contracts and rates pertaining to the population groups covered under this waiver consistent with the requirements of 42 CFR 438.6(c) prior to formal approval from CMS. The State intends to submit any new or updated Directed Payment 438.6(c) templates as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, such changes will go into effect the month following the month in which the State is notified of the change. The State is requesting that FMAP be available for any directed payments made to providers from the date of waiver approval.

Access to Care and Availability of Services

The State is requesting authority to adopt an approach to network adequacy, access to care, and availability of services. The State is currently incorporating standards into its current managed care contracts based on time and distance as well as provider type, to determine the sufficiency of a plan's network. As part of the initial

readiness review of managed care contracts covering the populations under this waiver, the State will validate the adequacy of each plan's network based on established standards. The State will conduct an annual review of these standards for each plan.

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

Section VI. Enrollment in Demonstration

Individuals Currently Eligible for Medicaid

Individuals currently eligible for Adult Expansion under Utah's 1115 PCN Demonstration waiver at the time this demonstration is implemented will be moved to this new demonstration group.

Eligible individuals will be notified of any benefit changes or new program requirements.

When the State elects to enroll the Adult Expansion group in managed care, enrollment in managed care plans for the Demonstration group will occur as it does for those covered under the State plan. Individuals eligible for the Demonstration who reside in one of the thirteen managed care counties will be notified of the requirement to choose a managed care plan. If they do not choose one, one will be assigned. Eligibles not enrolled in an integrated plan will also be enrolled in a prepaid mental health plan.

Individuals Eligible for ESI Reimbursement

As approved in the March 29, 2019 amendment to Utah's 1115 PCN Demonstration waiver, individuals with household income up to 95 percent of the FPL who are determined eligible for the Demonstration and have access to, or are enrolled in, a qualified ESI will receive premium reimbursement for the cost of the eligible individual's premium amount. ESI eligible individuals will be notified of the following:

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

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

Section VII. Demonstration Financing and Budget Neutrality

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

Table 7 shows the projected demonstration enrollees in each demonstration year (DY). These enrollment projections include all members in the demonstration as identified by the Budget Neutrality attachment. These

enrollment projections include members that may be excluded from the per capita cap funding calculations as described in that section.

Enrollment	DY 1	DY 2	DY 3	DY 4	DY 5
Targeted Adults	4,086	4,188	4,293	4,400	4,510
Dental - Targeted Adults	3,000	3,075	3,152	3,231	3,311
Expansion Parents	30,430	31,191	31,971	32,770	33,589
Expansion Adults without Children	46,133	47,287	48,469	49,680	50,922
SUD	503	516	528	542	555
Withdrawal Management	279	286	293	301	308

Table 7

Table 8 shows the projected demonstration expenditures in each demonstration year (DY). These amounts are calculated by applying the estimated per member per month estimates detailed in the following sections to the enrollment figures from Table 7. These amounts also assume the inflation factor applied to DY 2 remains constant for the remaining years of the demonstration. These expenditure projections include all projected expenditures covered by this demonstration as identified by the Budget Neutrality attachment (Demonstration With Waiver). These expenditures include some that may be excluded from the per capita cap funding calculations as described in that section.

Expenditures (Total Fund)	DY 1	DY 2	DY 3	DY 4	DY 5
Targeted Adults	\$74,659,000	\$79,740,000	\$85,166,000	\$90,962,000	\$97,152,000
Dental - Targeted Adults	\$1,375,000	\$1,469,000	\$1,569,000	\$1,675,000	\$1,789,000
Expansion Parents	\$245,247,000	\$261,936,000	\$279,760,000	\$298,798,000	\$319,131,000
Expansion Adults without Children	\$434,558,000	\$464,130,000	\$495,714,000	\$529,447,000	\$565,476,000
SUD	\$25,611,000	\$27,354,000	\$29,216,000	\$31,204,000	\$33,327,000
Withdrawal Management	\$2,345,000	\$2,504,000	\$2,675,000	\$2,857,000	\$3,051,000
Annual Total	\$783,795,000	\$837,133,000	\$894,100,000	\$954,943,000	\$1,019,926,000

Table 8

Per Capita Cap Funding Mechanism

The State requests that the increased FFP under 42 U.S.C. Section 1396d(y) be available up to a limit set by a per capita cap methodology for this demonstration. Under this methodology, the State will work with CMS to establish a per enrollee base amount for the first demonstration year with trending for future demonstration years. Separate per capita caps for distinct enrollment groups will account for differences in costs among populations. Expenditure caps will be set annually and reconciled with actual expenditures and enrollment. Per capita caps for the enrollment groups should aggregate into a total per capita cap weighted according to each enrollment group's respective member months.

The State requests that the entire 5-year demonstration period be used for reconciliation. Excess expenditures above the total per capita cap in a particular year may be allowable using room under the total per capita cap in a separate year. Expenditures in excess of the total per capita cap but within budget neutrality will receive the State's traditional FMAP.

Enrollment Groups

The State requests that separate per capita cap amounts be created for enrollment groups in order to account for differences in costs. The proposed enrollment groups have distinct attributes, benefits, and experience with the State's Medicaid program. The State recognizes that the enrollment trends of each group may vary. Therefore, establishing separate caps for each group will reduce the risk of a case mix change between populations. The State proposes three enrollment groups:

- Adults with Dependent Children;
- Adults without Dependent Children; and
- Targeted Adults and members residing in an IMD primarily to receive short-term residential treatment for SUD.

The State requests that individuals with verified membership in a federally recognized tribe be excluded from the per capita cap calculations. Expenditures for these individuals will be 100 percent FMAP when services are provided through facilities where 100 percent match is allowed. Otherwise costs for these individuals will be at the enhanced FMAP.

The State requests that inpatient stays lasting longer than 24 hours for incarcerated individuals that are otherwise Medicaid eligible under this demonstration be excluded from the per capita cap calculations. Expenditures for these individuals will be at the enhanced FMAP.

The State also requests that non-citizens enrolled under the Emergency Only program pursuant to 42 CFR § 435.139 be excluded from the per capita cap calculations. Expenditures for these individuals will be at the enhanced FMAP.

These members and related expenditures will be included in budget neutrality calculations, but excluded from the per capita caps. Estimated per enrollee costs and enrollment are provided in Table 9.

Exclusion Category	2020 Estimated Member Months	2020 Estimated PMPM
Emergency only program	6,806	\$3,973.31
Membership in federally recognized tribe	31,892	\$763.53
Inpatient Stays for Incarcerated Individuals	233	\$10,758.99

Table 9

Adults with Dependent Children

Adults with Dependent Children, hereinafter referred to as "Parents", are expected to have attributes similar to the State's existing 1115 PCN Demonstration Waiver population, "Current Eligibles". These newly eligible Parents have one or more dependent children, with household incomes between the limit for "Current Eligibles" and 95 percent of the FPL. This population excludes members residing in an IMD primarily to receive short-term residential treatment for SUD (members receiving residential treatment will be included in the Targeted Adult and SUD per capita cap). Parents will receive the State's non-traditional benefit package as described under Section IV.

The State proposes that per enrollee expenditures from the "Current Eligibles" demonstration population be used to set the base per capita cap for newly eligible Parents. The "Current Eligibles" demonstration population was created in 2002 and provides the State with extensive expenditure experience. Medical assistance payments are available from the State's quarterly CMS-64 submissions and distinguishable by

Waiver Name. Expenditures reported under the “Current Eligibles” Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included. The base period time frame should include the eight quarters in calendar years 2017 and 2018. This will effectively set the per capita cap based on experience by paid date.

The State proposes modifications to the State-reported pharmacy rebates and supplemental payments for the “Current Eligibles” demonstration in the base period. The State will adjust future CMS-64 reporting under this demonstration to match the proposed allocation methodologies.

Pharmacy rebates received under a Managed Care Organization (MCO) national agreement are reported by the State on CMS forms 64.9 and 64.9-Waiver under line 7A3. The State proposes that the rebates in the base period should be apportioned between Medicaid waivers according to pharmacy encounters received by the State. The proposed method under this per capita cap calculation will vary from the original CMS-64 apportionment between the State’s waivers. The original CMS-64 apportionment distributed all pharmacy rebates between the State’s waivers according to FFS pharmacy expenditures. This proposed modification to the apportionment of MCO pharmacy rebates based on MCO pharmacy encounters will provide more accuracy to per enrollee expenditures. The State receives pharmacy encounters from MCO plans and loads these encounters into the Medicaid Data Warehouse. These pharmacy encounters identify the client’s Medicaid Eligibility Group and allow for the proposed apportionment identified in Table 10.

Year	Parents MCO Pharmacy Encounters	All MCO Pharmacy Encounters	Parents MCO Pharmacy Percent	MCO Pharmacy Rebates	Apportionment of MCO Rebates to Parents
2017	\$18,483,138	\$101,391,836	18.2%	(\$63,335,170)	(\$11,545,631)
2018	\$19,554,324	\$104,821,674	18.7%	(\$75,428,600)	(\$14,071,091)
Total	\$38,037,462	\$206,213,510	18.4%	(\$138,763,770)	(\$25,616,721)

Table 10

Supplemental payments should also be included in the base period to reflect the total cost of medical assistance per person. The State proposes allocating certain supplemental payments according to the related fee-for-service expenditures. As an example, if the State made a \$5 million inpatient hospital supplemental payment in the base period and 20% of inpatient hospital base payments were paid for a population in this demonstration, then \$1 million of the inpatient hospital supplemental payment should be allocated to that population’s base period. The State proposes that five supplemental payment types be allocated to the base period expenditures for Parents. These supplemental payments are detailed in Table 11 with Medicaid State Plan reference; the 2017-2018 supplemental expenditure; the related base payments for allocation, Parent percentage of the related expenditure; and the resulting allocation of the supplemental payment.

Supplemental Type	State Plan Reference	2017-18 Supplemental	Related Expenditures	Parents Percentage	Parents Allocation
State Inpatient	4.19-A Section 800	\$47,712,351	Inpatient	8.1%	\$3,850,255
Private Outpatient	4.19-B (A)(13)	\$10,676,520	Outpatient	16.0%	\$1,703,999
State Outpatient	4.19-B (A)(11)	\$9,278,108	Outpatient	16.0%	\$1,480,809
Transitional Outpatient	4.19-B (A)(1)(E)	\$2,478,774	Outpatient	16.0%	\$395,619
University of Utah Medical Group	4.19-B (D)(7)	\$29,153,924	Physician	14.2%	\$4,148,813

Total Allocation					\$11,579,495
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Table 11

The State intends to exclude Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and State administration expenses from the per capita cap methodology.

CMS-64 base period expenditures, with the proposed adjustments herein, are divided by the member-months for Parents in order to establish the base period per capita amount. In the base period, the State enrolled 374,629 and 373,185 Parent member-months in 2017 and 2018 respectively. The base period member months are therefore 747,814. The resulting base period per-member-per-month (PMPM) expenditures are detailed in Table 12 with categorization by service type and data source.

Item	Source	Total Computable	Per Member Month (PMPM)
Medicaid MCO	CMS-64; Line 18A	\$293,485,860	\$392.46
Pharmacy	CMS-64; Line 7	\$30,382,505	\$40.63
Inpatient	CMS-64; Line 1A	\$25,031,181	\$33.47
Outpatient	CMS-64; Line 6A, 36	\$21,039,624	\$28.13
Physician	CMS-64; Line 5A	\$14,502,232	\$19.39
Behavioral Health	CMS-64; Line 18B1, 18B2, 40	\$32,067,163	\$42.88
Pharmacy Rebates-FFS	CMS-64; Line 7A1, 7A2	(\$16,856,536)	(\$22.54)
Other	CMS-64; All else	\$6,529,126	\$8.73
Pharmacy Rebates-MCO	Allocation (Table 10)	(\$25,616,721)	(\$34.26)
Supplemental Payment	Allocation (Table 11)	\$11,579,495	\$15.48
Total			\$524.37

Table 12

In order to account for growth in healthcare expenditures, a growth factor should be applied to base period expenditures in order to set the appropriate per capita cap in demonstration year one. The State proposes this growth factor to be equivalent to the growth factor provided to the State for budget neutrality purposes. CMS has established a growth rate of 5.3% for the “without waiver” PMPM for the comparison population of “Current Eligibles”. The State proposes to use this growth rate for per capita expenditures between the base period and demonstration year one. The State proposes that 2.5 years of growth be applied to the base period of 2017-18 in order to establish the demonstration year one per capita cap. This is equivalent to $(1+5.3\%)^{2.5}$ or 13.78%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State’s

intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL directed payment.

- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.
- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 13.

Funding	Effective Date	Parents 2020 PMPM
Private Outpatient UPL directed payment	July 1, 2019	\$17.76
Housing Supports	Approval of this demonstration	\$31.04
Mental Health Crisis Services	April 1, 2019	\$4.28
Total Benefit Addition		\$53.08

Table 13

The calculation of the per capita cap with the methodology described above is shown in Table 14.

Enrollment Group	Base PMPM (2017-18)	Growth Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Parents	\$524.37	1.1378	\$596.64	\$53.08	\$649.72

Table 14

Adults without Dependent Children

Adults without Dependent Children will be a new demonstration population with which the State has limited experience. These newly eligible adults do not have dependent children, and have a household income less than 95 percent of the FPL. These members are not enrolled as Targeted Adults or those residing in an IMD primarily for SUD (members in these groups will be included in the Targeted Adult and SUD per capita cap). This population will receive state plan benefits as described under Section IV.

The State is proposing to use a relativity factor applied to the Parents enrollment group in order to establish the per capita cap for Adults without Dependent Children. This relativity factor was developed by the State's independent actuary, Milliman, at the State's request. Milliman relied on the historical Medicaid Expansion experience in other expansion states as well as Utah specific data. Utah specific data includes expenditures from the Primary Care Network (PCN) demonstrations with and without dependent children. The State's experience with the PCN demonstrations is that adults without dependent children have a substantially higher per enrollee cost than parents. This cost relativity, along with other factors developed by Milliman results in a cost relativity factor of 1.17. The State proposes that this factor be applied to the base Parents PMPM to account for cost differences.

The State proposes to use the same growth factor for Parents base period expenditures in order to set the appropriate per capita cap in demonstration year one. As previously described, this is equivalent to $(1+5.3\%)^{2.5}$ or 13.78%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State's intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL directed payment.
- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.
- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 15.

Funding	Effective Date	Adults without Dependent Children 2020 PMPM
Private Outpatient UPL directed payment	July 1, 2019	\$20.79
Housing Supports	Approval of this demonstration	\$31.04
Mental Health Crisis Services	April 1, 2019	\$5.01
Total Benefit Addition		\$56.84

Table 15

The calculation of the per capita cap with the methodology described above is shown in Table 16.

Enrollment Group	Base PMPM (2017-18)	Growth Factor	Relativity Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Adults without Dependent Children	\$524.37	1.1378	1.17	\$698.28	\$56.84	\$755.12

Table 16

Targeted Adults and Members Residing in an IMD for SUD

Targeted Adults are an existing population under Utah's 1115 PCN Demonstration waiver and became eligible in November 2017. The State will retain this population as a separate demonstration population. This population receives state plan benefits, 12-month continuous eligibility, and dental benefits for individuals receiving Substance Use Disorder Treatment. Substance Use Disorder is also an existing population under Utah's 1115 PCN Demonstration waiver and was also established in November 2017. The State will retain this population as a separate demonstration population under this waiver. These two populations will be reported separately for purposes of budget neutrality, and combined for the purposes of the per capita cap. Hereinafter, this combined per capita cap enrollment group will be called "Targeted Adults and SUD".

The State proposes to use base period expenditures from calendar year 2018 to establish the per capita cap for this enrollment group. This will effectively set the per capita cap based on experience by paid date. Base period expenditures reported under the "Targeted Adults" Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included. Base period expenditures reported under the "SUD" Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included if the adult would otherwise fall under the "Current Eligibles" or "Targeted Adults" demonstration. These populations are the appropriate proxy population relevant to this demonstration and exclude other populations within the state plan. Table 17 details the total computable amounts reported on the CMS-64 under the SUD demonstration for the four quarters in calendar year 2018. The amount attributable to this per capita cap calculation are identified. Pharmacy rebates received under a Managed Care Organization (MCO) national agreement in the base period will be allocated separately as identified below.

Category	CMS-64 Form; Line	Total Computable	Base Period Allocation
Expenses	64.9 Waiver & 64.9P Waiver; All except 7A1, 7A2, 7A3	\$14,909,039	\$14,154,783
Pharmacy Rebates-FFS	64.9 Waiver & 64.9P Waiver; 7A1, 7A2	(\$653,972)	(\$620,391)
Pharmacy Rebates-MCO	64.9 Waiver & 64.9P Waiver; 7A3	(\$603,631)	\$0
Total			\$13,534,393

Table 17

The State proposes modifications to the State-reported pharmacy rebates and supplemental payments for the "Targeted Adults" and "Substance Use Disorder" demonstration in the base period. The State will adjust future CMS-64 reporting under this demonstration to match the proposed allocation methodologies.

Pharmacy rebates received under a Managed Care Organization (MCO) national agreement are reported by the State on CMS forms 64.9 and 64.9-Waiver under line 7A3. The State proposes that the rebates in the base period should be apportioned between Medicaid waivers according to pharmacy encounters received by the State. The proposed method under this per capita cap calculation will vary from the original CMS-64 apportionment between the State's waivers. The original CMS-64 apportionment distributed all pharmacy rebates between the State's waivers according to FFS pharmacy expenditures. This proposed modification to the apportionment of MCO pharmacy rebates based on MCO pharmacy encounters will provide more accuracy to per enrollee expenditures. The State receives pharmacy encounters from MCO plans and loads these

encounters into the Medicaid Data Warehouse. These pharmacy encounters identify the client's Medicaid Eligibility Group and allow for the proposed apportionment identified in Table 18.

Year	Targeted Adults & SUD MCO Pharmacy Encounters	All MCO Pharmacy Encounters	Targeted Adults & SUD MCO Pharmacy Percent	MCO Pharmacy Rebates	Apportionment of MCO Rebates to Targeted Adults & SUD
2018	\$3,473	\$104,821,674	0.003%	(\$75,428,600)	(\$2,499)

Table 18

Supplemental payments should also be included in the base period to reflect the total cost of medical assistance per person. The State proposes allocating certain supplemental payments according to the related fee-for-service expenditures. The State proposes that five supplemental payment types be allocated to the base period expenditures for Targeted Adults and SUD. These supplemental payments are detailed in Table 19 with Medicaid State Plan reference; the 2018 supplemental expenditure; the related base payments for allocation, Targeted Adults and SUD percentage of the related expenditure; and the resulting allocation of the supplemental payment.

Supplemental Type	State Plan Reference	2018 Supplemental	Related Expenditures	Targeted Adults & SUD Percentage	Targeted Adults & SUD Allocation
State Inpatient	4.19-A Section 800	\$24,120,881	Inpatient	6.8%	\$1,643,966
Private Outpatient	4.19-B (A)(13)	\$9,144,790	Outpatient	4.4%	\$398,960
State Outpatient	4.19-B (A)(11)	\$3,885,994	Outpatient	4.4%	\$169,534
Transitional Outpatient	4.19-B (A)(1)(E)	\$1,300,087	Outpatient	4.4%	\$56,719
University of Utah Medical Group	4.19-B (D)(7)	\$14,684,464	Physician	5.4%	\$786,835
Total Allocation					\$3,056,014

Table 19

The State intends to exclude Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and State administration expenses from the per capita cap methodology.

CMS-64 base period expenditures, with the proposed adjustments herein, are divided by the member-months for Targeted Adults and SUD in order to establish the base period per capita amount. In the base period, the State enrolled 3,596 member-months. The resulting base period per-member-per-month (PMPM) expenditures are detailed in Table 20 with categorization by service type and data source.

Item	Source	Total Computable	Per Member Month (PMPM)
Medicaid MCO	CMS-64; Line 18A	\$73,025	\$2.18
Pharmacy	CMS-64; Line 7	\$8,734,987	\$261.24

Inpatient	CMS-64; Line 1A	\$10,975,106	\$328.24
Outpatient	CMS-64; Line 6A, 36	\$5,060,723	\$151.36
Physician	CMS-64; Line 5A	\$2,949,533	\$88.21
Behavioral Health	CMS-64; Line 18B1, 18B2, 40	\$13,504,701	\$403.90
Pharmacy Rebates-FFS	CMS-64; Line 7A1, 7A2	(\$4,992,609)	(\$149.32)
Other	CMS-64; All else	\$4,409,962	\$131.89
Pharmacy Rebates-MCO	Allocation (Table 18)	(\$2,499)	(\$0.07)
Supplemental Payment	Allocation (Table 19)	\$3,056,014	\$91.40
Total			\$1,309.03

Table 20

In order to account for growth in healthcare expenditures, a growth factor should be applied to base period expenditures in order to set the appropriate per capita cap in demonstration year one. The State proposes this growth factor to be equivalent to the growth factor provided to the State for budget neutrality purposes. CMS has established a growth rate of 5.3% for the “without waiver” PMPM for the comparison population of “Targeted Adults” and “SUD”. The State proposes to use this growth rate for per capita expenditures between the base period and demonstration year one. The State proposes that 2 years of growth be applied to the base period of 2018 in order to establish the demonstration year one per capita cap. This is equivalent to $(1+5.3\%)^2$ or 10.88%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Inpatient Hospital Directed Payment - It is the intent of the State to eventually enroll the Targeted Adult population in managed care plans. The State currently provides funding to its managed care plans to make private inpatient hospital directed payments for other Medicaid populations. The State is requesting sufficient federal expenditure authority to be able to make these payments for the Targeted Adult population.
- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State’s intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL directed payment.
- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.
- Targeted Adult Dental - Effective with the February 1, 2019 CMS approval of Amendment #15 of the State’s PCN demonstration waiver, the State is beginning to deliver dental services for Targeted Adults.
- Clinically Managed Residential Withdrawal Pilot - Effective with the March 29, 2019 CMS approval of Amendment #16 of this demonstration waiver, the State is beginning to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries.
- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 21.

Funding	Effective Date	Targeted Adults & SUD 2020 PMPM
Private Inpatient Hospital directed payment	January 1, 2020	\$120.58
Private Outpatient UPL directed payment	July 1, 2019	\$27.00
Housing Supports	Approval of this demonstration	\$208.85
Targeted Adult Dental	February 1, 2019	\$24.97
Clinically Managed Residential Withdrawal Pilot	May 1, 2019	\$42.59
Mental Health Crisis Services	April 1, 2019	\$6.61
Total Benefit Addition		\$430.60

Table 21

The calculation of the per capita cap with the methodology described above is shown in Table 22.

Enrollment Group	Base PMPM (2018)	Growth Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Targeted Adults and SUD	\$1,309.03	1.1088	\$1,451.46	\$430.60	\$1,882.06

Table 22

Growth Rate

In order to account for the rising costs of healthcare, per capita caps should grow at a rate reflective of this population's characteristics. According to the Office of the Actuary's 2017 Actuarial Report, the Medical consumer price index is projected to grow at a rate of 4.2% in fiscal year 2021. The State believes that this projection is the most credible estimate for the growth of expenditures. The State proposes to use 4.2% as the growth rate for per capita caps from demonstration year one to demonstration year two.

The State proposes to use future Office of the Actuary projections of the Medical consumer price index as the per capita cap growth rate for subsequent demonstration years. Upon the release of the 2018 Actuarial Report on the Financial Outlook for Medicaid, the State proposes to use the report's projected Fiscal Year 2022

Medical consumer price index as the growth rate of per capita caps for demonstration year three. The State proposes to continue this process for per capita cap growth rates in subsequent demonstration years.

Method for Applying Cap and Reconciling Expenditures

The State will work with CMS regularly through the operation of this demonstration to reconcile and account for expenditures related to this demonstration. The State understands that accurate CMS-64 reporting will be vital to this goal. The State has certified and will continue to certify that quarterly CMS-64 expenditure reports provide an accurate accounting of Medicaid expenditures. The State will provide increased detail of expenditures reported under this demonstration in order to satisfy the requirements of the per capita caps.

Increased detail may include, but is not limited to, the following:

- Detailed enrollment counts.
- Detailed summarization of pharmacy encounters received through a Managed Care Organization and used for the purposes of allocating pharmacy rebates received through a Managed Care Organization.
- Detailed accounting of supplemental payments with related expenditures used for allocation to enrollment groups under this demonstration.
- Detailed reporting of enrollees under this demonstration with claiming under a separate demonstration authority (e.g. Clinically Managed Residential Withdrawal Pilot or SUD).

The State will provide CMS with a review performed by its independent actuary, Milliman, of the reasonableness of this increased detail.

While the State endeavors to estimate per enrollee expenditures under this demonstration as accurately as possible, there is a level of uncertainty for future years. The State requests that the following event automatically triggers a re-basing of per capita caps for any applicable enrollment group after demonstration year two:

- Actual per enrollee expenditures in the first two demonstration years are at least 5 percent below or above the established per capita cap amounts.

This re-basing of per capita caps may not be necessary for all enrollment groups, but it should apply to whichever groups trigger the re-basing event. Under these circumstances, the per capita caps should be based on the average of the eight quarters in demonstration years one and two. The growth rate approved under this demonstration for per capita caps should be applied to this eight-quarter average in order to set demonstration year three per capita caps. This re-basing formula is as follows:

$$(Average\ PMPM) * (1 + Growth\ Rate)^{1.5}$$

After demonstration year 3 per capita caps are re-based, they should continue to grow in subsequent years at the growth rate approved under this demonstration.

Special Circumstances

The State requests that CMS consider unforeseen special circumstances beyond the State's control in the establishment of per capita caps. Special circumstances may include the following:

- Public health emergency or natural disaster
- Major economic event
- New federal mandate, including changes to pharmacy rebate methodology
- Any subsequent waivers approved by CMS that impact the populations under this waiver.

In the event of a public health emergency, natural disaster, or major economic event, the State will engage its independent Actuary to estimate the impact to medical assistance expenditures and newly eligible members. The independent Actuary will estimate the impact already experienced by the State and the ongoing impact on future demonstration years. With sufficient documentation under these special circumstances, the State may request that a certain percentage or amount of medical assistance expenditures be excluded from per capita cap calculations. These excluded medical assistance expenditures should receive the enhanced FMAP.

In the event of a new federal mandate, including changes to pharmacy rebate methodology, the State will engage its independent Actuary to provide estimates for the effect on members covered in this demonstration. If the new federal mandate results in retroactive changes to medical assistance expenditures or rebates, the State will estimate the impact to medical assistance expenditures. If the new federal mandate results in prospective changes to medical assistance expenditures or rebates, the State may negotiate with CMS a change to the Special Terms and Conditions under this demonstration. The changes may include one or more of the following options:

- Creation of a new demonstration enrollment group;
- Modification to the per capita cap growth rate;
- Exclusion of certain medical assistance expenditures from the per capita cap; or
- Re-basing of the per capita caps.

Under each of these special circumstances, the State will provide CMS with a review by its independent Actuary.

Section VIII. Proposed Waivers and Expenditure Authorities

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

Waiver Authority	Reason and Use of Waiver
Section 1902(a)(10) and (a)(52)- Eligibility	To the extent necessary to enable the State to prohibit re-enrollment and deny eligibility for the Adult Expansion Medicaid demonstration group for a period of six months for individuals who commit an intentional program violation.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Adult Expansion eligibles compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide housing supports and services.
Section 1902(a)(1)- Statewide Operation	To the extent necessary to enable the State to implement housing supports in geographically limited areas of the state.
Section 1902(a)(10)(A)(i)(VIII)- 133 Percent Income Level	To enable the State to apply a lower income level to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y) for

	the Adult Expansion and Targeted Adult Medicaid Populations who have an income level of 95 percent FPL.
Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	Effective no sooner than January 1, 2020, to the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to beneficiaries subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs. Effective no sooner than January 1, 2020, to the extent necessary to enable the state to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.
Section 1906(i)(26)- Compliance with ABP Requirements	In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that the conditions for FFP in section 1903(i)(26) are not satisfied.

Table 23

Expenditures

Adult Expansion Demonstration Group: Expenditures for optional services not covered under Utah’s State Plan or beyond the State Plan’s service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR 438 et seq.

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

Section IX. Compliance with Public Notice and Tribal Consultation

Public Notice Process

The State certifies that public notice of the State’s request for this demonstration application, and notice of the public hearings were advertised in the newspapers of widest circulation, and sent to an electronic mailing list (Attachment 2). In addition, the abbreviated notice and full public notice were posted on the State’s Medicaid website at <https://medicaid.utah.gov/1115-waiver> (Attachment 2).

The State certifies that two public hearings to take public comment on this waiver application were held. The first public hearing was held on June 6, 2019 from 2:00 p.m. to 4:00 p.m., during a special session of the Medical Care Advisory Committee (MCAC) meeting, at the Cannon Health Building located at 288 N 1460 W, Salt Lake City, UT. The second public hearing was held on June 17, 2019 from 4:00 p.m. to 6:00 p.m., at the Multi-Agency State Office Building, located at 195 N 1950 W, Salt Lake City, UT. Telephonic conferencing was available for both public hearings.

Public Comment

The public comment period was held May 31, 2019 through June 30, 2019. The State received 1,755 comments during the public comment period. This includes comments provided during both public hearings, email and online portal comments, and mailed comments. The State reviewed and considered all public comments

received during the public notice period. Summarized comments and the State's responses are included in Attachment 3.

The majority of commenters did not agree with the State's application request to implement most components of the per capita cap waiver. They expressed concerns with the impact of the new waiver requests contained in this application, including: the per capita cap funding mechanism, intentional program violation lock-out, authority to receive the full FMAP (despite not implementing full expansion), and not allowing hospitals to make presumptive eligibility determinations. Commenters were generally supportive of providing housing supports and services and allowing up to 12-months of continuous eligibility.

In addition, the majority of commenters expressed concerns with already approved components of the waiver application, particularly the community engagement requirement, enrollment limits, and waiving the EPSDT requirement for 19 and 20 year olds. They stated these components will lead to a loss of coverage for individuals who would otherwise be eligible for Medicaid benefits or assistance, if not for these provisions.

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

In response to comments, the State made the following changes to its application:

- The State adjusted the directed payments included in the per capita cap section to reflect an equal payment model across populations.
- The State revised the hypothesis regarding the employer sponsored insurance component to respond to concerns regarding cost-effectiveness of this component.

Tribal Consultation

In accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver application. As a result of this notification, DMHF began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on June 7, 2019 to present this demonstration application. The meeting agenda is attached (Attachment 4).

During the meeting, two issues were raised by tribal members. The first involved the exemption policy for both community engagement and the enrollment limit. The question was asked if the exemption would include all tribal members, including those living in families with tribal and non-tribal members. The State clarified that tribal members who are members of federally recognized tribes would be exempt, even if they live with non-tribal members. The second issue raised was that they believe full expansion should be implemented as passed by Proposition 3. The State acknowledges the comment, but responded that the State agency must submit the waiver based on the current law enacted by Senate Bill 96.

Tribal Consultation Policy

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

- An initial meeting to present the intent and broad scope of the policy and waiver application to the UIHAB.
- Discussion at the UIHAB meeting to more fully understand the specifics and impact of the proposed policy initiation or change;
- Open meeting for all interested parties to receive information or provide comment;
- A presentation by tribal representatives of their concerns and the potential impact of the proposed policy;
- Continued meetings until concerns over intended policy have been fully discussed;
- A written response from the Department of Health to tribal leaders as to the action on, or outcome of tribal concerns.

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

Section X. Demonstration Administration

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ATTACHMENT 1

Compliance with Budget Neutrality Requirements



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

ELIGIBILITY GROUP	TREND RATE 1	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY01 (FFY20)	DY02 (FFY21)	DY03 (FFY22)	DY04 (FFY23)	DY05 (FFY24)	
Targeted Adults Medicaid (TAM)								
Pop Type:	Expansion	Started 11/1/17, suspended in previous 1115 waiver and transferred to the new 1115 waiver 10/1/19						
Eligible Member Months	2.5%	2.5%	49,028	50,254	51,510	52,798	54,118	
PMPM Cost	5.3%	5.3%	\$ 1,522.79	\$ 1,603.50	\$ 1,688.48	\$ 1,777.97	\$ 1,872.21	
Total Expenditure			\$ 74,659,348	\$ 80,581,701	\$ 86,973,844	\$ 93,873,045	\$ 101,319,524	\$ 437,407,462
Dental - TAM								
Pop Type:	Expansion	Started 3/1/19, suspended in previous 1115 waiver and transferred to the new 1115 Waiver 10/1/19						
Eligible Member Months	2.5%	2.5%	36,000	36,900	37,823	38,768	39,737	
PMPM Cost	5.3%	5.3%	\$38.20	\$40.22	\$42.35	\$44.60	\$46.96	
Total Expenditure			\$ 1,375,111	\$ 1,484,192	\$ 1,601,925	\$ 1,728,998	\$ 1,866,151	\$ 8,056,376
Expansion Parents								
Pop Type:	Expansion							
Eligible Member Months	2.5%	2.5%	365,164	374,293	383,650	393,241	403,072	
PMPM Cost	5.3%	5.3%	\$ 671.61	\$ 707.20	\$ 744.68	\$ 784.15	\$ 825.71	
Total Expenditure			\$ 245,246,656	\$ 264,700,847	\$ 285,698,242	\$ 308,361,255	\$ 332,822,011	\$ 1,436,829,011
Expansion Adults w/out Dependent Children								
Pop Type:	Expansion							
Eligible Member Months	2.5%	2.5%	553,599	567,439	581,625	596,166	611,070	
PMPM Cost	5.3%	5.3%	\$ 784.97	\$ 826.57	\$ 870.38	\$ 916.51	\$ 965.09	
Total Expenditure			\$ 434,557,732	\$ 469,029,024	\$ 506,234,751	\$ 546,391,823	\$ 589,734,354	\$ 2,545,947,684
Substance Use Disorder (SUD)								
Pop Type:	Expansion							
Eligible Member Months	2.5%	2.5%	6,036	6,186	6,341	6,500	6,662	
PMPM Cost	5.3%	5.3%	\$ 4,243.43	\$ 4,468.33	\$ 4,705.15	\$ 4,954.53	\$ 5,217.12	
Total Expenditure			\$ 25,611,365	\$ 27,642,987	\$ 29,835,767	\$ 32,202,489	\$ 34,756,951	\$ 150,049,558
Withdrawal Management								
Pop Type:	Expansion							
Eligible Member Months	2.5%	2.5%	3,350	3,434	3,520	3,608	3,698	
PMPM Cost	5.3%	5.3%	\$ 700.00	\$ 737.10	\$ 776.17	\$ 817.30	\$ 860.62	
Total Expenditure			\$ 2,345,000	\$ 2,531,017	\$ 2,731,790	\$ 2,948,489	\$ 3,182,378	\$ 13,738,675

Program transferred from current PCN 1115 Demonstration Waiver effective 10/1/19

Note: Member months and PMPMs are based on state fiscal year and have not been adjusted to reflect starting on federal fiscal year

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

ELIGIBILITY GROUP	DEMO TREND RATE	DY01 (FFY20)	DY02 (FFY21)	DY03 (FFY22)	DY04 (FFY23)	DY05 (FFY24)	TOTAL WW
Targeted Adults Medicaid (TAM)							
Pop Type:	Expansion	<i>Started 11/1/17, suspended in previous 1115 waiver and transferred to the new 1115 waiver 10/1/19</i>					
Eligible Member Months	2.5%	49,028	50,254	51,510	52,798	54,118	
PMPM Cost	4.2%	\$ 1,522.79	\$ 1,586.75	\$ 1,653.39	\$ 1,722.83	\$ 1,795.19	
Total Expenditure		\$ 74,659,348	\$ 79,739,917	\$ 85,166,218	\$ 90,961,779	\$ 97,151,728	\$ 427,678,991
Dental - TAM							
Pop Type:	Expansion	<i>Started 3/1/19, suspended in previous 1115 waiver and transferred to the new 1115 Waiver 10/1/19</i>					
Eligible Member Months	2.5%	36,000	36,900	37,823	38,768	39,737	
PMPM Cost	4.2%	\$ 38.20	\$ 39.80	\$ 41.47	\$ 43.22	\$ 45.03	
Total Expenditure		\$ 1,375,111	\$ 1,468,687	\$ 1,568,631	\$ 1,675,377	\$ 1,789,386	\$ 7,877,193
Expansion Parents							
Pop Type:	Expansion						
Eligible Member Months	2.5%	365,164	374,293	383,650	393,241	403,072	
PMPM Cost	4.2%	\$ 671.61	\$ 699.82	\$ 729.21	\$ 759.83	\$ 791.75	
Total Expenditure		\$ 245,246,656	\$ 261,935,691	\$ 279,760,415	\$ 298,798,111	\$ 319,131,323	\$ 1,404,872,196
Expansion Adults w/out Dependent Children							
Pop Type:	Expansion						
Eligible Member Months	2.5%	553,599	567,439	581,625	596,166	611,070	
PMPM Cost	4.2%	\$ 784.97	\$ 817.94	\$ 852.29	\$ 888.09	\$ 925.39	
Total Expenditure		\$ 434,557,732	\$ 464,129,385	\$ 495,713,390	\$ 529,446,686	\$ 565,475,533	\$ 2,489,322,727
Substance Use Disorder (SUD)							
Pop Type:	Expansion						
Eligible Member Months	2.5%	6,036	6,186	6,341	6,500	6,662	
PMPM Cost	4.2%	\$ 4,243.43	\$ 4,421.65	\$ 4,607.36	\$ 4,800.87	\$ 5,002.51	
Total Expenditure		\$ 25,611,365	\$ 27,354,218	\$ 29,215,673	\$ 31,203,800	\$ 33,327,218	\$ 146,712,274
Withdrawal Management							
Pop Type:	Expansion						
Eligible Member Months	2.5%	3,350	3,434	3,520	3,608	3,698	
PMPM Cost	4.2%	\$ 700.00	\$ 729.40	\$ 760.03	\$ 791.96	\$ 825.22	
Total Expenditure		\$ 2,345,000	\$ 2,504,577	\$ 2,675,014	\$ 2,857,048	\$ 3,051,471	\$ 13,433,110

Program transferred from current PCN 1115 Demonstration Waiver effective 10/1/19

Note: Member months and PMPMs are based on state fiscal year and have not been adjusted to reflect starting on federal fiscal year

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Current Eligibles		Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19								
Pop Type:		Medicaid								
Eligible Member Months	0.0%	0	377,866	0.0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	5.3%	0	\$ 949.03	5.3%	\$ 999.33	\$ 1,052.29	\$ 1,108.07	\$ 1,166.79	\$ 1,228.63	
Total Expenditure					\$ 377,612,830	\$ 383,420,334	\$ 355,641,571	\$ 372,830,227	\$ 390,798,881	\$ 1,880,303,842
Demo Pop I - PCN Adults with Children		PCN ends 3/31/19								
Pop Type:		Hypothetical								
Eligible Member Months	5.9%	0	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	5.3%	0	\$ 46.18	5.3%	\$ 48.63	\$ 51.21	\$ 53.92	\$ 56.78	\$ 59.79	
Total Expenditure					\$ 5,399,987	\$ 4,517,106	\$ -	\$ -	\$ -	\$ 9,917,093
Demo Pop III/V - UPP Adults with Children										
Pop Type:		Hypothetical								
Eligible Member Months	34.9%	0	6,067	34.9%	8,182	11,034	14,881	20,068	27,064	
PMPM Cost	5.3%	0	\$ 150.08	5.3%	\$ 158.03	\$ 166.41	\$ 175.23	\$ 184.51	\$ 194.29	
Total Expenditure					\$ 1,292,995	\$ 1,836,150	\$ 2,607,473	\$ 3,702,809	\$ 5,258,269	\$ 14,697,695
Dental - Targeted Adults		Suspend, then new subgroup in new waiver								
Pop Type:		Expansion								
Eligible Member Months		0			-	12,000	9,000	-	-	
PMPM Cost	5.3%	0		5.3%	\$ -	\$ 33.33	\$ 38.20	\$ 40.22	\$ 42.35	
Total Expenditure					\$ -	\$ 400,000	\$ 343,778	\$ -	\$ -	\$ 743,778
System of Care										
Pop Type:		Hypothetical								
Eligible Member Months		0			-	120	1,440	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	\$ -	\$ 2,100.00	\$ 2,211.30	\$ 2,328.50	\$ 2,451.91	
Total Expenditure					\$ -	\$ 252,000	\$ 3,184,272	\$ 3,353,038	\$ 3,530,749	\$ 10,320,060
Dental - Blind/Disabled										
Pop Type:		Hypothetical								
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			\$ 18.42	\$ 18.97	\$ 19.54	\$ 20.13	\$ 20.73	
Total Expenditure					\$ 7,595,690	\$ 7,823,560	\$ 8,058,267	\$ 8,300,015	\$ 8,549,016	\$ 40,326,548
Dental - Aged										
Pop Type:		Hypothetical								
Eligible Member Months	2.5%	0				108,000	110,700	113,468		
PMPM Cost	5.3%	0				\$ 30.75	\$ 32.38	\$ 34.10		
Total Expenditure					\$ -	\$ 3,321,000	\$ 3,584,438	\$ 3,868,774		\$ 10,774,212
Former Foster										
Pop Type:		Hypothetical								
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			\$ 990.87	\$ 1,038.43	\$ 1,088.28	\$ 1,140.51	\$ 1,195.26	
Total Expenditure					\$ 9,909	\$ 10,384	\$ 10,883	\$ 11,405	\$ 11,953	\$ 54,534

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Substance Use Disorder (SUD)										
Pop Type:		Hypothetical			Expansion SUD population transfers to new 1115 waiver 10/1/19					
Eligible Member Months	6.9%	18	36,913	6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18	\$ 3,163.77	5.0%	\$ 3,321.96	\$ 3,488.06	\$ 3,662.46	\$ 3,845.58	\$ 4,037.86	
Total Expenditure					\$ 131,072,269	\$ 147,108,390	\$ 148,527,403	\$ 166,698,858	\$ 187,093,676	\$ 780,500,596
Withdrawal Management										
Pop Type:		Hypothetical			Starts 5/1/19 Expansion Withdrawal Management population transfers to new 1115 waiver 10/1/19					
Eligible Member Months	0.0%	0		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost	5.0%	0		5.0%	\$ -	\$ 700.00	\$ 735.00	\$ 771.75	\$ 810.34	
Total Expenditure					\$ -	\$ 468,738	\$ 1,106,543	\$ 1,161,870	\$ 1,219,963	\$ 3,957,113

Assumes start date of 5/1/19 (2 months of SFY19)

Assumes start date of 7/1/2019 (SFY20); includes costs for porcelain crowns

Assumes start date of 10/1/19 for new 1115 waiver

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
				DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Current Eligibles									
Pop Type:		Medicaid	<i>Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19</i>						
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost		\$ 949.03	5.3%	\$ 999.33	\$ 1,052.29	\$ 1,108.06	\$ 1,166.79	\$ 1,228.63	
Total Expenditure				\$ 377,612,297	\$ 383,419,793	\$ 355,641,069	\$ 372,829,701	\$ 390,798,329	\$ 1,880,301,189
Demo Pop I - PCN Childless Adults									
Pop Type:		Medicaid	<i>PCN ends 3/31/19</i>						
Eligible Member Months		70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost		\$ 48.97	5.3%	\$ 51.57	\$ 54.30	\$ 57.18	\$ 60.21	\$ 63.40	
Total Expenditure				\$ 3,806,153	\$ 3,165,223	\$ -	\$ -	\$ -	\$ 6,971,376
Demo Pop III/V - UPP Childless Adults									
Pop Type:		Medicaid							
Eligible Member Months		159	4.9%	167	175	184	193	202	
PMPM Cost		\$ 68.45	5.3%	\$ 72.08	\$ 75.90	\$ 79.92	\$ 84.16	\$ 88.62	
Total Expenditure				\$ 10,702	\$ 11,237	\$ 11,799	\$ 12,388	\$ 13,008	\$ 59,133
Targeted Adults									
Pop Type:		Expansion	<i>Started 11/1/17, suspended in this 1115 waiver and transferred to the new 1115 waiver 10/1/19</i>						
Eligible Member Months			0%	78,000	78,000	78,000	78,000	78,000	
PMPM Cost			5.3%	\$ 979.53	\$ 1,031.45	\$ 1,086.11	\$ 1,143.68	\$ 1,204.29	
Total Expenditure				\$ 76,403,340	\$ 80,452,717	\$ 84,716,711	\$ 89,206,697	\$ 93,934,652	\$ 424,714,116
Dental - Targeted Adults									
Pop Type:		Expansion	<i>Started 3/1/19 Porcelain crowns anticipated start date of 7/1/19</i>						
Eligible Member Months				-	12,000	9,000	-	-	
PMPM Cost			5.3%	\$ -	\$ 33.33	\$ 38.20	\$ 40.22	\$ 42.35	
Total Expenditure				\$ -	\$ 400,000	\$ 343,778	\$ -	\$ -	\$ 743,778
System of Care									
Pop Type:		Hypothetical	<i>Start 6/1/19</i>						
Eligible Member Months				-	120	1,440	1,440	1,440	
PMPM Cost			5.3%	\$ -	\$ 2,100.00	\$ 2,211.30	\$ 2,328.50	\$ 2,451.91	
Total Expenditure				\$ -	\$ 252,000	\$ 3,184,272	\$ 3,353,038	\$ 3,530,749	\$ 10,320,060
Demo Pop I - PCN Adults w/Children									
Pop Type:		Hypothetical	<i>PCN ends 3/31/19</i>						
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost		\$ 46.18	5.3%	\$ 48.63	\$ 51.20	\$ 53.92	\$ 56.77	\$ 59.78	
Total Expenditure				\$ 5,399,479	\$ 4,516,681	\$ -	\$ -	\$ -	\$ 9,916,160
Demo Pop III/V - UPP Adults with Children									
Pop Type:		Hypothetical							
Eligible Member Months		6,067	34.9%	\$ 8,181.96	\$ 11,034.19	\$ 14,880.70	\$ 20,068.12	\$ 27,063.86	
PMPM Cost		\$ 150.08	5.3%	\$ 158.04	\$ 166.41	\$ 175.23	\$ 184.52	\$ 194.30	
Total Expenditure				\$ 1,293,049	\$ 1,836,227	\$ 2,607,582	\$ 3,702,963	\$ 5,258,489	\$ 14,698,309

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

ELIGIBILITY GROUP		DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
DY 15			DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	
Dental - Blind/Disabled								
Pop Type: Hypothetical								
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	\$ 18.42	\$ 18.97	\$ 19.54	\$ 20.13	\$ 20.73	
Total Expenditure			\$ 7,595,690	\$ 7,823,560	\$ 8,058,267	\$ 8,300,015	\$ 8,549,016	\$ 40,326,548
Dental - Aged								
Pop Type: Hypothetical		Anticipated start date of 7/1/19						
Eligible Member Months		0%	-	-	108,000	110,700	113,468	
PMPM Cost		3.0%	\$ -	\$ -	\$ 30.75	\$ 32.38	\$ 34.10	
Total Expenditure			\$ -	\$ -	\$ 3,321,000	\$ 3,584,438	\$ 3,868,774	\$ 10,774,212
Former Foster Care								
Pop Type: Hypothetical								
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	\$ 990.87	\$ 1,038.43	\$ 1,088.28	\$ 1,140.51	\$ 1,195.26	
Total Expenditure			\$ 9,909	\$ 10,384	\$ 10,883	\$ 11,405	\$ 11,953	\$ 54,534
Substance Use Disorder (SUD)								
Pop Type: Hypothetical		Expansion SUD population transfers to new 1115 waiver 10/1/19						
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	\$ 3,321.96	\$ 3,488.06	\$ 3,662.46	\$ 3,845.58	\$ 4,037.86	
Total Expenditure			\$ 131,072,269	\$ 147,108,390	\$ 148,527,403	\$ 166,698,858	\$ 187,093,676	\$ 780,500,596
Withdrawal Management								
Pop Type: Hypothetical		Starts 5/1/19 Expansion Withdrawal Management population transfers to new 1115 waiver 10/1/19						
Eligible Member Months		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost		5.0%	\$ -	\$ 700.00	\$ 735.00	\$ 771.75	\$ 810.34	
Total Expenditure			\$ -	\$ 468,738	\$ 1,106,543	\$ 1,161,870	\$ 1,219,963	\$ 3,957,113
		Assumes start date of 5/1/19 (2 months of SFY19)						
		Assumes start date of 7/1/2019 (SFY20); includes costs for porcelain crowns						
		Assumes start date of 10/1/19 for new 1115 waiver						

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.

ATTACHMENT 2

Public Notice Requirements



4770 S. 5600 W.
WEST VALLEY CITY, UTAH 84118
FED.TAX I.D.# 87-0217663
801-204-6910

PROOF OF PUBLICATION CUSTOMER'S COPY

CUSTOMER NAME AND ADDRESS

UTAH DEPARTMENT OF HEALTH BUREAU OF
COVERAGE/REIMBURSEMENT,
CRAIG DEVASHRAYEE
PO BOX 143102

SALT LAKE CITY UT 84114

ACCOUNT NAME

UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEMENT

TELEPHONE

8015386641

PUBLICATION SCHEDULE

START 05/31/2019 END 05/31/2019

CUSTOMER REFERENCE NUMBER

QAZ: Utah 1115 Demonstration Application

CAPTION

PUBLIC NOTICE Utah 1115 Demonstration Application The Utah Department of Health

SIZE

82 LINES

3 COLUMN(S)

TIMES

3

TOTAL COST

418.28

AFFIDAVIT OF PUBLICATION

AS NEWSPAPER AGENCY COMPANY, LLC dba UTAH MEDIA GROUP LE
ADVERTISEMENT OF **PUBLIC NOTICE Utah 1115 Demonstration Application**

Health Financing (DMHF) will hold public hearings t FOR UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEMENT, WAS PUBLISHED BY THE NEWSPAPER AGENCY COMPANY, LLC dba UTAH MEDIA GROUP, AGENT FOR DESERET NEWS AND THE SALT LAKE TRIBUNE, DAILY NEWSPAPERS PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON Start 05/31/2019 End 05/31/2019

DATE 5/31/2019

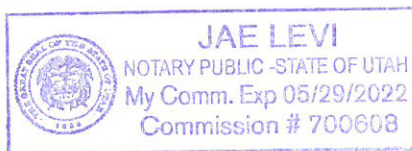
SIGNATURE

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 31ST DAY OF MAY IN THE YEAR 2019

BY LORAIN GUDMUNDSON.



**PUBLIC NOTICE
Utah 1115 Demonstration Application**

Deseret News

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) will hold public hearings to discuss a new section 1115 demonstration application. DMHF will also accept public comment regarding this demonstration application during the 30-day public comment period from May 31, 2019, through June 30, 2019.

DMHF is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. DMHF will submit a new 1115 demonstration application to request authority to implement these provisions. The provisions of Senate Bill 96 include:

- Authority to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Populations;
- Implement a per capita cap-funding mechanism;
- Implement a lock-out for committing an Intentional Program Violation for Medicaid;
- Federal expenditure authority to provide housing-related services and supports;
- Allow up to 12 months of continuous eligibility for the Adult Expansion Medicaid population;
- Not allowing hospitals to make presumptive eligibility determinations for the Adult Expansion Medicaid population;
- Allow for managed care flexibilities.

In addition, DMHF will also include in this request, to transition the following approved programs and provisions from Utah's approved 1115 Primary Care Network Demonstration, to this new application:

- Adult Expansion Population;
- Targeted Adult Population, including dental benefits for Targeted Adults who are receiving substance use disorder (SUD) treatment;
- Clinically managed residential withdrawal pilot for the Adult Expansion and Targeted Adult Populations only;
- SUD treatment benefits for the Adult Expansion and Targeted Adult Populations only;
- Enrollment limits for the Adult Expansion and Targeted Adult Populations;
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT);
- Implement a community engagement requirement under the full FMAP for the Adult Expansion Medicaid Population;
- Provide premium reimbursement and wrap-around Medicaid coverage under full FMAP, to eligible Adult Expansion individuals who have access to employer-sponsored insurance.

Public Hearings:

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

- Thursday, June 6, 2019, from 2:00 p.m. to 4:00 p.m., during a special session of the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in Room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.

- Monday, June 17, 2019, from 4:00 p.m. to 6:00 p.m., in Room 1020 of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.

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

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Tuesday, June 4, 2019.

Public Comment:

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

The public may comment on the proposed application request during the 30-day public comment period from May 31, 2019, through June 30, 2019.

Comments may be submitted:

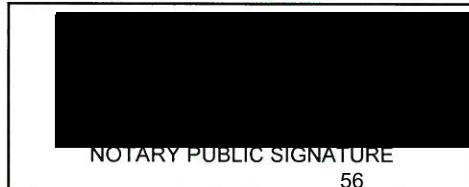
Online: <https://medicaid.utah.gov/1115-waiver>

Email: Medicaid1115waiver@utah.gov

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

1256261

UPAXLP



4770 S. 5600 W.
WEST VALLEY CITY, UTAH 84118
FED.TAX I.D.# 87-0217663
801-204-6910

Deseret News

Utah
Media
Group

PUBLIC NOTICE
Utah 1115 Demonstration Application

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) will hold a second public hearing to discuss a new section 1115 demonstration application. DMHF will also accept public comment regarding this demonstration application during the 30-day public comment period, which began May 31, 2019, and continues through June 30, 2019.

DMHF is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. DMHF will submit a new 1115 demonstration application to request authority to implement these provisions. The provisions of Senate Bill 96 include:

- Authority to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Populations;
- Implement a per capita cap-funding mechanism;
- Implement a look-out for committing an Intentional Program Violation for Medicaid;
- Federal expenditure authority to provide housing-related services and supports;
- Allow up to 12 months of continuous eligibility for the Adult Expansion Medicaid population;
- Not allowing hospitals to make presumptive eligibility determinations for the Adult Expansion Medicaid population;
- Allow for managed care flexibilities.

In addition, DMHF will also include in this request, to transition the following approved programs and provisions from Utah's approved 1115 Primary Care Network Demonstration, to this new application:

- Adult Expansion Population;
- Targeted Adult Population, including dental benefits for Targeted Adults who are receiving substance use disorder (SUD) treatment;
- Clinically managed residential withdrawal pilot for the Adult Expansion and Targeted Adult Populations only;
- SUD treatment benefits for the Adult Expansion and Targeted Adult Populations only;
- Enrollment limits for the Adult Expansion and Targeted Adult Populations;
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT);
- Implement a community engagement requirement under the full FMAP for the Adult Expansion Medicaid Population;
- Provide premium reimbursement and wrap-around Medicaid coverage under full FMAP, to eligible Adult Expansion individuals who have access to employer-sponsored insurance.

Public Hearing:

DMHF will conduct a second public hearing to discuss the demonstration application. The date, time, and location is listed below:

Monday, June 17, 2019, from 4:00 p.m. to 6:00 p.m., in Room 1020 of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.

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

Individuals requiring an accommodation to fully participate may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Friday, June 14, 2019.

Public Comment:

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

The public may comment on the proposed application request during the 30-day public comment period, which began May 31, 2019, and continues through June 30, 2019.

Comments may be submitted:

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

Email: Medicaid1115waiver@utah.gov

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

1257299

UPAXLP

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CUSTOMER NAME AND ADDRESS

UTAH DEPARTMENT OF HEALTH BUREAU OF
COVERAGE/REIMBURSEME,
CRAIG DEVASHRAYEE
PO BOX 143102

SALT LAKE CITY UT 84114

ACCOUNT NAME

UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME,

TELEPHONE

8015386641

PUBLICATION SCHEDULE

START 06/09/2019 END 06/09/2019

CUSTOMER REFERENCE NUMBER

QAZ: Utah 1115 Demonstration Application

CAPTION

PUBLIC NOTICE Utah 1115 Demonstration Application The Utah Department of Health,

SIZE

96 LINES

2 COLUMN(S)

TIMES

3

TOTAL COST

327.56

AFFIDAVIT OF PUBLICATION

AS NEWSPAPER AGENCY COMPANY, LLC dba UTAH MEDIA GROUP LEGAL BOOKER, I
ADVERTISEMENT OF **PUBLIC NOTICE Utah 1115 Demonstration Application The Utah Department of Health Financing (DMHF) will hold a second public hearing FOR UTAH DEPARTMENT OF COVERAGE/REIMBURSEME**, WAS PUBLISHED BY THE NEWSPAPER AGENCY COMPANY, LLC FOR DESERET NEWS AND THE SALT LAKE TRIBUNE, DAILY NEWSPAPERS PRINTED IN THE EN CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLIC UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODI

PUBLISHED ON Start 06/09/2019 End 06/09/2019

DATE 6/10/2019

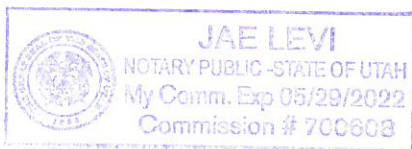
SIGNATURE

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 9TH DAY OF JUNE IN THE YEAR 2019

BY LORAIN GUDMUNDSON.



NOTARY PUBLIC SIGNATURE



For Immediate Release:

May 31, 2019

Media Contact:

Tom Hudachko

Utah Department of Health

(o) 801.538.6232

(m) 801.560.4649

News Release

UDOH Releases New Medicaid Waiver Proposal

Agency soliciting public comment on proposal

(Salt Lake City, UT) – The Utah Department of Health (UDOH) today [released a proposal](#) to increase the federal share of the costs associated with expanding the state’s Medicaid program while accepting limits on the amount of federal funds that would be available for the program.

On April 1 Utah expanded Medicaid coverage to approximately 70,000-90,000 adults who earn up to 100% of the federal poverty level (about \$12,492 for an individual or \$25,752 for a family of four). The federal government covers approximately 70% of the costs associated with caring for these newly eligible adults, with the state covering the remaining 30%.

More than 31,000 Utah adults are already enrolled in the expanded Medicaid program.

In preparing this proposal, the UDOH is implementing the requirements outlined in Senate Bill 96 (2019), which directs how Medicaid expansion will occur in the state.

Known as the ‘per-capita cap,’ the proposal seeks to increase federal cost sharing to 90%. It also allows the federal government to cap the amount of money it will direct to the state to cover the newly eligible adults. Other elements of the proposal include a self-sufficiency requirement, the ability to provide housing supports, an option to lockout individuals who deliberately violate program requirements, and allowing up to 12 months of continuous eligibility.

The UDOH will accept public comment on the new proposal through June 30, 2019. Comments may be submitted online at <https://medicaid.utah.gov/1115-waiver> or by email at medicaid1115waiver@utah.gov.

Comments may also be submitted at two public hearings in June. The public hearings will be held:

- **Thursday, June 6**
2:00 – 4:00 p.m.
Cannon Health Building – Room 125

288 North 1460 West
Salt Lake City

- **Monday, June 17**
4:00 – 6:00 p.m.
Multi Agency State Office Building – Room 1020
195 North 1950 West
Salt Lake City

Following the public comment period the UDOH will review submitted comments and determine if changes should be made to the proposal. Then the UDOH will submit its proposal to the Centers for Medicare and Medicaid Services (CMS), which is responsible for approving or denying the request.

“We have worked hard over the last couple of months to develop a proposal that adheres to Senate Bill 96 and provides Utah with the best chance of implementing a successful Medicaid expansion.” said Nate Checketts, UDOH deputy director and director of the state Medicaid program. “We hope CMS will act on our request in a timely manner so we can implement the new elements of the program later this year or early next year.”

To be eligible for the expanded Medicaid program, individuals must be a Utah resident between the ages of 19 and 64, be a U.S. citizen or legal resident, and meet income requirements. Information on how to apply for Medicaid can be found at <https://medicaid.utah.gov/apply-medicaid>. Enrollment for adults up to 100% of the federal poverty line has been open since April 1 and potentially eligible individuals are encouraged to apply to determine if they qualify for coverage.

#



Full Public Notice

Section 1115 Demonstration Application

Utah Per Capita Cap

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) intends to submit a request to the Centers for Medicare and Medicaid Services (CMS) to implement a new section 1115 demonstration as a result of Senate Bill 96- "Medicaid Expansion Amendments", which passed during the 2019 Utah Legislative Session. DMHF will hold two public hearings to discuss the demonstration application. In addition, DMHF will accept public comment regarding this demonstration application during the 30-day public comment period from May 31, 2019 through June 30, 2019.

With this application, the State is seeking approval to implement the following new proposals as directed by Senate Bill 96:

- Authority to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Populations
- Implement a per capita cap funding mechanism
- Implement a lock-out for committing an Intentional Program Violation for Medicaid
- Federal expenditure authority to provide housing related services and supports
- Allow up to 12-months of continuous eligibility for the Adult Expansion Medicaid population
- Not allowing hospitals to make presumptive eligibility determinations for the Adult Expansion Medicaid population
- Allow for managed care flexibilities.

The State is also requesting to administer the following components and programs under this new demonstration application, which are currently authorized under the State's 1115 Primary Care Network (PCN) Demonstration Waiver:

- Adult Expansion Population
- Targeted Adult Population, including dental benefits for Targeted Adults who are receiving substance use disorder (SUD) treatment
- Clinically managed residential withdrawal pilot for the Adult Expansion and Targeted Adult Populations only
- SUD treatment benefits for the Adult Expansion and Targeted Adult Populations only
- Enrollment limits for the Adult Expansion and Targeted Adult Populations
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement under the full FMAP for the Adult Expansion Medicaid Population
- Provide premium reimbursement and wrap-around Medicaid coverage under full FMAP, to eligible Adult Expansion individuals who have access to employer-sponsored insurance.

I. Program Description:

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

1. Adult Expansion Population, defined as:
 - Adults ages 19 through 64
 - A U.S. Citizen or qualified alien
 - Non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
 - A resident of Utah
 - Residents of a public institution are not eligible unless furloughed for an inpatient stay
 - Have a household income at or below 95 percent of the federal poverty level (FPL) using the Modified Adjusted Gross Income (MAGI) methodology which includes a five percent FPL disregard
 - Ineligible for other Medicaid programs that do not require a spenddown to qualify
 - Must not be eligible for Medicare under parts A or B of title XVIII of the Act
2. Targeted Adult Population, defined as:
 - Adults age 19 through 64, without a dependent child
 - A U.S. Citizen or qualified alien
 - A resident of Utah
 - Residents of a public institution are not eligible unless furloughed for an inpatient stay
 - Household income at or below five percent of the FPL
 - Ineligible for other Medicaid programs that do not require a spenddown
 - Must not be eligible for Medicare under parts A or B of title XVIII of the Act
 - Must also meet at least one of the following criteria:
 - Chronically homeless
 - Involved in the justice system and in need of substance use or mental health treatment
 - Needing substance use or mental health treatment

Overview of New Proposals:

The State is requesting to implement the following new components with this demonstration application:

1. Authority to Receive Increased FMAP

The State is requesting a waiver of the income level specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to allow the State to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y), which is 93 percent for 2019, and 90 percent for 2020 and each year thereafter, for this Demonstration group. The State is requesting this waiver for the Adult Expansion demonstration group, which includes adults with dependent children with household income using the 2014 Parent Caretaker Relative income standard up to 95 percent of the FPL, and adults without dependent children with household income between zero percent and 95 percent of the FPL. The State is also requesting to include the Targeted Adult Population in this request.

2. Lock-Out due to Intentional Program Violation

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

3. Housing Related Services and Supports

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

Because food insecurity, transportation insecurity, interpersonal violence or trauma pose potential barriers to housing and health, housing supports also include evidence-based services to address these barriers. Through this waiver, the State requests authority to provide housing supports across the Adult Expansion Population. The State also requests authority to target services to targeted populations through its administrative rulemaking process rather than waiver amendment. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the targeted services and/or targeted populations.

For initial implementation, the State intends the Targeted Adult Population to be one of the groups that will receive these evidence-based services and supports. In addition, the State's efforts to reduce barriers that impact individuals' health will initially focus on providing housing related services and supports to eligible populations.

4. Up to 12-Months Continuous Eligibility

The State proposes to allow up to 12-months of continuous eligibility for the Adult Expansion Population. If an individual's household income exceeds 95 percent of FPL, with a five percent FPL disregard, they will receive up to 12-months continuous eligibility.

The State requests the ability to limit the continuous eligibility provision for the Adult Expansion Population based on income or targeted populations as defined by the State in administrative rule. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the number of continuous months, the income level, and/or targeted populations.

It is anticipated that the State would initially implement 6-month continuous eligibility, without a maximum income, across the Adult Expansion Population that is not identified as Targeted Adults.

5. Not Allow Presumptive Eligibility Determined by a Hospital

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

6. Per Capita Cap Funding

The State proposes that Federal Financial Participation (FFP) be available up to a limit set by a per capita cap methodology for this demonstration. Under this methodology, the State will work with CMS to establish a per enrollee base amount for the first demonstration year with trending for future demonstration years. The per capita cap multiplied by the actual enrollment will be the total expenditure cap for this demonstration. Expenditure caps will be set annually and reconciled with actual expenditures and enrollment. Total computable expenditures in excess of the total expenditure cap will receive the State's regular FMAP.

Enrollment Groups: The per capita cap should allow for separate enrollment groups which account for differences in costs among categories. During reconciliation, the State requests that cost savings under one enrollment group be allowed to cover cost excesses in another enrollment group. The State requests that individuals with verified membership in a federally recognized tribe, incarcerated individuals with inpatient stays, and non-citizens enrolled under the Emergency Only program be excluded from the per capita cap calculations.

Base Period: The State will work with CMS to establish the appropriate base. To the greatest extent possible, the State's experience with other similar populations should be used. In particular, the State has experience with the demonstration population of parents known as "Current Eligibles" and adults without dependent children known as "Targeted Adults." Base period experience in these populations should be used to estimate expenditures for the new demonstration populations.

Re-Basing: After two years of experience under this demonstration, the State will work with CMS to re-base the per capita cap as needed. Re-basing will be necessary if actual expenditures are 5 percent or more below or above the cap

Trend: The State requests that the per capita cap amounts grow each year to account for medical inflation. This trend rate should take into account state and regional factors. The per capita cap growth should continue to increase by the selected growth rate every year.

Special Circumstances: The State requests that CMS considers unforeseen special circumstances beyond the State's control in the establishment of per capita caps. This may be a public health emergency, the introduction of a new high cost pharmaceutical that the State is required to cover, or a major economic event. Under these circumstances, the State shall provide any applicable data and documentation demonstrating the severity and scope of the event. With sufficient documentation under these special circumstances, the State requests that FFP for excess total expenditures be allowable.

Overview of Programs and Benefits Transitioning to this Demonstration:

The State is also requesting to administer the following components and programs under this new demonstration application, which are currently authorized under the State's 1115 Primary Care Network (PCN) Demonstration Waiver:

1. Adult Expansion Population

The State proposes to administer the Adult Expansion Population under this demonstration application. Adults included in this population are age 19 through 64 who have household income up to 95 percent of the federal poverty level (FPL) using the modified adjusted gross income (MAGI) methodology, which includes a five percent of FPL disregard.

2. Targeted Adult Medicaid Population and Targeted Adult Dental Benefits

The State requests authority to administer the Targeted Adult Population under this new waiver application, including the provision to allow 12-months continuous eligibility, as well as traditional state plan dental benefits provided to Targeted Adults who are receiving Substance Use Disorder treatment, as approved under the State's 1115 PCN Demonstration Waiver.

3. Clinically Managed Residential Withdrawal Pilot

Also as part of this request, the State proposes to include clinically managed residential withdrawal management services for the Adult Expansion and Targeted Adult Populations only, in this waiver application. This pilot is currently approved in the State's 1115 PCN Demonstration Waiver for all Medicaid eligible adults residing in Salt Lake County. The State proposes to administer this service under this demonstration, as approved under the State's 1115 PCN Demonstration Waiver. For all other eligible adults, these services will continue to be provided under the State's 1115 PCN Demonstration Waiver. The service will be provided to Medicaid eligible adults residing in Salt Lake County.

4. Substance Use Disorder treatment provided in an Institution for Mental Disease (IMD)

The State currently has approval through its 1115 PCN Demonstration Waiver to administer a benefit package for all Medicaid recipients that includes substance use disorder 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 is eligible to receive Federal Financial Participation (FFP) for Medicaid recipients residing in an IMD under the terms of the demonstration for coverage of medical assistance and SUD benefits, which would otherwise be matchable if the recipient were not residing in an IMD. This benefit is available to all Medicaid eligible individuals, including those in the Adult Expansion and Targeted Adult Populations.

5. Community Engagement through a Self Sufficiency Requirement

With this waiver application, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion Population, not to include Targeted Adults. The community engagement requirement was originally approved for this population, as part of the Medicaid expansion authorized in the March 29, 2019 amendment to the State's 1115 PCN Demonstration Waiver.

6. Enrollment Limits

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

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

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

8. Employer Sponsored Insurance (ESI Reimbursement)

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

II. Demonstration Goal/Objective:

The goals and objectives of the demonstration are to:

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

III. Proposed Delivery System:

Services for Demonstration individuals will be provided initially through FFS. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

By January 2020, the State intends to transition populations covered by this application into managed care. In Utah's four largest counties, individuals in the Adult Expansion program will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity.

Employer Sponsored Insurance- Individuals with Access to ESI

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

Managed Care Flexibilities

Utah intends to use managed care as the primary service delivery system for populations covered under this waiver. As part of this application request, Utah is asking for greater flexibility and authority to use alternative approaches to come into compliance with 42 CFR 438 in the following areas:

- Demonstration of actuarial soundness of rates
- Flexibility in managed care contract review
- Demonstration of directed payment compliance

- Access to care and availability of services

This will allow the state to administer its managed care delivery system upon approval of this waiver without delays related to additional federal approvals.

IV. Benefits and Cost Sharing Requirements:

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

Eligibility Group and Benefit Package

Eligibility Group	Benefit Package
Adults with Dependent Children	<ul style="list-style-type: none"> • Non-Traditional Benefits (see description below) • Up to 12-months continuous eligibility
Adults without Dependent Children	<ul style="list-style-type: none"> • State Plan Benefits • Up to 12-months continuous eligibility
ESI Eligible Adults with Dependent Children	<ul style="list-style-type: none"> • Premium Reimbursement with Non-Traditional Benefit Wrap-around • Up to 12-months continuous eligibility
ESI Eligible Adults without Dependent Children	<ul style="list-style-type: none"> • Premium Reimbursement with State Plan Benefit Wrap-around • Up to 12-months continuous eligibility
Targeted Adults	<ul style="list-style-type: none"> • State Plan Benefits, and dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms & Conditions #23(h)) of the 1115 PCN Demonstration Waiver • 12-months continuous eligibility
Housing Related Services and Supports for Individuals Meeting Needs Based Criteria	<ul style="list-style-type: none"> • Tenancy Support Services • Community Transition Services • Supportive Living/Housing Services

Non-Traditional Benefit Package

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

Benefits Different from State Plan

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

Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Dental	Dental services are not covered, with exceptions.

Cost Sharing

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

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

Cost Sharing for Certain American Indian/Alaskan Native Eligibles: American Indian/Alaskan Native individuals enrolled in the Demonstration are subject to cost sharing exemptions of section 5006 of the American Recovery Reinvestment Act of 2009, and are not required to pay premiums or cost sharing for services received through the Indian health care system.

V. Annual Enrollment and Expenditures:

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

Enrollment	DY 1	DY 2	DY 3	DY 4	DY 5
Targeted Adults	4,086	4,188	4,293	4,400	4,510
Dental - Targeted Adults	3,000	3,075	3,152	3,231	3,311
Expansion Parents	30,430	31,191	31,971	32,770	33,589
Expansion Adults without Children	46,114	47,267	48,448	49,660	50,901
SUD	503	516	528	542	555
Withdrawal Management	279	286	293	301	308

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

Expenditures (Total Fund)	DY 1	DY 2	DY 3	DY 4	DY 5
Targeted Adults	\$68,013,000	\$72,641,000	\$77,585,000	\$82,864,000	\$88,503,000
Dental - Targeted Adults	\$1,375,000	\$1,469,000	\$1,569,000	\$1,675,000	\$1,790,000
Expansion Parents	\$245,248,000	\$261,937,000	\$279,762,000	\$298,799,000	\$319,133,000
Expansion Adults without Children	\$431,654,000	\$461,028,000	\$492,401,000	\$525,909,000	\$561,697,000
SUD	\$25,613,000	\$27,356,000	\$29,218,000	\$31,206,000	\$33,330,000
Withdrawal Management	\$2,345,000	\$2,505,000	\$2,675,000	\$2,857,000	\$3,051,000

VI. Waivers and Expenditure Authorities:

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

Waiver Authority	Reason and Use of Waiver
Section 1902(a)(10) and (a)(52)- Eligibility	To the extent necessary to enable the State to prohibit re-enrollment and deny eligibility for the Adult Expansion Medicaid demonstration group for a period of six months for individuals who commit an intentional program violation.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Adult Expansion eligibles compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide housing supports and services.
Section 1902(a)(1)- Statewide Operation	To the extent necessary to enable the State to implement housing supports in geographically limited areas of the state.
Section 1902(a)(10)(A)(i)(VIII)- 133 Percent Income Level	To enable the State to apply a lower income level to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Medicaid Populations who have an income level of 95 percent FPL.

Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	Effective no sooner than January 1, 2020, to the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to beneficiaries subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs. Effective no sooner than January 1, 2020, to the extent necessary to enable the state to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.
Section 1906(i)(26)- Compliance with ABP Requirements	In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that the conditions for FFP in section 1903(i)(26) are not satisfied.

Expenditure Authority

Adult Expansion Demonstration Group: Expenditures for optional services not covered under Utah's State Plan or beyond the State Plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR 438 et seq.

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

VII. Hypotheses and Evaluation Parameters of the Demonstration:

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

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

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

promote engagement with the employment process will improve the health outcomes of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	<ul style="list-style-type: none"> • Number of non-emergent ED visits • Number of cancer screenings • Number of well-care visits 		measures to include quasi-experimental comparisons
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	Reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid	Beneficiary Surveys	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Up to 12-Months Continuous Eligibility			
The Demonstration will not discourage increases to household earned income.	Percentage of adults increasing earned income compared to a comparison group	eREP Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Per Capita Cap Funding			
Medicaid expenditures under this demonstration will grow at a slower rate than the national average of Medicaid Adult Expansion per enrollee spending which will demonstrate program sustainability.	Demonstration growth rate compared to Medicaid national growth rate in equivalent basis years of expansion (e.g. year one, year two, etc.)	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

The Demonstration will not negatively impact an individual's health.	<ul style="list-style-type: none"> • Number of prescriptions • Number of non emergent ED visits • Number of cancer screenings • Number of well-care visits 	Claims/encounter data CMS Adult Core Measures	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Lock-Out for Intentional Program Violation			
The Demonstration will discourage individuals from committing an IPV by disqualifying individuals who commit an IPV.	Percentage of IPV's compared to a comparison group	Enrollment and IPV Lock-Out Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Housing Supports			
The demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

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

VIII. Review of Documents and Submission of Comments

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

A copy of the DMHF's proposed demonstration is available for review online at:

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

A copy of the DMHF's proposed demonstration may be requested in writing from:

Utah Department of Health

Division of Medicaid and Health Financing

PO Box 143106

Salt Lake City, UT 84114-3106

Attn: Jennifer Meyer-Smart

Submitting Public Comments:

The public may comment on the proposed demonstration application during the 30-day public comment period, from May 31, 2019 through June 30, 2019.

Comments may be submitted:

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

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health

Division of Medicaid and Health Financing

PO Box 143106

Salt Lake City, UT 84114-3106

Attn: Jennifer Meyer-Smart

Public Hearings:

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

- Thursday, June 6, 2019
2:00 p.m. to 4:00 p.m. (as part of a special session of the Medical Care Advisory Committee (MCAC) meeting)
Cannon Health Building
288 N 1460 W, Salt Lake City, Utah
Room 125
- Monday, June 17, 2019
4:00 p.m. to 6:00 p.m.
Multi-Agency State Office Building
195 N 1950 W, Salt Lake City, Utah
Room 1020

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

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Tuesday, June 4, 2019.



PUBLIC NOTICE

Utah 1115 Demonstration Application

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) will hold public hearings to discuss a new section 1115 demonstration application. DMHF will also accept public comment regarding this demonstration application during the 30-day public comment period from May 31, 2019 through June 30, 2019.

DMHF is requesting authority to implement the provisions of Senate Bill 96 “Medicaid Expansion Adjustments”, which passed during the 2019 Utah Legislative Session. DMHF will submit a new 1115 demonstration application to request authority to implement these provisions. The provisions of Senate Bill 96 include:

- Authority to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Populations
- Implement a per capita cap funding mechanism
- Implement a lock-out for committing an Intentional Program Violation for Medicaid
- Federal expenditure authority to provide housing related services and supports
- Allow up to 12-months of continuous eligibility for the Adult Expansion Medicaid population
- Not allowing hospitals to make presumptive eligibility determinations for the Adult Expansion Medicaid population
- Allow for managed care flexibilities.

In addition, the DMHF will also include in this request, to transition the following approved programs and provisions from Utah’s approved 1115 Primary Care Network Demonstration, to this new application:

- Adult Expansion Population
- Targeted Adult Population, including dental benefits for Targeted Adults who are receiving substance use disorder (SUD) treatment
- Clinically managed residential withdrawal pilot for the Adult Expansion and Targeted Adult Populations only
- SUD treatment benefits for the Adult Expansion and Targeted Adult Populations only
- Enrollment limits for the Adult Expansion and Targeted Adult Populations
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement under the full FMAP for the Adult Expansion Medicaid Population
- Provide premium reimbursement and wrap-around Medicaid coverage under full FMAP, to eligible Adult Expansion individuals who have access to employer-sponsored insurance

Public Hearings:

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

- Thursday, June 6, 2019 from 2:00 p.m. to 4:00 p.m., during a special session of the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.
- Monday, June 17, 2019 from 4:00 p.m. to 6:00 p.m., in room 1020 of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.

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

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Tuesday, June 4, 2019.

Public Comment:

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

The public may comment on the proposed application request during the 30-day public comment period from May 31, 2019 through June 30, 2019.

Comments may be submitted:

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

Email: Medicaid1115waiver@utah.gov

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

ATTACHMENT 3

Public Comments and State Responses



Summary of Public Comments and State Responses

Per Capita Cap

The State received 1,755 comments from individuals, advocacy groups and other community partners. The State appreciates all comments and feedback submitted regarding this waiver application. A summary of the comments submitted related to the waiver application and the State's responses to those comments are detailed below. Some comments were outside the scope of the waiver application and are not addressed in the State's responses.

Full Expansion

1. Many commenters stated that they do not want the State to pursue a waiver and instead would like the State to pursue full Medicaid expansion as approved by Proposition 3. They claim that various components of the waiver request violate the purpose of the Medicaid program and that it would be illegal for the Secretary of Health and Human Services to approve the State's request.

Response: In November 2018, Utah voters approved Proposition 3. The proposition expanded Medicaid to 133 percent of the federal poverty level (FPL) for adults ages 19-64, mandated an annual inflationary increase for all Medicaid providers across the entire Medicaid program (both in and out of expansion), and raised the State's sales tax. In February 2019, the Utah Legislature passed and Governor Herbert signed Senate Bill 96 citing concerns that Proposition 3's sales tax was insufficient to cover both the expansion and the mandatory provider rate increases and that growth in the Medicaid program might not be sustainable for the State in the long term. Senate Bill 96 directed the Utah Department of Health (UDOH) to seek a series of waivers that, if approved, would expand Medicaid up to 100 percent FPL, obtain enhanced match (90 percent federal/10 percent state), and implement other provisions designed to create an expansion program that closed the coverage gap while putting in place program integrity requirements and fiscal circuit breakers. Senate Bill 96 outlines a Medicaid expansion proposal that the Utah Legislature and Governor Herbert believe is feasible for Utah.

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

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and

individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

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

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

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

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

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

Both under this administration and under President Obama's administration, the Centers for Medicare and Medicaid Services (CMS), has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking. It is not uncommon for CMS's interpretation of its authorities to evolve. As CMS Administrator Seema Verma said to state Medicaid directors in November 2017, "So now it is up to you, the states, to put your innovative ideas into practice. We very much look forward to your proposals and helping you implement successful initiatives that improve the health and lives of the diverse set of beneficiaries you serve." The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to approve this waiver proposal, which will improve the health and lives of an estimated 70,000 to 90,000 Utahns.

On July 27, 2019, CMS released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely the Secretary will use his authority at this time to allow enhanced funding for an expansion up to 100 percent FPL, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

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

Second, the State believes there is value in getting a formal response from CMS on its waiver request. Since June 2018, the State has discussed several proposals with CMS and submitted a waiver request for enhanced match for partial expansion. These discussions have elicited verbal feedback from the administration which the State believed were helpful in crafting its proposal. However, a more formal response from CMS would best serve the State in knowing where this administration is positioned on key items contained in the State's waiver request.

Finally, the State's waiver request also contains many other program features beyond the request for enhanced match for expansion up to 100% FPL. The State believes that obtaining a response from CMS

on these other features will help the State in constructing the next waiver request envisioned by Senate Bill 96.

Request to Obtain Enhanced Federal Medical Assistance Percentage (FMAP)

2. Several commenters stated they believe the State’s request to obtain the enhanced FMAP amount allowable under the ACA is not a legal request because the State has not fully expanded to 138 percent FPL. They believe that Section 1115 waiver authority does not extend to section 1905 of the Social Security Act. They therefore believe CMS does not have authority to approve this request, and it should be denied.

Response: This waiver proposal seeks to implement policy established by the Utah Legislature and Governor Herbert through Senate Bill 96. The bill directs UDOH to submit a waiver proposal for a Medicaid expansion up to 100% FPL with costs matched at the enhanced 90/10 match rate. As stated in the response to Comment 1, the State believes that the combination of the Secretary’s authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient for the Secretary to approve this proposal.

3. One commenter stated the proposal for enhanced FMAP is questionable as to whether it would comply with budget neutrality requirements.

Response: As seen in the documents included in the State’s waiver request, the State used the budget neutrality spreadsheets provided by CMS to demonstrate budget neutrality. The federal share percentage used in the budget neutrality test is the same between “Without Waiver” sheet and “With Waiver” sheet. Several states have operational 1115 demonstrations with budget neutrality that include enhanced FMAP.

4. Several commenters stated neither Senate Bill 96, nor the waiver application, provide rationale to explain how the waiver of enhanced FMAP provision services Medicaid goals, while providing a partial expansion.

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

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

As stated in the response to Comment 1, the Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. Utah policy makers determined that the practicable way to close the coverage gap in Utah is to limit expansion to adults with incomes from 0 to 100 percent FPL. While it is argued that coverage in the marketplace may not be affordable, individuals with incomes over 100 percent FPL have access to the marketplace with significant federal subsidies to gain access to healthcare coverage. The State seeks to maximize the availability of federal funds to help pay for the costs of providing medical assistance to a group not previously covered by Medicaid - expansion adults. The State's waiver request would allow the State to draw down the enhanced funding for Medicaid expansion up to 100% FPL while providing medical assistance to this population. The State believes this waiver request is consistent with the intent of the Act. If approved, this waiver will provide coverage to 70,000-90,000 adults who otherwise would have little if no access to health care coverage.

Per Capita Cap Funding Mechanism

5. Many commenters stated the request for a per capita cap funding mechanism puts the State in unnecessary financial risk, which will lead to increased health care costs, increased cost sharing, and will lower provider payments.

Response: State policy makers determined that the fiscally responsible way to expand Medicaid to adults who do not otherwise qualify was through Senate Bill 96. As stated in the response to Comment 1, there are many needs in the State vying for the same tax dollars. Costs for traditional Medicaid populations continue to grow as well. It is not practicable for the State to allow Medicaid expenditures to continue to grow as an ever larger share of the available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base. This shrinking sales tax base will not be a reliable long term funding source for the program without additional budgetary flexibility.

6. Many commenters state they believe the per capita cap will force the State to constrain eligibility, reduce benefits and cap enrollment in order to control costs. Commenters also stated reducing benefits would include not covering breakthrough therapies or drugs.

Response: The Per Capita Cap funding model is designed to allow for enrollment growth that may occur due to changes in economic conditions. This funding structure provides no incentives for capping enrollment growth. Optional benefits may be evaluated by the State to ensure they may continue to be furnished in a practicable manner as stated in the response to Comment 1. This has been a long-standing process for the existing Medicaid populations. The State is required to continue to cover new FDA-approved drugs for expansion adults. Some of these new therapies may present cost savings. Other breakthrough therapies and drugs primarily benefit children and adults with disabilities, populations that are outside of this waiver request. The State would need additional waiver authority in order to reduce benefits beyond optional services. We have not requested this authority.

7. Several commenters expressed concern about the impact of per capita caps on pregnant women, children, or individuals that are elderly or have a disability.

Response: Medicaid has various eligibility categories. This waiver request for a per capita cap does not apply to pregnant women, children or individuals that are elderly or have a disability categories. The State's request for a per capita cap would only apply to individuals in the adult expansion category.

8. Several commenters stated the per enrollee base would not accurately reflect the cost of care for the variety of individuals covered. They stated there is great variation among people of all ages living with disabilities or chronic medical conditions and it cannot be addressed by division into three simple groups.

Response: The State understands that individuals covered under this waiver will likely have a large variety of medical conditions and associated costs. Members were grouped together in three overall categories reflecting the three main eligibility categories. The State's proposed Per Capita Cap does not set a limit on an individual's medical costs or limits; instead, it sets a maximum amount of federal funds the State would receive on average for all individuals subject to the Per Capita Cap. While some individuals in the demonstration may have an expensive inpatient stay one month, other individuals may experience much lower costs. The per capita caps were calculated based on the State's best estimate of the average cost per member and allow for some variation within groups.

9. Many commenters stated that they are concerned that a per capita cap would not be sufficient to meet Utah's needs during an economic downturn or other crisis. They state the waiver tries to address this risk by requesting CMS allow the State to make changes in a few special circumstances, but these circumstances are not clearly defined.

Response: The State understands that we may not be able to foresee all events that occur during the demonstration. For this reason, the special circumstances requested in the waiver application are not narrowly defined. Some economic events may result in increased enrollment, which does not present a problem in the per capita cap funding model. However, the State may experience risk if a major event substantially increases per-member per-month costs. If such an event is beyond the State's control, the State will provide necessary documentation and independent analysis as part of a request for enhanced match within budget neutrality limits.

10. Several commenters stated that Congress had an opportunity to approve a per capita cap funding mechanism and did not. They believe CMS does not have the authority to fundamentally change the structure of Medicaid funding

Response: As stated in the response to Comment 1, CMS has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to

approve this waiver proposal, which will improve the health and lives of an estimated 70,000 to 90,000 Utahns.

11. One commenter stated they have issues with the trend factor. They believe that even if the initial rate is adequate, significant issues will arise in out years if the approved trend factor proves to be inadequate. Enrollment growth does not pose a threat under per capita caps. However, if the trend rate increases do not adequately address increases in health costs, changes in technology or higher utilization of prescription drugs it will create significant financial exposure to the State. They believe using a trend factor based on historic Medicaid spending is not appropriate.

Response: Changes in technology and higher utilization would likewise present a significant risk to the State without the budgetary flexibilities requested within this waiver. The State is requesting to use a trend factor based on the projected medical component of the consumer price index, currently projected at 4.2% per year. If the nation experiences higher medical prices, the index will also be higher allowing more space for the State to experience costs while remaining within the overall cap. The State is also requesting that expenditures in excess of the total per capita cap but within budget neutrality receive the State's traditional FMAP.

In addition, it is important for the State to make efforts to slow the growth of medical costs in order to achieve long term fiscal sustainability. The potential for increasing medical costs is a significant reason why a strategy for fiscal sustainability is so critical.

12. One commenter stated that the per capita funding mechanism should include directed payments to all of the expansion populations. They do not believe current directed payments for the legacy Medicaid population should be diluted over additional lives. They believe it is essential that the proposed per capita cap allow for both inpatient and outpatient directed payments to be added to expansion utilization. In addition, they believe the draft waiver's base year financial estimates and future years projections should ensure that provider payment rates will be the same amount across provider types for all covered benefits across all three proposed Medicaid expansion populations. In particular, they advise that additional costs should be built into the per capita cap for the targeted adult/substance use disorder (SUD) population.

Response: We appreciate the comment. The State has adjusted the Per Capita Cap additions for the targeted adult and SUD population in anticipation of the move to managed care. The adjustment will achieve equity in the directed payments for covered populations.

13. One commenter stated that it is not enough for the per capita cap to have enough room for equal payments to hospitals, UDOH must have the authority to negotiate increased accountable care organization (ACO) rates as well. CMS's policy is that states may not vary reimbursement rates by population. If CMS were to approve differential rates by population, states would simply move payments from the traditional population to the expansion population to leverage the enhanced federal match.

Response: We appreciate the comment. The State will share this comment with state policy makers as discussions regarding rates occur.

14. One commenter stated that according to 438.6(c)(2), the directed payments under this section must be developed in accordance with 42 CFR 438.4 and 438.5. Section 438.4 requires that, "Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations," and further states, "Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell." The costs of the services provided to expansion adults are not different than for other populations, and therefore the rates paid to providers should not be different.

Response: We appreciate the comment. The State will continue to comply with valid rate development standards. The State will share this comment with state policy makers as discussions regarding rates occur.

15. Several commenters stated the Medical Consumer Price Index can fluctuate considerably from year to year, making it difficult to establish a realistic growth rate.

Response: The State is requesting to use CMS Office of the Actuary projections for the Medical Consumer Price Index beyond the current budget year. By using future projected rates, the State will be able to budget accordingly and limit the uncertainty in the Medical Consumer Price Index through forward planning. The State plans to achieve program efficiencies in order to slow the growth of medical costs.

16. Many commenters stated that a per capita cap is not likely to promote the objectives of Medicaid and requested that it be rescinded from the waiver application.

Response: As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. In addition, CMS has encouraged states to propose innovative ideas. The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to approve this waiver proposal, which will improve the health and lives of an estimated 70,000 to 90,000 Utahns.

17. One commenter stated the State should ensure that the calculated historical base year expenditure amounts allow for all provider types to be paid the same amount for services provided to the expansion populations as the providers are paid for those same services when provided to other Medicaid populations. The Department has used the term "supplemental" in its description of some payment arrangement. The Department should also include the term "directed payments" when appropriate to avoid confusion given recent CMS clarification of these terms.

Response: We appreciate the comment. The State will share this comment with state policy makers as discussions regarding rates occur. The State will also update language to include usage of the term “directed payments.”

18. One commenter stated the state’s application is internally inconsistent in its proposals for what amount of spending will receive enhanced match. According to the waiver application, “expenditures in excess of the total per capita cap but within budget neutrality will receive the State’s traditional FMAP.” It is unclear whether the “per capita cap” in this sentence refers to the “Per Capita PMPMs” for the enrollment groups in the tables on pages 38-43 of the application, or to the “PMPM Costs” in the “Demonstration With Waiver Budget Projection” table on page 48 of the application.

Response: As noted by the commenter, the State is requesting to receive the State’s traditional FMAP for expenses in excess of the total per capita cap but within budget neutrality. Per Capita PMPMs are identified in pages 38-43. The budget neutrality limit is identified in the without waiver sheets in the appendix.

19. One commenter stated it is also unclear if “budget neutrality” in the above sentence refers to the “Demonstration Without Waiver Budget Projection” table on page 47 or the “Demonstration With Waiver Budget Projection” table on page 48, which references the 4.2% trend rate.

Response: Budget neutrality is measured against the estimate of without waiver expenditures. Without this waiver, the State estimates a growth of 5.3% annually. The State achieves budget neutrality by controlling the growth of healthcare costs below the without waiver growth rate. The State expects the “with waiver” costs to grow at 4.2% annually.

Lock out from the Medicaid expansion for committing an Intentional Program Violation (IPV)

20. Many commenters stated that this request is not needed because fraud is already defined under state law and prosecuted accordingly. They would like to know how an IPV is different from a fraud determination. In addition, they state the application already clearly indicates that individuals can be charged for overpayments while appealing an IPV.

Response: The determination of an intentional program violation has been part of policy for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid for many years. The determination of an IPV is made through an administrative adjudication under the Utah Administrative Procedures Act. A determination of fraud is made through a judicial procedure. The burden of proof is with the State. The standard of evidence is clear and convincing in both an administrative or judicial proceeding. Section 76-8-1205 Utah Code Annotated, defines public assistance fraud.

76-8-1205 Public assistance fraud defined.

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

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

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

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

Response: Current policy requires Medicaid members to report changes that affect eligibility within ten (10) days from the date of the change. The waiver makes no change to current reporting requirements

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

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

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

Response: The determination of an intentional program violation (IPV) is currently in Medicaid policy. This is not new nor is it a change. The DWS Investigation unit conducts the investigation. The Overpayment unit processes the overpayment through the IPV determination process. Therefore there is no change to the current administrative burden to the State or members.

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

Response: The determination of an IPV has been in place for at least two decades for the SNAP, TANF and Medicaid programs. The burden of proof rests with the State. The State complies with judicial standards of evidence. When fault is alleged, the State must prove by clear and convincing evidence that the overpayment was obtained intentionally, knowingly, recklessly as "intentionally, knowingly, and recklessly" are defined in Section [76-2-103](#), by false statement, misrepresentation, impersonation, or other fraudulent means, including committing any of the acts or omissions described in Sections [76-8-1203](#), [76-8-1204](#), or [76-8-1205](#).

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

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

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

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

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

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

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

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

29. One commenter stated that the State's projected enrollment impact is not reflected in the State's budget projections on page 47 and 48, and the State indicates that Medicaid enrollment will remain the same. They state this is not possible if this is implemented, as the application states 500 people per year will lose coverage.

Response: Enrollment projections include an assumption that 500 people will be sanctioned due to an IPV. 42 CFR §431.412 requires that we include the estimated impact to enrollment. The State has included this estimate in the narrative of the waiver application. The budget neutrality documents included in the addendum require enrollment figures to be equivalent for “without waiver” and “with waiver.” Budget neutrality is calculated at a per-member level and there are no calculated budget savings that result from reduced enrollment.

30. Several commenters stated that disenrollment policies reduce access to care, disrupt the continuity of care, and cause increased utilization of emergency departments. They believe this proposal will lead

to these issues. They also believe locking individuals out of coverage does not achieve Medicaid objectives.

Response: While the State acknowledges the commenters' concerns, the State currently has IPV policy in place. Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. Due to limited resources, the State believes only those individuals truly eligible for Medicaid should receive benefits. As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State.

31. One commenter stated the purported justification for Utah's Medicaid 1115 waiver is fiscal responsibility. However, implementation of the lock-out process would require Utah Medicaid to divert already thin administrative resources to oversee and conduct the program for, at their own estimation, approximately 500 people per year. They also state the potential dollar amount of savings that Utah Medicaid would achieve from locking low-income individuals out of Medicaid for 6-months is not provided, and input cannot be given without this.

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

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

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

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

Response: The State is unclear how charging individuals for overpayments incurred during a period of ineligibility will discourage them from appealing the decision. If an individual appeals a decision, and the individual prevails, they will reclaim the overpayment that was initially assessed, but if they don't

appeal, the individual will have no possibility of reclaiming the overpayment. The State believes individuals would have an incentive, rather than a disincentive to seek an appeal.

Housing Related Services and Supports (HRSS)

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

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

35. One commenter stated they believe the development, implementation and monitoring of this component will redirect scarce resources from providing access to all Medicaid members, to improve the likelihood that a small group of enrollees can successfully maintain access to housing.

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

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

Response: The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. The State believes the rulemaking process is transparent and allows for public input. The State will follow the standard rulemaking process set forth in the Utah Administrative Rulemaking Act.

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

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

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

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

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

37. One commenter stated more information is needed in regards to how the ongoing need will be verified every six months. They believe the process should be designed with flexibility and in consideration of the circumstances of the population. They believe the assessment should be at twelve months instead of six months.

Response: The State will develop a standardized screening tool to determine if individuals meet target criteria, with reassessments occurring every six months. The State modeled components of its housing related services and supports request after North Carolina's 1115 waiver approved October 2018, and includes the same requirements. Recognizing there are limits on the amount of funding designated for these services within the overall Medicaid Expansion funding, the State seeks to provide housing related services to those with the most acute need and believes that reevaluating housing services eligibility at six month intervals, will assure services to the intended populations.

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

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

39. One commenter stated they are concerned that individuals receiving Targeted Case Management (TCM) services will not be eligible for HRSS. It is their experience that mental health providers can often focus TCM services on health issues and may not have the knowledge and experience to provide housing supports or do not use TCM for the purpose of housing supports. The TCM services are restricted to those outlined in a behavioral health treatment plan, which may not include housing stability supports. They recommend that the HRSS benefit be available to support those who receive TCM as a supplement to focus on housing stability, which will help keep them engaged in TCM and stable in their housing.

Response: To ensure no duplication of services, the State cannot seek authority to cover services under an 1115 waiver that are already available in the Medicaid State Plan. Under TCM for Individuals with Serious Mental Illness, the service definition allows for housing related services, such as providing assistance to find housing, helping with housing applications, working with an individual’s landlord to address issues, etc. The State will work with current TCM providers to assure they understand the scope of housing related services that can be provided under TCM.

In addition, within the housing related services category, the State is seeking authority to cover Community Transition Services, which are not available under the Medicaid State Plan and will be available to those who also have TCM. This service will assist eligible members to secure, establish, and maintain a safe and healthy living environment by making one-time purchases of essential household items or one-time payments of a security deposit and the first and last month’s rent, when a member moves to a new residence.

40. One commenter stated that Utah has a number of experienced and qualified organizations to provide HRSS services. Many of those organizations are not current Medicaid providers. They request that in conjunction with the 1115 Waiver, the State create a mechanism and funding for capacity

building to assist HRSS organizations in building a Medicaid reimbursement component into their organizations.

Response: Recognizing there are limits on the amount of funding designated for housing related services within the overall Medicaid Expansion appropriation, and that the State was not appropriated additional funding to support agencies' construction of a Medicaid reimbursement component to their organizations, the State currently does not have a mechanism to fund a paid, capacity-building process for HRSS providers. However, the State intends to work closely with qualified HRSS organizations to more fully develop provider qualifications, payment rates, etc. and will provide technical assistance and training to providers on enrollment, billing, documentation and other requirements, prior to implementation

Up to 12-months of Continuous Eligibility

41. One commenter stated that capping eligibility at 12-months would leave thousands without medical care.

Response: This comment reflects some confusion or misunderstanding about this policy, which does not cap enrollment at 12 months. The up to 12-months continuous eligibility policy refers to the ability to continue an individual's benefits longer if their income were to increase. A person meeting the income limits of the program may receive multiple consecutive periods of eligibility under this provision. Without this provision, an increase in income would potentially remove someone from coverage much sooner.

42. Several commenters stated while they oppose the waiver, they support 12-month continuous, but believe it should be extended to children.

Response: Senate Bill 96 directs the State to implement this provision for adults on the Adult Expansion Medicaid program and does not address coverage for children. Funding was appropriated for this bill to cover several months of continuous coverage for the adults on this program.

43. One commenter stated they are supportive of this proposal, as it will reduce churn and ensure continuity of care.

Response: The State appreciates the comment and agrees that this provision will benefit these adults.

44. Several commenters stated they are supportive of this proposal but they are confused as to why UDOH chose to offer 6-months of eligibility. They believe Senate Bill 96 intended that the State provide 12-months of continuous eligibility for all Adult Expansion members. They believe 12-month continuous eligibility should not just be offered to Targeted Adults.

Response: Senate Bill 96 directs UDOH to seek continuous eligibility for these adults for a period of up to 12 months. The State’s fiscal note estimate for the impact of continuous eligibility assumed that the State would be able to receive the 90% enhanced federal share for all additional months of eligibility. In discussion with the CMS after Senate Bill 96 was signed into law, the State learned that an adjustment would likely be required reducing the federal share that can be claimed due to continuous eligibility. The CMS requires this reduction of federal share because a continuous eligibility policy may grant additional months while a member is above the income limit where 90% enhanced federal share is allowable. In order to stay within State budget in light of CMS requirements, UDOH is proposing to offer 6 months of continuous eligibility.

45. One commenter stated while they do support the proposal to allow 12-months of continuous eligibility, they believe this benefit will be limited when people lose Medicaid due to onerous work requirements or being subject to an IPV lock-out period.

Response: All Adult Expansion Medicaid individuals will have up to 12-months continuous coverage. However, the State acknowledges that individuals who do not comply with community engagement requirements, or those who commit an IPV may not receive the full months of continuous eligibility.

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

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

Response: Senate Bill 96 directs the state not to implement hospital presumptive eligibility for adults on the Adult Expansion Medicaid program. Most Medicaid programs (including Adult Expansion Medicaid program) offer retroactive eligibility for the 3-months prior to the month the application is received. Three months retroactive coverage is not a benefit available in the commercial, marketplace, or Medicare plans. Due to the availability of retroactive coverage, uncompensated care costs and individual out-of-pocket expenses will only occur when an individual was never eligible for Medicaid.

47. One commenter stated that the proposal did not include the required information for the impact on enrollment.

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

48. One commenter stated the State has not addressed the gap between those who would have qualified under presumptive eligibility, and those who successfully complete the Medicaid application process.

Response: Under federal law, those applying for presumptive eligibility may ‘opt out’ of applying for full Medicaid coverage. The State is not allowed to require these individuals to apply. Presumptive eligibility (PE) decisions are audited to ensure that the PE decision(s) were made correctly and we track whether or not those cases move to full coverage with the Medicaid program. Our data shows about half of those approved for PE coverage continue on to receive Medicaid. Longer term comprehensive coverage is better than temporary PE benefits, and this will encourage providers to work collaboratively with individuals to submit a full Medicaid application for ongoing coverage.

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

Response: The State has not waived retroactive eligibility for the adult Medicaid Expansion, nor is it requesting a waiver of retroactive eligibility for this population. These adults can continue to request retroactive eligibility when applying for Medicaid.

Managed Care Flexibilities

50. One commenter stated they are concerned with an October 2019 implementation date for implementing managed care. They ask if education and awareness of the change will be sufficient.

Response: The State is seeking approval of a managed care waiver for this population by October 2019; however, these individuals will not be enrolled in managed care until January 1, 2020. In order to better educate and provide awareness to this group, the State will run a longer than usual open enrollment period from mid October to mid December 2019. The State agrees that this group will need additional assistance to understand their benefits and their plan options.

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

Response: Under current regulations (42 CFR 438.806) a state must obtain prior approval of a managed care organization (MCO) (comprehensive risk) contract and rates. Prior approval by CMS is a condition for federal financial participation. All managed care rates are calculated under very specific rate setting

guidance from CMS by the State's contracted actuarial firm, Milliman, Inc. The rates must be certified by the actuary as being actuarially sound. The current CMS process for rate approval takes months to complete. At the end of the process, CMS typically approves the rates originally submitted by the State.

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

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

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

Response: Please see the State's response to Comment 51.

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

Response: Directed payments are part of the rate setting process. Please see the State's response to Comment 51.

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

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

Benefits

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

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

Demonstration Hypotheses and Evaluation

56. Two commenters stated they had concerns that several of the demonstration hypotheses cannot be tested as described. For example, “the Demonstration will assist previously uninsured individuals in purchasing employer sponsored insurance to help reduce the number of uninsured adults” (pages 24-25). They state this is not a hypothesis that can be tested as it is based on a logical fallacy of ‘affirming the consequent’.

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

The State agrees with the particular example described above and will modify the hypothesis to: “the Demonstration will assist individuals in enrolling in employer sponsored insurance plans in a cost effective manner.”

57. One commenter stated they believe the proposed waiver hypotheses and evaluation framework fail to address the impact of several significant risks and potential changes to Utah’s Medicaid program. For example, they believe there should be an evaluation component to track the impact of enrollment caps on beneficiaries that assesses how many individuals could be denied coverage and the impact on their access to care. They also stated that many of the program requirements conflict and should be evaluated to determine their overall impact. They also believe there should be greater transparency in the evaluation process and opportunities for consumer and stakeholder input in this process.

Response: As stated in the waiver application, the State will work with an independent evaluator to develop an evaluation plan. The suggested hypotheses may be refined and/or amended after consulting with the evaluator. The State intends to include the recommended community engagement hypotheses, provided by CMS, in the evaluation design. The State has also committed to engage its Medical Care Advisory Committee (MCAC) in the evaluation process.

Enrollment Limit

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

Response: As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. While the State understands the commenters' concerns, enrollment in this adult expansion population will be limited by the amount of the state tax collected and other funds appropriated by the Legislature to fund the state share of the cost to operate this Medicaid program. Current estimates place funded enrollment at 70,000-90,000.

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

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

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

60. One commenter stated that enrollment limits are contrary to CMS Q & A guidance published in 2013, which has not been rescinded.

Response: The State acknowledges the reference from a prior administration referenced by the commenter. As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. The purpose of enrollment caps is to assure that Medicaid expansion is sustainable. In spite of the referenced CMS guidance, enrollment caps have been approved by the current and prior administrations through 1115 waivers such as in Utah's Primary Care Network program and the Targeted Adult Medicaid program.

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

Response: The State is operating its current “Bridge” expansion program with an enrollment limit. This waiver proposal is expected to continue coverage for an estimated 70,000 to 90,000 Utahns. These are individuals who previously had no health care coverage, many of whom sought care through health centers. Continuation of this coverage for these adults helps relieve the financial burden of health centers for the care of the uninsured.

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

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

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

Response: As stated in the response to Comment 1, Medicaid’s General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent over the last 19 years. Senate Bill 96 directs the State to request approval of an enrollment limit to stay within the appropriations for this program.

64. One commenter stated they have concerns with how the enrollment limit will impact individuals transitioning from the Parent/Caretaker/Relative (PCR) Medicaid program to Adult Expansion Medicaid because of a slight income increase.

Response: DWS is tasked to consider all other available programs when any program closes. Specific to the PCR program, individuals with increased earned income may be eligible for 12-month Transitional Medicaid, which does not have an enrollment limit. If they do not qualify for 12-month Transitional Medicaid, eligibility for all other Medicaid programs will be determined. Additionally, the State is proposing several exceptions to the enrollment limit, such as allowing individuals to move from adult expansion program to PCR and back to the adult expansion program.

65. One commenter suggested that if the State does not wish to maintain a waitlist to automatically enroll individuals when enrollment is re-opened, then it may want to consider creating a notification list

for those eligible but unable to enroll during a closed enrollment period. When enrollment is once again open, then the Department can notify these individuals of their opportunity to re-apply.

Response: The State appreciates the commenter's suggestion. Unfortunately Medicaid members commonly fail to keep their addresses and contact information current. Maintaining a notification list will not assure that individuals can be reached at a later date. The State operated the PCN program from 2002 to 2019. Pursuant to the State's 1115 PCN waiver, the PCN program included caps on enrollment and open and closed enrollment periods. Similar to PCN, the State will use other means to notify the public that enrollment has reopened. This includes, notification on the State's website, release of a media advisory, providing information to community partners that can be shared with those they serve who may be eligible for Medicaid.

Community Engagement Requirement

66. One commenter sought clarity on whether loss of eligibility for non-compliance only applies to the remainder of the annual eligibility period, or indefinitely until the requirements are met and the individual reapplies for benefits.

Response: If an individual fails to comply with the community engagement requirement, they will remain ineligible until the end of their current recertification period, unless they later meet an exemption. Once that timeframe has expired, the individual may reapply for Medicaid. If the individual does meet an exemption at that time, they will be referred for community engagement participation again.

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

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

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

Response: The State recently received approval to implement a community engagement requirement. As stated in the CMS approval letter dated March 29, 2019, "Utah and CMS will be able to evaluate the effectiveness of a policy that is designed to improve the health of Medicaid beneficiaries and promote their financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes.""

69. Several commenters stated they would like additional clarity on how some exemptions will be defined, specifically “physically or mentally unable to work”.

Response: The State is largely aligning with the SNAP program in how exemptions are defined. For example, being physically or mentally unable to work will be left up to the individual’s medical provider to determine. Verification of this exemption will be accepted from the medical provider. Another example provided by the commenter is “status as a parent”. If the individual is responsible for the care of a dependent child under age 6 living in the home, the individual will be exempt. The State will automatically use this exemption if it is determined that a child under age 6 lives in the home with a single parent. If there are two adults in the household, and only one child under age 6, the adults will decide who claims the exemption. It will be “verified” by accepting client statement.

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

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

71. One commenter stated that their understanding is that some individuals who would otherwise be subject to the CE requirement, but for the (mild) disability would instead be exempt as opposed to being provided with a “reasonable modification”. They do not support discrimination against person with disabilities.

Response: In order for an individual to be considered exempt for being “physically or mentally unable to work”, the individual would have to report this as an exemption (although the State is considering exempting some individuals with specific diseases or illnesses). Generally, individuals with a disability are exempt. However, any individual that feels they can participate, and needs an accommodation in order to do so, can request a disability accommodation. The State will comply with all applicable federal civil rights laws in ensuring individuals needing an accommodation are provided one.

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

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

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

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

74. Several commenters state that the State assumed that if participants become employed they will have access to employer sponsored insurance. They indicate that only 49 percent of employed individuals receive health insurance through their employer.

Response: While the State appreciates the comment regarding national figures, the report cited indicates Utah's experience is 60 percent. Having access to insurance would not cause someone to disenroll from the program. If an individual's income increases, the State will determine eligibility for Utah's Premium Partnership for Health Insurance Program (UPP).

75. One commenter stated that the application does not provide enough information regarding beneficiary supports and how these will be implemented. They also state that there is no concrete plan for how the requirements will be fully accessible to populations with limited computer literacy, limited literacy or language obstacles.

Response: The State is still in discussion regarding beneficiary supports that will be available to individuals who are required to participate. However, in regards to individuals needing language assistance services, these services are currently offered, and they will continue to be offered to this population. Information regarding language assistance services will be included in correspondence sent to impacted individuals, as well as on the DWS and Medicaid websites.

76. One commenter stated the drop in enrollment due to the community engagement requirement is not reflected in the State's budget projections, rather the budget projections indicate that Medicaid enrollment will stay the same with or without waiver.

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

77. One commenter stated that the State cites several studies in its application that show a causal link between employment and health outcomes. They believe this is inappropriate and is not supported by a substantial body of research that shows even minor requirements and barriers can cause people to fail to participate in programs even when they value and need the benefits involved.

Response: As stated by CMS in the 1115 PCN waiver approval letter dated March 29, 2019, "research shows a positive link between community engagement and improved health outcomes." However, also as stated in the approval, since none of the existing research shows whether community engagement as a condition of Medicaid coverage improves health outcomes, the State will use the 1115 demonstration project to determine if this result can be achieved through the State's community engagement requirement.

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

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

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

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

Response: Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary care network Waiver in 2002. As of November 2017, all adults on Utah Medicaid receive the full array of behavioral health services.

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

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

Response: Previous Secretaries have approved and reauthorized Utah's current waiver of EPSDT. Utah's 1115 Primary Care Network demonstration waiver includes a waiver of EPSDT for 19-20 year Current Eligible (Non-Traditional parents 0-40% FPL).

In addition, effective November 1, 2017 full mental health benefits were restored for all adults as a result of a waiver amendment to the PCN Waiver. Therefore there are no differences in behavioral health benefits for adults.

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

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

Employer-Sponsored Insurance (ESI) Requirement

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

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

83. One commenter stated the proposed ESI model contains no information regarding the number of potential beneficiaries, which makes it impossible to evaluate its financial impact.

Response: We appreciate the comment. The State has now added this information to the waiver application.

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

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

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

Response: The State is proposing to lock out individuals from Medicaid when they miss the opportunity to enroll, up until such time that the person enrolls in their employer sponsored plan, lose access to their employer sponsored plan, or 3 years, whichever comes first. The State will be clear in its communication to beneficiaries so they will know when this requirement applies to them. The State will validate the premium using all available verification methods except "customer statement", meaning that health plan enrollment may be validated electronically, through a collateral contact with the employer or insurance company, or by other paperwork turned in by the beneficiary. In order to protect beneficiaries, they always have the right to request a fair hearing if they believe they have been closed or denied in error.

Changes through Administrative Rulemaking

86. Several commenters expressed concern that the request to allow the State to make certain changes through the administrative rule process would relinquish federal oversight of the areas where the State is allowed to make these changes.

Response: Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all rulemaking during the monthly meeting of the MCAC which is open to the public. By state law the process for administrative rulemaking is as transparent as the federal process for amendment requests. However, the administrative rule making process is more timely which allows the State to implement necessary changes without unnecessary delays.

Finally, the State anticipates that the federal government will include language in the State's Standard Terms and Conditions that requires the State to notify CMS of any proposed and final rulemaking so CMS can maintain its oversight of the State's waiver.

General Comments

87. Several commenters stated this waiver application will result in a large number of individuals who have incomes between 100 and 138, not receiving coverage.

Response: Adults with incomes between 100 and 138% FPL are eligible to enroll through healthcare.gov for low cost health insurance (2% of income), if they are not eligible under another Medicaid program. Utah has a high participation rate in the federal exchange that provides subsidized coverage for adults in this income range.

88. One commenter stated that congressional report language states that demonstration waivers "usually cannot be statewide in operation," and the Ninth Circuit Court of Appeals notes "the Secretary would abuse his authority if he were to approve a project which... subject[ed] an unreasonably large population to the experiment or continue[ed] it for an unreasonably long period."

Response: Multiple federal administrations have exercised the authority to allow 1115 demonstration waivers to operate statewide, as well as to continue for many years. Many states have received approval to operate statewide waivers, and have received ongoing approval to continue demonstration projects. For example, Utah has had approval to operate the statewide PCN program through its 1115 PCN Demonstration Waiver since 2002. Without this waiver authority, thousands of Utahns would not have otherwise received medical coverage.

ATTACHMENT 4

Tribal Consultation





Utah Indian Health Advisory Board (UIHAB) Meeting

6/7/2019

9:00 AM –12:30 PM

Paiute Indian Tribe of Utah

Tribal Office Building

440 North Paiute Drive,

Cedar City, UT 84721

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

**Medicaid Expansion
Consultation**

Meeting called by:

UIHAB

Type of meeting:

Monthly UIHAB

Facilitator:

Melissa Zito

Note taker:

Recorded

Call In **1-877-820-7831** **passcode 868079 #**

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

Agenda topic

9:00 AM

Utah Medicaid Expansion Per Capita Cap Waiver
*Meeting in Tribal Council Chambers

Nate Checketts, Dir. UT Medicaid

10:30 AM

BREAK

10:40 AM

UIHAB Meeting *Tribal Health Board Rm.
Welcome & Introductions
Approval of Minutes

Lorena Horse, Chair & Ed Napia,
Vice Chair

10 :45 AM

Committee Updates & Discussion

- ✦ UT Medicaid Eligibility Policy
- ✦ Medicaid & CHIP State Plan Amendments (SPA) & Rules
- ✦ DWS Medicaid Eligibility Operations
- ✦ Federal and State Health Policy Impacting I/T/U
- ✦ MCAC & CHIP Advisory Committees
- ✦ Opioid Crisis Project

Jeff Nelson
Craig Devashrayee

Jacoy Richins
Melissa Zito
Donna Singer & Ryan Ward
Jeremy Taylor

11:45 AM

State Plan Modifications to CHIP

Jennifer Wieser

12:15 PM

I/T/U & UDOH Updates

ALL

12:30 PM

Adjourn



Utah Indian Health Advisory Board Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Utah Medicaid Expansion Per Capita Waiver

Utah Medicaid Eligibility Policy

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC & CHIP Advisory Committee

Opioid Crisis

Agenda Item Updates:

State Plan Modifications to CHIP

Tribal leadership Feedback

NOTES

DRAFT