

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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November 13, 2025

Nathen Checketts  
State Medicaid Director  
Division of Integrated Healthcare  
Department of Health & Human Services  
P.O. Box 143101  
Salt Lake City, UT 84101

Dear Director Checketts:

The Centers for Medicare & Medicaid Services (CMS) is approving Utah's (the "state") request to amend the section 1115(a) demonstration titled, "Utah Medicaid Reform 1115 Demonstration" (Project Numbers 11-W-00145/8 and 21-W-00054/8) (the "demonstration") in accordance with section 1115(a) of the Social Security Act (the Act). The amendment will be effective on the date of approval, November 13, 2025, through June 30, 2027, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

CMS has determined that Utah's demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute by increasing access to family planning services and family planning related services for the beneficiaries in the demonstration; promoting continuity of coverage for postpartum women in the demonstration; and improving oral health outcomes of beneficiaries in the demonstration. Additionally, while the Intensive Stabilization Services (ISS) program is being removed from this demonstration at the request of the state, CMS has determined that there will be no disruption in care due to the same service existing through a 1915(b) waiver authority. Lastly, CMS is removing the Housing-Related Services and Supports (HRSS) program from the demonstration as coverage for those services has fully transitioned to the Health-Related Social Needs (HRSN) program.

CMS's approval is subject to the limitations specified in the attached expenditure authority, special terms and conditions (STCs), and any supplemental attachments, defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or are not applicable to expenditures under the demonstration.

CMS acknowledges that chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the Working Families Tax Cuts Legislation (WFTCL), makes additional changes to the Medicaid and CHIP programs. To the extent that any of those changes will affect the authorities within this demonstration, CMS will partner with Utah to ensure compliance with and

successful implementation of changes as described in the WFTCL during this demonstration period.

### **Extent and Scope of Demonstration**

Approval of Utah's Medicaid Reform 1115 Demonstration amendment will allow the state to provide family planning services and family planning related services to individuals age 18 or older with a household income at or below 185 percent of the Federal Poverty Level (FPL) (using Modified Adjusted Gross Income (MAGI) methodology which includes a 5 percent FPL income disregard) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and are not in a public institution.

The demonstration provides a set of family planning services and family planning related services delivered through a fee-for-service (FFS) delivery system. Examples of the services offered under the demonstration include:

- Comprehensive family planning visits, which include counseling, education, and initiation or management of contraceptive methods;
- Food and Drug Administration (FDA)-approved methods of contraception;
- FDA-approved vaccination for Human Papillomavirus (HPV);
- Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears, and pelvic exams. Laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood counts, and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception;
- Drugs, supplies, or devices related to family planning services that are prescribed by a health care provider;
- Contraceptive management, patient education, and counseling;
- Treatment for STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines, may be covered;
- STI/STD diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling; and
- Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, laboratory testing necessary to complete a sterilization or long-acting reversible contraception insertion, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure. The covered procedures are vasectomies, salpingectomy, tubal occlusions, and tubal ligations, which must meet the requirements of 42 CFR 441, Subpart F.

As a part of the amendment, the state is also making changes to the existing coverage for postpartum women, dental services, and the ISS and HRSS programs. CMS is approving an amendment request to move the authority for extended postpartum coverage for individuals enrolled in Medicaid (up to 12 months from the last day of an individual's pregnancy) from the state plan into this demonstration. This approval is in alignment with the state plan option and does not include the state's originally requested eligibility requirements relating to the manner in which the pregnancy ended, which the state subsequently agreed to proceed without. CMS and Utah both acknowledge that Utah will submit a state plan amendment (SPA) to remove its authority for extended postpartum coverage from its state plan and will only provide extended postpartum coverage under the demonstration on or after the effective date of the SPA. CMS is also approving an amendment request to move dental services for Medicaid-eligible children and pregnant or postpartum women into the demonstration and the FFS delivery system (from managed care plans) in partnership with the University of Utah School of Dentistry's (UUSOD) and their associated statewide provider network. Additionally, the ISS program provided through this demonstration will end. ISS-covered services will be addressed through the 1915(b) waiver authority. Lastly, CMS is removing the HRSS program from the demonstration as coverage for those services has fully transitioned to the HRSN program.

### **Budget Neutrality**

This demonstration project is amended using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.<sup>1</sup> However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the Working Families Tax Cuts Legislation (WFTCL), adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.<sup>2</sup> CMS intends to provide additional information prior to January 1, 2027 about the section 1115(g) requirements.

CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.<sup>3</sup> The demonstration amendment is projected to be budget neutral to the federal government. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

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<sup>1</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf>

<sup>2</sup> <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

<sup>3</sup> For more information on CMS's current approach to budget neutrality, see <https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html>

### *Hypothetical Budget Neutrality Treatment*

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or other title XIX authority, such as a section 1915 waiver, as “hypothetical” for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality “supplemental test” for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state’s “with waiver” (WW) hypothetical spending exceeds the supplemental test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the federal financial participation (FFP) to CMS.

The Family Planning, Extended Postpartum Coverage, and Dental Services – Comprehensive Medicaid Eligibility Groups (MEGs) will be treated as hypothetical for budget neutrality purposes. For each of these MEGs, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline (except MEGs with aggregate cost limits) have been trended forward using the President’s Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President’s Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

### **Monitoring and Evaluation**

The state is required to conduct systematic monitoring and robust evaluation of the demonstration amendment in accordance with the STCs. In collaboration with CMS, the state must include this amendment, as appropriate, in its monitoring activities. In addition, the state is required to incorporate the amendment into its evaluation to support a comprehensive assessment of whether the initiatives are effective in producing the desired outcomes for beneficiaries and the state’s overall Medicaid program. Evaluation of the amendment must align with the requirements detailed in the STCs, including examining impacts on access to care, utilization of services, and beneficiary health outcomes.

### **Consideration of Public Comments**

#### *Family Planning Services and Family Planning Related Services*

The federal comment period for the family planning amendment application opened on August 3, 2023, and closed on September 4, 2023. CMS received two comments related to the amendment. The commenters were supportive of the demonstration amendment, while both advocated for changes to the proposal, including lowering the age of eligibility and ensuring retroactive coverage. These changes are not being incorporated into the demonstration at this time.

#### *Extended Postpartum Coverage*

The federal comment period for the extended postpartum coverage amendment application opened on June 3, 2023, and closed on July 2, 2023. CMS received three comments related to the amendment. Two commenters were unsupportive of the demonstration amendment due to eligibility limitations which the state agreed to proceed without. One commenter was supportive of the amendment, noting that the amendment would provide women who have HIV with extended access to treatment.

#### *Dental Services*

The federal comment period for the dental services amendment application opened on July 10, 2025, and closed on August 9, 2025. CMS received one comment related to the amendment which was supportive of dental coverage for children and pregnant/postpartum women.

#### **Other Information**

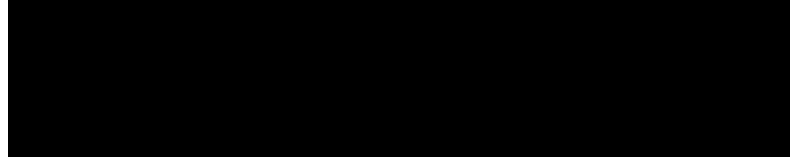
CMS's approval of this demonstration is conditioned upon compliance with the enclosed set of waiver authorities, expenditure authorities, and STCs defining the nature, character, and extent of anticipated federal involvement in the demonstration. The award is subject to our receiving your acknowledgement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

Your project officer, Julia Buschmann, is available to answer any questions concerning this demonstration and may be contacted as follows:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services  
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7500 Security Boulevard  
Baltimore, Maryland 21244-1850  
Email: [Julia.Buschmann@cms.hhs.gov](mailto:Julia.Buschmann@cms.hhs.gov)

If you have any questions regarding this approval, please contact Karen Llanos, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at [Karen.Llanos@cms.hhs.gov](mailto:Karen.Llanos@cms.hhs.gov).

Sincerely,



Dan Brillman  
Deputy Administrator, CMS  
Director, Center for Medicaid and CHIP Services

Enclosure

cc: Tyler Deines, State Monitoring Lead, Medicaid and CHIP Operations Group

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

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

**TITLE:** Utah Medicaid Reform 1115 Demonstration

**AWARDEE:** Utah Department of Health and Human Services

All Medicaid and Children's Health Insurance Program (CHIP) requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning November 13, 2025, through June 30, 2027, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

**Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

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

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

**TITLE:** Utah Medicaid Reform 1115 Demonstration

**AWARDEE:** Utah Department of Health and Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, from July 1, 2022 through June 30, 2027, be regarded as matchable expenditures under the state's Medicaid Title XIX state plan. The expenditure authorities listed below promote the objectives of title XIX.

- 1. Current Eligibles.** Expenditures for optional services not covered under Utah's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR Part 438 *et seq.* This expenditure authority terminates no later than December 31, 2023.
- 2. Demonstration Population III.** Expenditures for premium subsidies related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the health insurance premium for employer sponsored insurance (ESI) to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the federal poverty level (FPL), but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid, as described in the Special Terms and Condition (STCs). This population is subject to cost-sharing requirements established by the ESI plan.
- 3. Demonstration Population V.** Expenditures for premium subsidies related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the FPL, but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs. This population is subject to cost-sharing requirements established by the ESI plan.
- 4. Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has



elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.

- 5. Targeted Adults.** Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs. Expenditures for state plan coverage for individuals who have been determined eligible as a Targeted Adult for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination (continuous eligibility).
- 6. Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).
- 7. Adult Expansion Population.** Expenditures to provide coverage to adults, age 19 through 64, who are not Current Eligibles, and have household income at or below 133 percent of the FPL, as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents receive state plan Alternative Benefit Package (ABP) coverage as specified in the STCs and Attachment D, while members of the Adult Expansion Population who are custodial parents/caretaker relatives receive the ABP benefit package specified in the STCs and Attachment C to the STCs. No later than January 1, 2024, all beneficiaries in the Adult Expansion Population will receive the same full state plan ABP coverage, as outlined in Attachment D in the STCs.
- 8. Mandatory Employer Sponsored Insurance.** Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.
- 9. Residential and Inpatient Treatment for Individuals with Serious Mental Illness.** Expenditures for services furnished to eligible individuals age 21 through 64 who receive treatment for a serious mental illness (SMI) and who are short-term residents in facilities that meet the definition of an IMD.
- 10. Expenditures Related to Fertility Preservation for Beneficiaries Diagnosed with Cancer.** Expenditures for fertility preservation provided to eligible individuals with an active diagnosis of cancer which puts them at risk for sterility or iatrogenic infertility as described in STC 5.10.
- 11. Expenditures Related to In Vitro Fertilization and Genetic Testing Services.** Expenditures for in vitro fertilization and genetic testing services for qualifying individuals as described in STC 5.11.
- 12. Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in section 13 of these STCs, furnished to individuals who meet qualifying criteria in STC

13.3 for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

- 13. Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 13.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.
- 14. Dental Services.** Expenditures for dental services provided to all Medicaid-eligible adults and children as well as Medicaid-eligible pregnant and postpartum women.
- 15. Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 12. This expenditure authority is contingent upon compliance with Section 14, as well as all other applicable STCs.
- 16. Health-Related Social Needs Services Infrastructure.** Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in section 12 of the STCs.
- 17. Expenditures for Non-Medical Transportation (NMT).** Expenditures for NMT described in STC 12.20.
- 18. Expenditures for Continuous Eligibility for State Plan Benefits For the Full Pregnancy and 12-Month Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 4.3(i).
- 19. Family Planning Services and Family Planning Related Services.** Expenditures for providing Medicaid eligibility for family planning services and family planning related services, limited to:

Women and men age 18 and older with family income at or below 185 percent of the FPL (using MAGI methodology which includes a 5 percent FPL income disregard) who are not in a public institution and are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP), as described in STC 5.12.

### **Title XIX Requirements Not Applicable to the Demonstration Eligible Populations**

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

#### **1. Comparability; Amount, Duration and Scope**

#### **Section 1902(a)(10)(B) and**

## **Section 1902(a)(17)**

- a. To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group, with the exception of Former Foster Care Youth from another state to whom state plan services will be provided.
- b. To enable the state to vary the amount, duration, and scope of services to individuals in the Targeted Adults, blind, aged, and disabled expenditure populations.
- c. To enable the state to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system.
- d. To enable the state, through December 31, 2023, to vary the amount, duration, and scope of services offered to individuals in the Adult Expansion Population demonstration, based on whether the individual is a custodial parent/caretaker or not a custodial parent/caretaker.
- e. To enable the state to provide a benefit package consisting only of ESI and COBRA premium subsidies to Populations III and V.
- f. To enable the state to provide fertility treatment as described in STC 5.10 for beneficiaries diagnosed with cancer.
- g. To enable the state to provide in vitro fertilization and genetic testing services as described in STC 5.11.
- h. To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.
- i. To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 12 of the STCs.
- j. To enable the state to provide a benefit package consisting only of family planning services and family planning-related services, as described in STC 5.12.

## **2. Retroactive Eligibility**

## **Section 1902(a)(34)**

- a. To permit the state not to provide retroactive eligibility for individuals in Demonstration Populations III and V.
- b. To permit the state not to provide retroactive eligibility for individuals receiving family planning services and family planning related services.

## **3. Statewideness/Uniformity**

## **Section 1902(a)(1)**

- a. To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX populations affected by this demonstration.
- b. To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.
- c. To enable the state to provide housing and home environment interventions without

room and board, short-term recuperative care, and short-term rental assistance services on a less-than statewide basis, per the phase-in schedule described in STC 12.11.

#### **4. Freedom of Choice**

**Section 1902(a)(23)(A)**

- a. To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this demonstration.
- b. To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

#### **5. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**

**Section 1902(a)(43)**

- a. Through December 31, 2023, to enable the state not to cover certain services required to treat a condition identified during an EPSDT screening. This not applicable applies to individuals age 19 and 20 in Title XIX populations who are not part of the Adult Expansion Population. This not applicable does not apply to blind and disabled enrollees who receive dental benefits through the demonstration.
- b. The state will not furnish or arrange for EPSDT services to the demonstration population receiving family planning services and family planning related services.

#### **6. Methods of Administration**

**Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

Through December 31, 2023, to the extent necessary to relieve the state of the responsibility to assure non-emergency medical transportation to and from providers for beneficiaries with dependent children enrolled the Adult Expansion Population, except that this requirement nevertheless shall apply with respect to those eligible for EPSDT services.

#### **7. Compliance with ABP requirements**

**Section 1902(a)(10)(A)(i)(VIII) insofar as it incorporates section 1902(k), and sections 1902(k) and 1903(i)(26) insofar as they incorporate section 1937 and 42 CFR 440.390**

Through December 31, 2023, to permit federal financial participation (FFP) to be provided in expenditures to the extent that non-emergency medical transportation (NEMT) is not covered for certain beneficiaries for whom its assurance would otherwise be required.

### **Title XXI Expenditure Authorities**

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, July 1, 2022 through June 30, 2027, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for Demonstration

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

- 1. COBRA Children (Demonstration Population VI).** Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.
- 2. Current Eligible CHIP Children.** Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who meet the definition of a targeted low-income child, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving direct coverage under the CHIP state plan. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.

**Title XXI Requirements Not Applicable to Children's Health Insurance Program (CHIP)**  
**Expenditure Authorities for Demonstration Population VI and Current Eligible CHIP**  
**Children**

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

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

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

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

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

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

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

To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged

premiums and/or cost sharing by the plans in which they are enrolled.

**5. Benefit Package Requirements**

**Section 2103**

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

**6. Cost Sharing**

**Section 2103(e)**

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

## **CENTERS FOR MEDICARE & MEDICAID SERVICES**

### **SPECIAL TERMS AND CONDITIONS**

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

**TITLE:** Utah Medicaid Reform 1115 Demonstration

**AWARDEE:** Utah Department of Health and Human Services

#### **1. PREFACE**

The following are the Special Terms and Conditions (STCs) for Utah's Medicaid Reform 1115 Demonstration Waiver (hereinafter referred to as "demonstration") to enable the Utah Department of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. The STCs set forth conditions and limitations on the expenditure authorities and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional expenditure authorities, nor expand upon those separately granted. The STCs are effective from July 1, 2022 through June 30, 2027, unless otherwise specified. The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility
5. Benefits
6. Enrollment and Implementation
7. Cost Sharing
8. Delivery Systems
9. Federal Medical Assistance Percentage
10. Substance Use Disorder Program
11. Serious Mental Illness Program
12. Health-Related Social Needs
13. Reentry Demonstration Initiative
14. Monitoring and Reporting Requirements
15. General Financial Requirements Under Title XIX
16. Monitoring Budget Neutrality for the Demonstration
17. Evaluation of the Demonstration
18. Provider Rate Requirements

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

|               |                                                                        |
|---------------|------------------------------------------------------------------------|
| Attachment A. | SUD Implementation Plan                                                |
| Attachment B. | SMI/SED Implementation Plan                                            |
| Attachment C. | Non-Traditional Benefit Package                                        |
| Attachment D. | Traditional Benefit Package                                            |
| Attachment E. | Modified Adjusted Gross Income (MAGI) Conversion Table                 |
| Attachment F. | Claiming Methodologies                                                 |
| Attachment G. | Reentry Demonstration Initiative Implementation Plan <i>[reserved]</i> |
| Attachment H. | Reentry Demonstration Initiative Reinvestment Plan <i>[reserved]</i>   |
| Attachment I. | Protocols for HRSN Infrastructure and HRSN Services                    |
| Attachment J. | HRSN Implementation Plan <i>[reserved]</i>                             |
| Attachment K. | Provider Payment Rate Increase Assessment – Attestation Table          |
| Attachment L. | Postpartum Proxy Methodology                                           |

## 2. PROGRAM DESCRIPTION AND OBJECTIVES

Utah’s demonstration is a statewide section 1115 demonstration, originally approved in 2002, to provide additional benefits to Medicaid beneficiaries, as well as provide demonstration coverage or premium subsidies for some populations that do not qualify for Medicaid. The demonstration has historically allowed for slightly reduced benefits for parent/caretaker relatives (PCR), medically needy adults, age 19-64, and the transitional medical assistance (TMA) population who are not aged, blind, or disabled (Current Eligibles). Through the demonstration, in January 2020 the state expanded Medicaid to adults with incomes up to 133 percent of the federal poverty level (FPL) exclusively through the demonstration; this is called the Adult Expansion Population. Beneficiaries in the Adult Expansion Population with incomes above 100 percent of the FPL who have access to affordable employer sponsored insurance (ESI) are required to enroll in the ESI program. The state wraps benefits and cost-sharing so beneficiaries receive all Medicaid benefits they are entitled to and do not have cost-sharing above Medicaid state plan levels.

Through the demonstration, the state also covers Targeted Adults, who are adults without children with income at zero percent of the FPL who meet one of the following criteria: (1) chronically homeless; (2) involved in the justice system and in need of substance use or mental health treatment; or (3) needing substance use or mental health treatment.

The demonstration offers ESI (Demonstration Population III), or Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) (Demonstration Population V) premium subsidies for state qualified insurance plan. Individuals, their spouses, and their children, ages 19 through 26, who have household incomes above 133 percent of the FPL up to and including 200 percent of the FPL are eligible to enroll in the ESI or COBRA programs. In addition, Children’s Health Insurance Program (CHIP) eligible children with household income up to 200 percent of the FPL can elect ESI or COBRA premium subsidies as an alternative to direct coverage, provided the ESI or COBRA coverage meets the minimum benefit requirements. The state provides dental wrap around benefits through direct CHIP coverage if dental is not offered in the child’s ESI or COBRA plan.

Before the state expanded Medicaid, the state covered an expansion population at regular Federal



Medical Assistance Percentage (FMAP) consisting of adults not otherwise eligible for Medicaid with incomes up to 95 percent of the FPL (effectively 100 percent of the FPL with the five percent disregard) called Demonstration Population I. This expansion population had a choice of the primary/preventative care program (Demonstration Population I), premium subsidies for ESI, or premium subsidies for COBRA. The authority for this population ended as of April 1, 2019 and all members of the population moved into the Adult Expansion Group. As of this extension, the language for this population has been removed.

The demonstration also authorizes dental benefits for all beneficiaries who are ages 21 and over, children, and pregnant or postpartum women. In addition, all Medicaid beneficiaries, age 21 through 64, have access to Medicaid services while residing in an institution for mental diseases (IMD) for SUD or serious mental illness (SMI) short-term residential stays. The demonstration also provides full state plan coverage for former foster care youth who were enrolled in Medicaid upon “aging out” of foster care in another state or tribe and are now applying for Medicaid as a resident in Utah.

The demonstration also allows Utah to provide housing support services as described in section 1915(i) of the Social Security Act, such as tenancy support services, community transition services, and supportive living services to beneficiaries in the Targeted Adult population under the demonstration who are experiencing homelessness, housing, food or transportation insecurity, interpersonal violence or trauma.

On January 8, 2025, CMS approved coverage of a HRSN services and expanded dental services to all Medicaid-eligible adults. As part of this approval, CMS has authorized payments for allowable infrastructure costs related to implementation of the HRSN initiative. CMS also approved expenditure authority for the state to provide non-medical transportation (NMT) to and from HRSN services for beneficiaries who meet HRSN criteria. Lastly, CMS authorized an increase in the upper age limit for fertility preservation services for individuals diagnosed with cancer; the upper age limit increased from 40 years of age to 50 years of age.

On November 13, 2025, CMS approved coverage for family planning services and family planning related services for adults. CMS also approved authority for the state to provide extended postpartum coverage to individuals enrolled in Medicaid for the period of time up to 12 months from the last day of an individual’s pregnancy. Lastly, CMS approved coverage for dental services for children and pregnant or postpartum women enrolled in Medicaid. These individuals will receive these services through the fee-for-service (FFS) delivery system, rather than through managed care plans, in partnership with the University of Utah School of Dentistry and their associated statewide provider network.

During the extension period, of July 1, 2022 through June 30, 2027, the state seeks to achieve the following goals:

- Provide health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage;
- Improve beneficiary health outcomes and quality of life;
- Lower the uninsured rate of low income Utahns;
- Provide continuity of coverage for individuals eligible under the demonstration;

- Increase access to primary care;
- Reduce uncompensated care provided by Utah hospitals;
- Reduce barriers to health care and housing, an important social determinant of health;
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
- Improve access to services across the continuum of care;
- Provide for better care coordination for individuals transitioning to community-based care;
- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
- Reduce the overdose death rate; and
- Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

### **3. GENERAL PROGRAM REQUIREMENTS**

- 3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act (ADA) of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).
- 3.2. **Compliance with Medicaid and Children’s Health Insurance Program Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
- 3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified

budget neutrality agreement for the demonstration as necessary to comply with such change as well as an allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

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

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

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary of Health and Human Services in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

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

- a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;
- b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

- c. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- d. An up-to-date CHIP allotment worksheet, if necessary;
- e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

**3.8. Extension of the Demonstration.** If the state intends to request an extension of the demonstration, it must apply to CMS from the Governor or Chief Executive Officer of the state in accordance with the requirements of 42 CFR §431.412(c). If the state does not intend to request an extension of a demonstration beyond the period authorized in these STCs, it must submit a phase-out plan consistent with the requirements of STC 3.9.

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

- a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than 6 months before the effective date of the demonstration’s suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.
- b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary’s appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

- c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.
- d. Transition and Phase-out Procedures. The state must comply with all applicable notice and fair hearing requirements found in 42 CFR 435.917 and 42 CFR part 431 subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).
- e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR section 431.416(g).
- f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not to extend this demonstration, during the last 6 months of the demonstration, enrollment of the new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.
- g. Federal Financial Participation. If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

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

3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and

enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

- 3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to applying to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates. For substantial modifications to the ABP in this demonstration, the state must follow the public notice requirement set forth in 42 CFR 440.386.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

- 3.13. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.
- 3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
- 3.15. **Common Rule Exemption.** The state must ensure the only involvement of human subjects in research activities authorized and/or required by this demonstration is for projects conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

#### **4. ELIGIBILITY**

- 4.1. **Eligibility Criteria.** Mandatory and optional Medicaid state plan populations derive their eligibility through the Medicaid state plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly not applied and as described in these STCs.

- 4.2. **Use of Eligibility Methodologies.** Any Medicaid state plan amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for access to additional benefits not described in the state plan. Expansion groups which are not eligible under the state plan and are eligible only for benefits under this demonstration are subject to all Medicaid requirements except as expressly not applied in this demonstration, or expressly listed as not applicable to the specific expansion group. These requirements include determination of financial eligibility using MAGI-based methodologies (and exceptions for non-MAGI based methodologies, as appropriate) in the same manner as for populations eligible under the Medicaid state plan.

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

- 4.3. **Eligibility Groups.** The demonstration is comprised of the following Eligibility Groups.
- a. Current Eligibles are the following individuals, whose eligibility is derived from the state plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the state plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum. Expenditures on current eligibles are considered demonstration expenditures for purposes of calculation of demonstration budget neutrality. There is no enrollment limit for this group. This demonstration eligibility group will be terminated no later than December 31, 2023 and this state plan population will receive benefits via the state plan after that date.
  - b. Demonstration Population III is comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.
  - c. Demonstration Population V consists of adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

- d. Current Eligible CHIP Children is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.
- e. Demonstration Population VI is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:
  - i. COBRA-Eligible Children: A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.
  - ii. COBRA Continuation Children: A child that meets the definition of a targeted low-income child except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium subsidies.
- f. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:
  - i. Be chronically homeless, defined as:
    - 1. An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
    - 2. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;



3. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or
  4. An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (i)(1), (i)(2), or (i)(3), above.
- ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
1. An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);
  2. An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;
  3. An individual on probation or parole with serious mental illness and/or serious substance use disorder;
  4. An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
  5. Individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.
- iii. Needing substance use or mental health treatment, defined as:
1. An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or
  2. An individual recently discharged from the Utah State Hospital who was civilly committed, to be further specified in the Utah Administrative Code.
- g. Former Foster Care Youth from Another State are defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.

Beginning January 1, 2023, the Former Foster Care Youth from Another State population will include individuals who otherwise meet the definition and turned age

18 on December 31, 2022, or earlier. Individuals who turn age 18 on January 1, 2023, or later, and who qualify as a Former Foster Care Youth, will be eligible under the state plan.

- h. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state.
- i. The Extended Postpartum Coverage population is comprised of women who are eligible for Medicaid during their pregnancy.
  - i. The state will extend postpartum coverage for individuals from the end of the state plan 60-day postpartum period to the end of the 12th month following the end of the pregnancy.
  - ii. To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum coverage will remain enrolled continuously within their eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination, or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.
  - iii. The state will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916 prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 CFR 435.917 and 42 CFR Part 431, Subpart E, and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916.
  - iv. Postpartum Coverage for the Adult Group. The state has submitted to CMS a proxy methodology for state expenditures to qualify for the newly eligible FMAP under section 1905(y) of the Act, consistent with requirements provided in 42 CFR 433.206(d). This methodology has been approved by CMS and is incorporated as Attachment L to these STCs. The proxy methodology identifies the proportion of claimed expenditures for beneficiaries receiving post-partum benefits who are reasonably estimated to meet the definition of newly eligible under section 1905(y)(2)(A) of the Act for whom enhanced newly eligible FMAP may be claimed, and the proportion

claimed for beneficiaries who do not meet this definition for whom the regular FMAP must be claimed.

- j. The Family Planning and Family Planning Related population is comprised of adults, ages 18 and older, who are not in a public institution.

## 5. BENEFITS

- 5.1. **Minimum for Current Eligibles.** Current Eligible adults enrolled in the demonstration receive most of the services covered under Utah’s state plan according to the limitations specified in the state plan, except as modified below. This benefit package is reduced from that available under the state plan in accord with changes detailed in Table 1. Any changes that would result in coverage limitations that are more restrictive than those listed in Table 1, or less restrictive than both Table 1 and the corresponding section of the Medicaid state plan, must be submitted as a demonstration amendment. If the state were to amend its Medicaid state plan to provide benefit limitations that are more restrictive than those listed in Table 1 (including elimination of any of the listed services), the revised state plan would determine the benefit. The state must notify the Project Officer of all planned changes to benefits for Current Eligibles, and provide an updated budget neutrality analysis with each such notification that shows the likely effect of the planned changes. CMS reserves the right to determine whether a change in benefits under the state plan that impacts this demonstration and effects budget neutrality for the demonstration would warrant an amendment. The state may not amend its Medicaid state plan to provide a Benchmark Benefit under section 1937 of the Act to Current Eligibles, or any subset of Current Eligibles, so long as this demonstration is in effect. By January 1, 2024, Current Eligibles will no longer be enrolled in the demonstration and receive all benefits in accordance with the state plan.

| <b>Table 1. Benefits for Current Eligibles and for Members of the Adult Expansion Population who are Custodial Parents/Caretaker Relatives that are Different than State Plan Covered Services and Limitations</b> |                                                                                                                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Service</b>                                                                                                                                                                                                     | <b>Special Limitations for Current Eligibles</b>                                                                                                                                      |
| 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.                                                                            |

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

## 5.2. Benefit Definition for Premium Subsidies.

- a. For Adults and Adult Children in Demonstration Populations III and V – Premium Subsidy. The sole benefit provided to persons eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.
- b. For Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI) – Premium Subsidy. The primary benefit provided to children eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the child's share of the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.
  - i. Dental benefits for children will be offered through two paths. If the health benefit package that is available to a child through qualified premium subsidies coverage includes dental benefits, the child's premium subsidies will be approximately equivalent to the per-child-per-month cost under the Title XXI state plan including dental costs. However, if a child does not receive dental benefits through the qualified premium subsidy plan, the state's minimum dental coverage for children is set by legislation, and is benchmarked to the coverage of the largest private carrier. In this case, the coverage is the same as direct coverage.
- c. Minimum Coverage. Utah will ensure that all participating premium subsidy insurance plans cover well- baby/well-child care services, age-appropriate immunizations, and emergency care. The state will also ensure children receive physician visits, hospital inpatient, and pharmacy benefits, at a minimum. To be a "qualified plan" the plans must meet the criteria established in Utah Administrative Code R414-320-2 (12).
- d. Additional Benefits. Benefits furnished by qualified premium subsidy insurance plans are not benefits under this demonstration; the only benefit under this demonstration is premium subsidies. Qualified plans are not restricted from offering additional benefits, at the option of the plan, which may vary by the plan to which the individual or family has access.

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

- 5.4. **Premium Subsidy Determination.** Demonstration Population III, V, and VI beneficiaries, as well as Current Eligible CHIP children, will receive premium subsidies, under the following conditions:
- a. In accordance with the enrollment and implementation procedures as defined in Section 6, the state will provide an eligible and enrolled individual or family with a premium subsidy.
  - b. For children, the premium subsidy amount for participating plans must not exceed the maximum amount of the participant's share of the premium:
    - i. For ESI plans –
      - 1. Children = \$180 per enrollee per month with state wrap around dental benefits,
      - 2. Children = \$200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage,
    - ii. For COBRA plans –
      - 1. Children = \$180 per enrollee per month with state wrap around dental benefits,
      - 2. Children = \$200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage.
  - c. Adjustments for Health Care Inflation. For adults and children enrolled in the premium subsidy programs, the state may increase the maximum amount per month through the state's rulemaking process as long as it does not exceed the without waiver ceiling amount established in the budget neutrality calculation of estimated service expenditures and the subsidy amount found in Utah Administrative Code R414-320-16.
  - d. For demonstration populations III and V, the maximum premium subsidy will be determined by the amounts found in Utah Administrative Code R414-320-16. Any future changes to decrease the maximum premium subsidy amount must be approved by CMS through an amendment to the demonstration in accordance with the process outlined in STC 3.7.
  - e. The premium subsidy will be paid directly to the individual/family up to the maximum amount specified in STC 5.4(b) (d).
- 5.5. **Dental Benefit.** All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women will receive dental benefits that are defined in the Utah Medicaid Provider Manual, *Dental, Oral Maxillofacial, and Orthodontia Services*.
- 5.6. **Targeted Adults.** Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

- 5.7. **Former Foster Care Youth from Another State.** Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.
- 5.8. **Adult Expansion Population.** By January 1, 2024, all beneficiaries in the Adult Expansion Population will receive the same benefits, regardless of parental status. Any changes to this coverage must be approved through a future amendment to the demonstration or as a technical change to the demonstration when the change would conform Attachments D or F to the state plan. The benefits the beneficiaries receive after this date are described in Attachment D, which are aligned with the state plan. CMS will update Attachment D at a future date, and any subsequent time, to reflect the changes made to the state plan. Before January 1, 2024, beneficiaries in this category will receive benefits as follows:
- a. Custodial Parents/Caretaker Relatives enrolled in this eligibility category will receive the same benefits as Current Eligibles, the non-traditional benefits, which are outlined in Table 1 and Attachment C. These beneficiaries will receive benefits as described in Attachment C. Utah has fully aligned the non-traditional benefit package with the Medicaid state plan except for those benefits limitations listed under table 1. The state has ensured all requirements of section 1937 of the Act are met including the inclusion of coverage for the ten categories of essential health benefits (EHBs). The non-traditional benefit package does not differ in amount, duration or scope from Medicaid state plan benefits, except to the extent that it includes coverage required under section 1937 of the Act that is not included under the state plan and the benefit limitations listed under Table 1. Any changes to this coverage must be approved through a future amendment to the demonstration.
  - b. Childless Adults/Non-custodial Parents enrolled in this eligibility category will receive full Medicaid state plan benefits, the traditional benefits, as outlined in Attachment D. These beneficiaries will receive benefits as described in Attachment D. Utah has fully aligned its traditional benefit package with the Utah Medicaid state plan while ensuring all requirements of section 1937 of the Act are met, including the inclusion of coverage for the ten categories of EHBs. The traditional benefit package does not differ in amount, duration or scope from Medicaid State plan benefits, except to the extent that it includes coverage required under section 1937 of the Act that is not included under the state plan. Any changes to this coverage must be approved through a future amendment to the demonstration.
  - c. With respect to the coverage described in STC 5.9 (a) and (b), the non-traditional benefits and traditional benefits provided to specified categories of beneficiaries within the Adult Expansion Population, Utah assures that these benefit packages comport with the requirements of section 1937 of the Act, except as limitations discussed in this STC, and specifically makes the following assurances:
    - i. Utah assures that all services in the EHB benchmark plan used to define the benefit package have been accounted for throughout the Alternative Benefits Plan (ABP) 5 charts found in Attachments C and D and Utah assures the accuracy of all information in ABP 5 depicting amount, duration and scope

parameters of services authorized in the currently approved Medicaid State Plan.

- ii. Utah assures Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services will be provided to individuals under 21 years of age who are covered under the traditional and non-traditional benefit packages.
- iii. Utah assures that it does not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- iv. Utah assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (42 CFR 440.347(d) and 45 CFR 156.115(a)(5)(iii). Further, Utah assures that it will not impose combined limits on habilitative and rehabilitative services and devices.
- v. Utah assures that substituted benefits are actuarially equivalent to the benefits they replaced from the EHB benchmark plan used to define EHB benefits, and that the state has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.
- vi. Utah assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act. Utah assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- vii. Utah assures that it will comply with the requirement of section 1937(b)(5) of the Act by ensuring that the benefit package includes at least the EHBs as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- viii. Utah assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ix. Utah assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to beneficiaries include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- x. Utah assures necessary medical transportation (emergency and non-emergency) for the Adult Expansion Population beneficiaries who receive the traditional benefits in accordance with 42 CFR 431.53 and necessary

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

- xi. Utah assures, in accordance with 42 CFR 440.347(a) and 45 CFR 156.115(a)(4), that it will provide benefits that include preventive services identified at 45 CFR 147.130.
  - xii. Utah assures that, for each benefit provided under the benefit packages that is not provided through managed care, it will use the payment methodology in its approved state plan for the benefit.
  - xiii. Utah assures that prescription drug coverage is the same as under the approved Medicaid State Plan for prescribed drugs.
  - xiv. Utah assures that when it pays for outpatient prescription drugs covered under the benefit packages, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345.
  - xv. Utah assures that when conducting prior authorization of prescription drugs for Adult Expansion Population beneficiaries receiving the traditional and non-traditional benefit packages, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.
  - xvi. The state assures it will comply with section 1115 Public Notice and Tribal Consultation requirements in STC 3.12 before amending benefits, include in public notice, the method for assuring compliance with 42 CFR 440.345 related to full access to EPSDT services and a description of the method for complying with the provisions of the amendments made by section 5006(e) of the American Recovery and Reinvestment Act of 2009.
- d. Mandatory ESI Enrollees. Beneficiaries in this eligibility group that are eligible to enroll in a qualified ESI plan (as described in STC 4.3(h)), are required to enroll in that plan and will be reimbursed for the full amount of the beneficiary's share of the monthly premium cost of the qualified ESI plan. In order to ensure the beneficiary receives Medicaid benefits, wrap-around benefits will be provided through a fee-for-service (FFS) delivery system.

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

- a. Psychoeducational services (mental health rehabilitation);
- b. Personal services;
- c. Respite care; and



- d. Supportive living services (mental health services in residential treatment settings).

5.10. **Fertility Preservation for Individuals Diagnosed with Cancer.** Fertility preservation services are available for beneficiaries undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile. Cost sharing requirements for this benefit will not differ from those under the state plan. Reimbursement for cryopreservation storage is covered as a single payment for five years. Additional 5-year storage increments may only be requested for members that retain eligibility.

- a. **Eligibility.** To be eligible for this benefit, a beneficiary must meet the below requirements.

- i. A beneficiary must have been diagnosed by a physician or other qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility;
- ii. The beneficiary is post-pubertal and younger than 50 years of age;
- iii. The beneficiary's state of health is sufficient to undergo fertility preservation procedures; and
- iv. The member has received fertility counseling as well as psychotherapy, when medically indicated.

- b. **Scope of Benefit.** Eligible beneficiaries can receive the following services once per lifetime.

- i. Collection and storage of eggs and sperm consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine or the American Society of Clinical Oncology.
- ii. Preimplantation genetic testing prior to cryopreservation storage, with coverage as described in Utah's coverage and reimbursement materials and policy manuals.
- iii. Cryopreservation storage, which is covered as a single payment for a five-year period. If the individual remains eligible for Medicaid or demonstration coverage, the state will continue to provide cryopreservation storage in five-year increments.

- 1. If an individual loses eligibility during the five-year period, the stored specimens will remain in storage until the five-year period ends. Towards the end of the five-year period, the state Medicaid agency will contact the former beneficiary and communicate needed steps for the individual to assume financial responsibility for continued cryopreservation storage. The state may also, at this time, reevaluate

their eligibility for Medicaid.

c. **Limitations.** This benefit is subject to the following limitations.

- i. Services provided under this benefit require prior authorization.
- ii. Investigational or experimental procedures will not be covered.
- iii. Post-cryopreservation procedures are not covered under this benefit.
- iv. Cryopreservation of eggs or sperm for fertility preservation purposes other than iatrogenic infertility are not covered.

d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 16 (Monitoring and Reporting Requirements) and 19 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

5.11. **In Vitro Fertilization and Genetic Testing Services.** In vitro fertilization services and genetic testing services are available for eligible individuals who meet the below requirements and have had a prior authorization for these services approved by the Medicaid agency. This benefit is intended to reduce the likelihood that beneficiaries who have a serious inherited disorder, or who carry a genetic trait associated with a serious inherited disorder, pass the disorder on to their child.

a. **Eligibility.**

- i. To be eligible for genetic testing services, an individual must have a familial medical history or be in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.
- ii. To be eligible for IVF services, a beneficiary must meet the below requirements.
  1. Be between the ages of 18 and 35; and,
  2. Has been diagnosed by a physician or other qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition.
  3. Has been diagnosed by a physician or other qualified health professional as having a genetic trait associated with myotonic

dystrophy.

- b. **Scope of Benefit.** For eligible beneficiaries, this benefit includes the following services.
  - i. Genetic testing services for individuals that satisfy the requirements in STC 5.11(a);
  - ii. Preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus; and
  - iii. In vitro fertilization services for individuals that satisfy the requirements in STC 5.11(a).
- c. **Limitations.** Access to this benefit is subject to the following limitations.
  - i. Qualifying beneficiaries may receive up to three cycles of IVF per lifetime.
  - ii. The eligible individual has had a prior authorization for this service approved by DIH.
- d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 16 (Monitoring and Reporting Requirements) and 19 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

#### 5.12. **Family Planning Services and Family Planning Related Services.**

Family Planning Services. Individuals eligible under this demonstration will receive family planning services and supplies as described in section 1905(a)(4)(C) of the Act. Family planning services and supplies are reimbursable at the 90 percent Federal matching rate and are limited to those services and supplies whose primary purpose is family planning to prevent or delay pregnancy. The specific family planning services provided under this demonstration are as follows:

- a. Comprehensive family planning preventive visits based on nationally recognized clinical guidelines that must have a primary focus and diagnosis of family planning,

- which includes counseling, education, and initiation or management of contraceptive methods.
- b. FDA-approved methods of contraception;
  - c. Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears, and pelvic exams.  
Note: The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood counts, and pregnancy tests. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception.
  - d. Drugs, supplies, or devices related to family planning services described above that are prescribed by a health care provider who meets the state's provider enrollment requirements, subject to the national drug rebate program requirements;
  - e. Contraceptive management, patient education, and counseling; and
  - f. Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, laboratory testing necessary to complete a sterilization or long-acting reversible contraception insertion, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure. The covered procedures are vasectomies, salpingectomy, tubal occlusions, and tubal ligations, which must meet the requirements of 42 CFR 441, Subpart F. All prescription medications must be directly related to the sterilization procedure and align with the State's preferred drug list.

Family Planning Related Services. Individuals eligible under this demonstration will also receive family planning related services and supplies, defined as those services provided as part of or as follow-up to a family planning visit for diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling, and are reimbursable at the state's regular Federal Medical Assistance Percentage (FMAP) rate. Examples of family planning related services and supplies include:

- g. Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines, may be covered;
- h. STI/STD diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling; and

- i. FDA-approved vaccination for Human Papillomavirus (HPV).

## **6. ENROLLMENT AND IMPLEMENTATION**

### **6.1. General Requirements**

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

### **6.2. Enrollment in ESI Premium Subsidies (Demonstration Populations III and Current Eligible CHIP Children).**

- a. Adults with incomes above 133 percent, up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population III will be given the option to receive premium subsidies for ESI.
- b. Families with dependent children that are eligible for CHIP may elect to have their children receive premium subsidies for ESI, instead of receiving CHIP coverage. However, children may opt back into direct coverage at any time.
- c. The state must establish and maintain procedures (which may be done through rulemaking) that will:
  - i. Ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving subsidies from the state;
  - ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between CHIP coverage and ESI coverage, so that they can make an informed choice (if the individual is eligible for CHIP);
  - iii. Ensure the consent of the responsible adult family member to receiving ESI premium subsidies instead of coverage through CHIP (if the individual is eligible for CHIP);
  - iv. Allow children to opt out of ESI and begin receiving CHIP coverage at any time, with an immediate effective date upon request;
  - v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage and the individual's/family's share of the premium;

- vi. Require clients to notify the Utah Department of Health and Human Services within ten days if they change their ESI plan, there is a change in the amount of their premium, or their ESI coverage is terminated;
- vii. Ensure that the total amount of subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation toward their ESI coverage;
- viii. Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage. The federal share must be returned within the timeframes established in statute and regulations; and
- ix. Provide for a redetermination of eligibility at least once every 12 months.

### **6.3. Enrollment in Utah COBRA Premium Subsidy Program**

- a. Adults with incomes above 133 percent up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population V will be given the option to receive premium subsidies for COBRA.
- b. Families with dependent children that are eligible for CHIP, and whose children have lost COBRA-eligible ESI coverage, may elect to have their children receive premium subsidies for COBRA coverage, instead of receiving CHIP coverage.
- c. The state may offer premium subsidies for COBRA coverage to all adults and children who are receiving COBRA coverage. COBRA premium subsidies may be offered to adults and children who would be eligible for CHIP, if uninsured. The state must establish and maintain procedures (which may be done through rulemaking) that will:
  - i. Ensure that at least one adult family member is eligible for COBRA continuation coverage, that the COBRA benefit qualifies for the COBRA premium subsidy, and that the eligible individual elects to participate and maintains participation in the COBRA plan for all individuals receiving COBRA subsidies from the state;
  - ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between CHIP coverage and COBRA coverage, so that they can make an informed choice (if the individual is eligible for CHIP);
  - iii. Ensure the consent of the responsible adult family member to receiving COBRA premium subsidies instead of coverage through CHIP (if the individual is eligible for CHIP);
  - iv. Allow children to opt out of the Utah COBRA Premium Subsidy Program and begin receiving CHIP coverage at any time; with an immediate effective date upon request.

- v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in COBRA coverage and the individual's/family's share of the premium. Verification may include the use of the Coverage Election Notice, forms developed by the state, and use of inter-agency administrative databases such as eFILE;
- vi. Require clients to notify the Utah Department of Health within 10 days if there is a change in the amount of their premium or their COBRA coverage is terminated;
- vii. Ensure that the total amount of the Utah COBRA Premium Subsidy Program subsidy(ies) provided to an individual or family does not exceed the amount of the former employee's financial obligation toward their COBRA coverage
- viii. Provide for recovery of payments made for months in which the individual or family did not receive COBRA coverage. The federal share must be returned within the timeframes established in statute and regulations; and
- ix. Provide for a review of benefits on a timeframe consistent with anticipated changes in COBRA coverage or premiums and a redetermination of eligibility at least once every 12 months.

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

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

**6.5. Interaction with Medicaid.** For individuals eligible for Demonstration Populations III (ESI adults) and V (COBRA adults), the state will offer opportunities for these individuals to enroll in direct Medicaid coverage if they are later determined to be eligible for such coverage.

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

6.6. **Enrollment in Dental Benefits.** There is no separate enrollment process required for Medicaid-enrolled individuals to receive dental services through this demonstration.

6.7. **Targeted Adults Enrollment.**

- a. Individuals applying for Medicaid will be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults eligibility group.
- b. This state has 12-month continuous eligibility and the state will provide for a redetermination of eligibility at least once every 12 months. Within a beneficiary's 12-month eligibility period, the state's eligibility system automatically identifies Targeted Adults with household incomes above 133 percent of the FPL. The beneficiary will remain a Targeted Adult for the remaining 12-month eligibility period, but expenditures made during the time the beneficiary is over income will have the claims submitted to receive the state's regular FMAP, instead of newly eligible enhanced FMAP. The state will report on the percentage for which they submit regular claims under this group on the quarterly and annual monitoring reports.
- c. The Targeted Adults group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period. However, closing enrollment does not preclude individuals from being enrolled in the Adult Expansion Population, which is always open for enrollment.
- d. The state will provide continuous benefits for a period of 12 months to the Targeted Adults. Changes during this period will not affect a beneficiary's benefits with the exception of the following reasons:
  - i. Moving out of state;
  - ii. Death;
  - iii. Determined eligible for another Medicaid eligibility category;
  - iv. Fraud; or
  - v. Client request.
- e. All eligibility criteria, including income, will be considered at the time of the individual's annual eligibility redetermination to determine if the individual continues to meet eligibility for Medicaid.

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



- a. **Beneficiary Enrollment Requirements.** The state may mandatorily enroll members of the Adult Expansion Population into UMIC managed care organizations (MCO) for delivery of their physical and behavioral health services in the five urban counties in the state (Davis, Salt Lake, Utah, Washington, and Weber), except as provided in paragraph (e) of this STC. Further, the state may mandatorily enroll members of the Adult Expansion Population in an ACO and a PMHP, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC.
- b. **Auto-Assignment.** If a beneficiary does not choose a managed care plan (UMIC MCO or ACO/PHMP) within the time frames defined in (b)(iii), he or she may be auto-assigned to a managed care plan. When possible, the auto assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with a managed care plan. If this is not possible, the state will equitably distribute beneficiaries among managed care plan as specified in this STC.
  - i. Beneficiaries who are newly enrolling in the Adult Expansion Population and residing in a mandatory managed care county (either a UMIC MCO or ACO/PMHP model) will receive a pending managed care plan selection that will be placed on the beneficiary's case using a "round robin" method, consistent with the auto-assignment standards described in the previous paragraph, so that each managed care plan receives approximately the same number of new cases.
  - ii. Returning Medicaid beneficiaries will have their previous managed care plan reinstated if it has been less than two years since they were enrolled in managed care. If it has been more than two years or if their previous managed care plan is no longer available for enrollment, their pending assignment will be based on the "round robin" method, after taking into consideration the beneficiary's history with a primary care provider.
  - iii. All beneficiaries subject to mandatory enrollment into managed care will receive a letter that informs them of the need to select a plan(s) and that if they do not respond within 10 days, the state will assign a plan(s). If a beneficiary (including beneficiaries with special health care needs) contacts the state and indicates that he or she has a current primary or specialty provider, the state will assist the member in selecting a plan(s) that includes that provider in its network. After 10 days, if a member has not responded, the system-assigned (i.e., pending) plan(s) will be the member's plan(s).
- c. **Open Enrollment Period.** An open enrollment period will be held for beneficiaries from mid-May to mid-June each year, during which such beneficiaries may select a different available managed care plan for enrollment.
- d. **Enrollment Exemptions.** The following populations are exempt from mandatorily enrolling in UMIC MCO or ACO and PMHP:

- i. Utah Medicaid beneficiaries residing in the Utah State Hospital or the Utah State Developmental Center;
    - ii. Beneficiaries with presumptive eligibility;
    - iii. Individuals enrolled in the Healthy Outcomes Medical Excellence (HOME) program;
    - iv. Medicaid members enrolled in Utah's Buyout Program; and
    - v. Adult Expansion Population beneficiaries mandatorily enrolled in ESI.
  - e. **Enrollment Exemption Process.** The state will allow a beneficiary not to enroll in or to disenroll from a managed care plan and to enroll in a FFS delivery system, or to switch from a managed care plan to another available managed care plan, in the event that enrollment in the current managed care plan or in any available managed care plan, as applicable, would not meet the beneficiary's health care needs and there is a reasonable expectation that the beneficiary's health would suffer if he or she were not permitted to switch to a different available managed care plan or enroll in FFS delivery. Exemption requests must be submitted for approval to the state Medicaid agency.
  - f. **Disenrollment.** The state allows enrollees to make a request to disenroll from/transfer between managed care plan plans or enroll in FFS as described in STC 6.8(e). The determination must be made no later than the first day of the second month following the month in which the enrollee or a plan files the request with the state. If determination is not made within this time frame, the request is deemed approved.
- 6.9. **Mandatory ESI Enrollment.** For beneficiaries in the Adult Expansion Population who are required to enroll in a qualified ESI plan as specified in STC 4.3(h), access to and enrollment in a qualified ESI plan and the beneficiary's premium amount will be verified at initial application, every three months, and at annual recertification.

## 7. COST SHARING

- 7.1. **Cost Sharing.** Cost sharing must comply with Medicaid requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR §447.56(a), and be reflected in the state plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447.52(b) applies to the demonstration.
- 7.2. **Demonstration Populations III and Current Eligible CHIP Children in ESI and Demonstration Populations V and VI in COBRA.** Adults and children of families that choose premium subsidies will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium subsidies will be charged cost sharing amounts set by their ESI or COBRA coverage and will not be limited to the Title XXI five percent out-of-pocket family income maximum. All other cost sharing, including co-payments, and co-insurance, are set by the qualified plan and the responsibility of the participant.

- 7.3. **Cost Sharing for Certain American Indian/Alaskan Native Eligibles.** American Indian/Alaskan Native beneficiaries enrolled in the demonstration are subject to cost sharing exemptions of section 5006 of the American Recovery Reinvestment Act of 2009 (and are not required to pay premiums or cost sharing for services received through the Indian health care system). American Indian/Alaskan Native beneficiaries who have received a service or referral from an Indian Health Care Provider are exempt from premiums/enrollment fees and cost sharing as described at 42 CFR 447.56(a). Those who are eligible to receive services or a referral through an Indian Health Care Provider are also exempt from premiums and enrollment fees.
- 7.4. **Enrollment Fee.** The state must not impose an enrollment fee on any demonstration populations.

## **8. DELIVERY SYSTEMS**

- 8.1. **Comprehensive Service Delivery System.** Utah's MCOs, ACOs, and PMHPs must provide a comprehensive service delivery system that provides the full array of benefits and services offered under the program for which the relevant organization or plan has contracted to provide coverage. This includes the integration of a participant's physical health and behavioral health needs as further articulated by the delivery system requirements set forth below.
- 8.2. **Compliance with Managed Care Regulations.** The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.
- 8.3. **Description of Managed Care Program.** Under terms of this demonstration, the state is authorized to provide managed medical assistance benefits through managed care delivery systems, consistent with regulations in 42 CFR part 438. The state may mandatorily enroll Current Eligibles, Targeted Adults, Adult Expansion Population to receive the health care benefits pursuant to Section 6 of the STCs.
- 8.4. **Managed Care Contracts.** In accordance with managed care regulations published at 42 CFR part 438, CMS requires that the state must submit MCO contracts to CMS for review and approval to ensure compliance with beneficiary informational requirements, quality outcome provisions, and other applicable federal requirements. The state must provide CMS with a minimum of 90 days to review and approve contracts and/or any changes to contracts. The state must submit any supporting documentation deemed necessary by CMS. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the requirements of this STC are met or any identified deficiency in a contract is corrected.
- 8.5. **ESI and COBRA Delivery Systems.** Demonstration Populations III through VI will receive services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium subsidies.

## 8.6. Dental Services.

- a. The state will deliver services through a fee-for-service (FFS) payment model and contract with entities to provide dental services.
  - i. The contracted entities will enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described in STC 5.5 above through an intergovernmental transfer (IGT) consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
  - ii. The contracted entities must guarantee access statewide.

## 9. FEDERAL MEDICAL ASSISTANCE PERCENTAGE

- 9.1. The state will receive the enhanced Federal Medical Assistance Percentage (FMAP) for the Adult Expansion Population, as well as the Targeted Adults, who are newly eligible within the meaning of section 1905(y)(2)(A) of the Act. As part of the standard 1115 demonstration process, Utah may request to amend the demonstration, including coverage for the Adult Expansion Population, if the enhanced FMAP for the newly eligible beneficiaries in this population changes.
- 9.2. For beneficiaries who are members of the Adult Expansion Population and Targeted Adults, the state will make an individual income-based determination for purposes of the enhanced FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan approved by CMS on December 20, 2019. In general, and subject to any adjustments described in this STC under the enhanced FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the enhanced FMAP is not available. The relevant MAGI-converted standards for each population group in the Adult Expansion Population and Targeted Adults are described in Attachment E.
- 9.3. **Claiming Methodology.** For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to the Adult Expansion Population, the determination of which beneficiaries qualify for enhanced FMAP methodology as a newly eligible adult shall be determined pursuant to a claiming methodology deliverable found in Attachment F.
- 9.4. **Resource Proxy Adjustment.** The state has elected not to apply a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

- 9.5. **Enrollment Cap Adjustment.** The state has elected to not apply an enrollment cap adjustment.
- 9.6. **Special Circumstances and Other Adjustments to the Adult Group FMAP Methodology.** The state has elected to not apply a special circumstances adjustment.
- 9.7. **Expansion State Designation.** The state does not meet the definition of expansion state in 42 CFR 433.204(b) and therefore does not qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- 9.8. **Assurances.** The state assures the following:
- a. The application of the enhanced FMAP claiming methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
  - b. The application of the enhanced FMAP claiming methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

## 10. SUBSTANCE USE DISORDER

- 10.1. **Opioid Use Disorder/Substance Use Disorder Program.** The demonstration benefit package for Medicaid members includes opioid use disorder (OUD)/SUD 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 FFP for Medicaid members residing in IMDs under the terms of this demonstration for coverage of medical assistance and OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD as CMS approved the state's Implementation Plan on November 9, 2017. Under this demonstration, beneficiaries have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

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

| Table 3. Utah OUD/SUD Benefits Coverage with Expenditure Authority           |                                          |                       |
|------------------------------------------------------------------------------|------------------------------------------|-----------------------|
| SUD Benefit                                                                  | Medicaid Authority                       | Expenditure Authority |
| Early Intervention (Screening, Brief Intervention and Referral to Treatment) | State plan (Individual services covered) |                       |
| Outpatient Therapy                                                           | State plan (Individual services covered) |                       |

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

- 10.2. **SUD Implementation Plan.** The state's SUD Implementation Plan, initially approved for the period from November 1, 2017 through June 30, 2022, remains in effect for the approval period from July 1, 2022 through June 30, 2027, and is affixed to the STCs as Attachment A. Any future modifications to the approved SUD Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

The approved SUD Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

- a. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;
- b. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

- c. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Utah Administrative Code R501 Residential Treatment Programs. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
- d. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;
- e. **MAT Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;
- f. **Sufficient Provider Capacity at Critical Levels of Care including MAT:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;
- g. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;
- h. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 10.2; and
- i. **Improved Care Coordination and Transitions:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

10.3. **SUD Health Information Technology (Health IT).** The state provided CMS with an assurance that it has a sufficient health IT infrastructure/“ecosystem” at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This “SUD Health IT Plan,” is included as a section of the state’s SUD Implementation Plan (see STC 10.2). The SUD Health IT Plan details the necessary

health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan also identifies areas of SUD health IT ecosystem improvement.

- a. The SUD Health IT section of the Implementation Plan includes implementation milestones and dates for achieving them (see Attachment A).
- b. The SUD Health IT Plan must align with the state’s broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state’s Behavioral Health (BH) “Health IT” Plan.
- c. The SUD Health IT Plan describes the state’s goals, each DY, to enhance the state’s prescription drug monitoring program (PDMP).<sup>1</sup>
- d. The SUD Health IT Plan addresses how the state’s PDMP enhances ease of use for prescribers and other state and federal stakeholders.<sup>2</sup> This also includes plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan describes ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients’ history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.
- e. The SUD Health IT Plan describes the state’s capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery, as applicable. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
- f. The SUD Health IT Plan describes how the activities described in (a) through (e) above will: (a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns<sup>3</sup> and (b) ensure that Medicaid does not inappropriately pay for opioids—and that states implement effective controls to minimize the risk.
- g. In developing the Health IT Plan, states shall use the following resources.

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

<sup>2</sup> *Ibid.*

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



- i. States may use resources at Health IT.Gov (<https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/>) in “Section 4: Opioid Epidemic and Health IT.”
  - ii. States may also use the CMS 1115 Health IT resources available on “Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability” at <https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>. States should review the “1115 Health IT Toolkit” for health IT considerations in conducting an assessment and developing their Health IT Plans.
  - iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.
- h. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Reports (see STC 14.5).
  - i. The state shall advance the standards identified in the ‘Interoperability Standards Advisory—Best Available Standards and Implementation Specifications’ (ISA) in developing and implementing the state’s SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.
    - i. Wherever it is appropriate, the state must require that contractors providing services paid for by funds authorized under this demonstration shall adopt the standards, referenced in 45 CFR Part 170.
    - ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170 but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standards.

## 11. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

- 11.1. **SMI/SED Program Benefits.** Since CMS’s approval of the SMI/SED Implementation Plan, beneficiaries have had access to the full range of otherwise covered Medicaid services, including SMI treatment services. SMI services range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state worked to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration’s SMI Program.
- 11.2. **SMI/SED Implementation Plan.** The state’s SMI/SED Implementation Plan, initially approved for the period from December 16, 2020 through June 30, 2022, remains in effect

for the approval period from July 1, 2022 through June 30, 2027, and is affixed to the STCs as Attachment B. Any future modifications to the approved SMI/SED Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

The approved SMI/SED Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SMI/SED demonstration project:

**a. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.**

- i. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
- ii. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
- iii. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
- iv. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
- v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based

screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

- vi. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for comorbid physical health conditions and SUDs and demonstrate the capacity to address comorbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

**b. Improving Care Coordination and Transitions to Community-Based Care.**

- i. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
- ii. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;
- iii. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;
- iv. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

- v. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

**c. Increasing Access to Continuum of Care Including Crisis Stabilization Services.**

- i. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
- ii. Commitment to implementation of the SMI/SED Financing Plan described in STC 11.4;
- iii. Implementation of strategies to improve the state’s capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
- iv. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

**d. Earlier Identification and Engagement in Treatment and Increased Integration.**

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

**11.3. SMI/SED Health Information Technology (Health IT) Plan.** The Health IT Plan is intended to apply only to those State Health IT functionalities impacting beneficiaries within this demonstration and providers directly funded by this demonstration. The state has provided CMS with an assurance that it has a sufficient health IT infrastructure/“ecosystem” at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. The state submitted to CMS a Health IT

Plan, and was included as a section of the SMI/SED Implementation Plan (see STC 11.2) to develop the infrastructure/capabilities of the state's health IT infrastructure.

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

The state monitors progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 14.5).

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

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

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

Components of the Health IT Plan include:

- a. The Health IT Plan describes, as applicable, the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SED/SMI care delivery. The state also indicated efforts to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.
  - i. The Health IT Plan describes the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.
  - ii. In developing the Health IT Plan, the state should have used the following resources:

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

11.4. **SMI/SED Financing Plan.** As part of the SMI/SED Implementation Plan referred to in STC 11.2, the state submitted a financing plan for approval by CMS. The SMI Financing Plan is incorporated into the STCs as part of the Implementation Plan in Attachment B and, may only be altered with CMS approval. Components of the SMI/SED Financing Plan include:

- a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers;
- b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings; and
- c. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

11.5. **Availability of FFP for the SMI/SED Services Under Expenditure Authority #11.** FFP is only available for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services in an IMD. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at

the mid-point assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

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

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

## 12. HEALTH-RELATED SOCIAL NEEDS

12.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 12.2 and Attachment I, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. All HRSN interventions must be evidence-based and medically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary’s receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 12.10 (Service Delivery) and Attachment I.

12.2. **Allowable HRSN services.** The state may cover the following HRSN services:

- a. Housing Interventions, including:
  - i. Housing supports without room and board, including:
    - 1. Pre-tenancy navigation services (e.g., finding and securing housing).
    - 2. One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, cooking supplies, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing.
    - 3. Tenancy and sustaining services (e.g., eviction prevention, tenant rights education).
  - ii. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.
  - iii. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars.
  - iv. Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:
    - 1. Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care.
    - 2. Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.
  - v. Room and board-only supports (also referred to as “rent-only” supports or interventions), limited to a clinically appropriate amount of time, including:
    - 1. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

### 12.3. HRSN Intervention Duration and Frequency.

- a. Housing interventions with room and board.



- i. Housing interventions that are classified as episodic interventions, as described in STC 12.2(b)(iv) may be covered for a qualifying beneficiary, as medically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.
  - ii. Housing interventions that are classified as room and board-only support, as described in STC 12.2(b)(v), may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.
  - iii. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions with room and board (including episodic interventions and room and board-only supports), per beneficiary, in any 12-month period. However, if a beneficiary is considered to have received room and board-only support because that intervention was covered for another member of the beneficiary's household as specified in STC 12.3(b), the beneficiary still may receive up to 6 months of coverage for episodic interventions in the same 12-month period without violating this STC.
- b. The state will define other HRSN service duration limitations in Attachment I, subject to CMS approval as indicated in STC 12.19.

**12.4. Excluded Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

- a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications specified in STC 12.2;
- b. Capital investments;
- c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 12.2 and 12.3;
- d. Research grants and expenditures not related to monitoring and evaluation;
- e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;
- f. Services provided to individuals who are not lawfully present in the United States;
- g. Expenditures that supplant services and/or activities funded by other local, state and/or federal governmental entities;

- h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and
- i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.
  - i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

#### 12.5. HRSN Infrastructure.

- a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of HRSN services, subject to STC 12.3. This FFP will be available for the following activities:
  - i. Technology – e.g., electronic referral systems, shared data platforms, electronic health record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.
  - ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.
  - iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.
  - iv. Outreach, education, and interested parties convening – e.g., design and production of outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.
- b. The state may claim FFP for HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 5. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

**Table 5. Annual Limits of Allowable Total Computable Expenditures for HRSN Infrastructure**

|                               | DY21 | DY22 | DY23        | DY24         | DY25         | Total        |
|-------------------------------|------|------|-------------|--------------|--------------|--------------|
| Total Computable Expenditures | \$0  | \$0  | \$4,150,000 | \$16,600,000 | \$12,450,000 | \$33,200,000 |

- c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure
- d. The infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 12.5 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.
- e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment I: HRSN Infrastructure Protocol is approved, as described in STC 12.9. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.
- f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

12.6. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment I, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid (or Medicaid demonstration)-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described STC 12.1, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment I. Attachment I, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state anticipates incorporating into Attachment I over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment I reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment I. Additionally, the state can later include additional clinical and social risk factors in compliance with STC 12.7 and 12.8.

12.7. **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service

descriptions, the criteria for defining a medically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment I must be effectuated through the process indicated in STC 12.8. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment I.

If the state adds new HRSN services beyond those specified in STC 12.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a medically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

- a. A list of the covered HRSN services (not to exceed those allowed under STC 12.2), with associated service descriptions and service-specific provider qualification requirements.
- b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.
- c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be medically appropriate.
  - i. Plan to identify medical appropriateness based on clinical and social risk factors.
  - ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.
- d. A description of the process for developing care plans based on assessment of need.
  - i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.
  - ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

**12.8. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:**

- a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachment I. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment I, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria :
  - i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
  - ii. The state must provide public notice.
  - iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.
- b. In addition to the requirements in (a) above, if the state seeks to implement additional clinical and/or social risk factors than what are included in approved Attachment I, the state must follow the process below to update the protocol:
  - i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in Table 12.
  - ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 12.8(b).
  - iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 12.8(b). This restriction is not applicable to the process and scope of changes outlined in STC 12.8(a).

**12.9. HRSN Infrastructure Protocol.** The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can

claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment I: HRSN Infrastructure Protocol. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted.

Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

- 12.10. **Service Delivery.** HRSN services will be delivered through the FFS) delivery system.
- a. HRSN services will be paid on a FFS basis when those HRSN services are provided to beneficiaries through the Medicaid FFS.
  - b. In accordance with STC 12.1, CMS expects the state to have appropriate claims data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate documentation for claims payment. Therefore, CMS requires that, for HRSN services delivered in a FFS delivery system, the state must clearly document the name and definition of each HRSN service as well as the coding used on claims data. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology codes that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 12.15. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the delivery of HRSN services through FFS.
- 12.11. **Phased In Implementation of HRSN Services.** As further discussed in the state's Implementation Plan as required in STC 12.19, the state will phase in HRSN service(s) on the following schedule: housing/home environment interventions without room and board will be available to the TAM population upon approval and will expand to additional populations on July 1, 2025; short-term recuperative care will be available once the state has secured no more than two qualified providers to deliver the service; short term rental assistance will be available no sooner than January 1, 2026 for a single urban county and, over the subsequent two years, will be available statewide.
- 12.12. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.
- 12.13. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12

months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

- 12.14. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.
- 12.15. **HRSN Rate Methodologies.** For FFS payment methodologies and/or rates, the state must comply with the payment rate-setting requirements in 42 CFR Part 447, as though a state plan amendment were required, to establish any payment rate and/or methodology for HRSN services as approved under demonstration expenditure authority 16. The state must conduct state-level public notice under 42 CFR 447.205 prior to the implementation of the applicable FFS payment rates or methodologies for HRSN and maintain documentation of these FFS payment rates or methodologies on its website described in 42 CFR 447.203. The state may receive FFS for HRSN service expenditures authorized under this demonstration upon implementation of the FFS payment rates and/or methodologies for which it has conducted prior public notice and may begin claiming for this FFS (for dates of service no earlier than the effective date of approval for the relevant expenditure authority) no earlier than the date of submission of the payment rates and/or methodology to CMS for approval. However, any FFS payments to providers or claims for FFS prior to CMS approval of the payment rate or methodology must be reconciled to the ultimately approved FFS payment rate and/or methodology within one year of CMS's approval. All requirements for timely filing of claims for FFS continue to apply.

For managed care payments and rates (including capitation rates, non-risk payments, and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs. As applicable, the state must also notify CMS at least 60 days prior to intended implementation if it intends to direct its managed care plans on how to pay for HRSN services (i.e., state directed payments).

All rates/payment methodologies for HRSN services, for both FFS and managed care delivery systems, must be submitted to CMS for review and approval, including but not limited to fee-for-service payments as well as managed care capitation rates, any state directed payments that require prior written approval, and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, for both FFS and managed care delivery systems, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

- 12.16. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports for the duration of the demonstration, not including one-time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN

Implementation Plan required by STC 12.19 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

- 12.17. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 14.5, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.
- 12.18. **Provider Payment Rate Increase.** As a condition of approval of the HRSN services expenditure authority, the state must comply with the provider rate increase requirements in Section 18 of these STCs.
- 12.19. **HRSN Implementation Plan.**
  - a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 12.15 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan



as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment I.

- b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.
- c. The Implementation Plan must include information on, but not limited to, the following:
  - i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;
  - ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);
  - iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;
  - iv. A plan for tracking and improving the share of demonstration beneficiaries in the state who are eligible and enrolled in federal, state, and local housing assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);
  - v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;
  - vi. Information as required per STC 12.16 (MOE); and

- vii. Information as required per STC 12.17 (Partnerships with State and Local Entities).

- 12.20. **Non-Medical Transportation.** Non-medical transportation<sup>4</sup> (NMT) services may be provided to Medicaid beneficiaries eligible for HRSN services to and from HRSN services authorized under this demonstration. The HRSN services must be described in the beneficiary's care plan.
- a. All NMT must be provided in alignment with the technical specifications, and safeguards required for NMT authorized under 1915(c) waiver or under 1915(i) state plan authorities.

### 13. REENTRY DEMONSTRATION INITIATIVE

- 13.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in state prisons, county jails, or youth correctional facilities (hereinafter "correctional facilities") as further specified in the STCs below. To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid or as determined pursuant to an application filed before or during incarceration, and must have an expected release date no later than 90 days as further specified in the STCs below.
- 13.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

- a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

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<sup>4</sup> Non-Medical Transportation is defined as transportation services offered in order to enable participants to gain access to 1915(c) waiver-coverable activities, community services, and resources, as specified by the beneficiary's care plan. NMT may be provided to receive HRSN services.

- b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;
- c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;
- d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;
- e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs;
- f. Reduce all-cause deaths in the near-term post-release;
- g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care; and
- h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

13.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

- a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 13.1;
- b. Have been determined eligible for Medicaid; and
- c. Have an expected release date within 90 days.

13.4. **Scope of Pre-Release Services.** The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 13.10. The state may provide these services in-person or, as-needed, through telehealth.

- a. The covered pre-release services are:
  - i. Case management to assess and address physical and behavioral health needs, and health-related social needs;
  - ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

- iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;
- iv. Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning;
- v. Diagnostic services, including laboratory and radiology services, and treatment services in addition to those identified in STC 13.4(a)(ii);
- vi. Prescribed drugs, in addition to those identified in STCs 13.4(a)(ii) and 13.4(a)(iii), and medication administration;
- vii. Family planning services and supplies;
- viii. Services provided by community health workers;
- ix. Peer support services;
- x. Treatment for Hepatitis C; and
- xi. Medical equipment and supplies and/or medical equipment provided upon release.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Utah Medicaid State Plan, as relevant, that are not included in the above-described pre-release services benefit (e.g., EPSDT treatment services) for qualifying Medicaid individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

**13.5. Participating Correctional Facilities.** The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the State Medicaid Agency's approval of a facility's readiness, according to the implementation timeline described in STC 13.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

**13.6. Participating Providers.**

- a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Utah's scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.
- b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.
- c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.
- d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

13.7. **Suspension of Coverage.** Upon entry of a Medicaid enrolled individual into a correctional facility, the State Medicaid Agency must not terminate and generally shall suspend their Medicaid coverage.

- a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

13.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles.** To the extent Utah's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

13.9. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). The State Medicaid Agency will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

- a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

- b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 13.3
- c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable.
- d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments and managed care plans.
- e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;
- f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;
- g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;
- h. Reporting of data requested by the State Medicaid Agency to support program monitoring, evaluation, and oversight; and
- i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

13.10. **Reentry Demonstration Initiative Implementation Plan.** The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the [State Medicaid Director Letter \(#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated\)](#). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key

implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment G titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing of the Implementation Plan.

- 13.11. **Reentry Demonstration Initiative Reinvestment Plan.** To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment H). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment H the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.
- a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:
    - i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;
    - ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

- iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;
  - iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;
  - v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;
  - vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and
  - vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.
- b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.
  - c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment H) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment H titled "Reentry Demonstration Initiative Reinvestment Plan."

### **13.12. Reentry Demonstration Initiative Planning and Implementation.**

- a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the State Medicaid



Agency and Qualified Applicants listed in STC 13.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

- i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 13.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 13.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.
- ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 13.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.
- iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.
- iv. **Purchase of Billing Systems.** Expenditures for the purchase of billing systems for Qualified Applicants.
- v. **Development of Protocols and Procedures.** Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.
- vi. **Additional Activities to Promote Collaboration.** Expenditures for additional activities that will advance collaboration among Utah's Qualified Applicants in STC 13.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

- vii. **Planning.** Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.
- viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

- b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 6. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 15.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

**Table 6. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program**

|                               | DY 21 | DY 22 | DY 23          | DY 24          | DY 25          |
|-------------------------------|-------|-------|----------------|----------------|----------------|
| Total Computable Expenditures | —     | —     | \$2,847,829.00 | \$4,271,743.50 | \$4,271,743.50 |

- c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.
- d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid/CHIP Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid/CHIP agency.

## 14. MONITORING AND REPORTING REQUIREMENTS

- 14.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of \$5,000,000 (\$5M) per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as “deliverable(s)”) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

- a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).
- b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issues, and the state’s anticipated date of submission. Should CMS agree in writing to the state’s request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state’s written extension request.
- c. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.
- d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released

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

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

- 14.2. **Deferral of Federal Financial Participation from IMD claiming for Insufficient Progress Toward Milestones.** Up to \$5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to \$5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.
- 14.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.
- 14.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:
  - a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
  - b. Ensure all section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
  - c. Submit deliverables to the appropriate system as directed by CMS.
- 14.5. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis.

- a. Operational Updates. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key

operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

- b. Performance Metrics. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative(s), as described below and per applicable CMS guidance:

- i. For the SUD and SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMD #17-003) and the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).
- ii. For the Reentry demonstration initiative, the state must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 13.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional

facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

- iii. For the HRSS and HRSN components of the demonstration, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations.

For the HRSN initiatives, in alignment with STC 12.17, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing agencies to leverage their expertise and existing housing resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol for Other Policies on the implementation of infrastructure investments tied to the HRSN initiatives.

As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs, and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives.

The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

- c. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress

of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

**14.6. SUD, SMI/SED, and Reentry Mid-Point Assessment.** The state must contract with an independent entity (herein referred to as the Independent Assessor) to conduct an independent SUD Mid-Point Assessment and SMI/SED Mid-Point Assessment by June 30, 2025, and a Reentry Mid-Point Assessment by June 30, 2027. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders such as, representatives of managed care organizations (MCO), health care providers, beneficiaries, community groups and other key partners.

- a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.
- b. Elements of the Mid-Point Assessment must include:
  - i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;
  - ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;
  - iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;
  - iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

**14.7. Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan

may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 3.10 are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

- 14.8. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.
- a. The Close-Out Report must comply with the most current guidance from CMS
  - b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim or Summative Evaluation Reports stipulated in 19.7 and 19.8, respectively.
  - c. The state will present to and participate in a discussion with CMS on the Close-Out report.
  - d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.
  - e. The final Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.
  - f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 14.1.
- 14.9. **Monitoring Calls.** CMS will convene, no less frequently than quarterly, monitoring calls with the state.
- a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.
  - b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.
  - c. The state and CMS will jointly develop the agenda for the calls.



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

## 15. GENERAL FINANCIAL REQUIREMENTS

- 15.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.
- 15.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.
- 15.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

- a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.
- b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.
- c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

**15.4. State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

- a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.
- b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).
- c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.
- d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its

implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

- e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

**15.5. Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

- a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

**15.6. Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

- a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).
- b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).
- c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.
- d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).
- e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

**15.7. State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 14.2. This report must include:

- a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;
- b. Number of providers in each locality of the taxing entities for each locality tax;
- c. Whether or not all providers in the locality will be paying the assessment for each locality tax;
- d. The assessment rate that the providers will be paying for each locality tax;
- e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;
- f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;
- g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and
- h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

**15.8. Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 16:

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

**15.9. Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

- 15.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart (table 7) provides a master list of MEGs defined for this demonstration.

| <b>Table 7: Master MEG Chart</b>                                          |                                          |                       |                      |           |                                     |
|---------------------------------------------------------------------------|------------------------------------------|-----------------------|----------------------|-----------|-------------------------------------|
| <b>MEG</b>                                                                | <b>To Which BN Test Does This Apply?</b> | <b>WOW Per Capita</b> | <b>WOW Aggregate</b> | <b>WW</b> | <b>Brief Description</b>            |
| <b>Current Eligibles</b>                                                  | Main Budget Neutrality                   | X                     |                      | X         | See Expenditure Authority #1        |
| <b>Adult Expansion Population</b>                                         | Hypo                                     | X                     |                      | X         | See Expenditure Authority #7        |
| <b>Mandatory ESI for Adult Expansion</b>                                  | Hypo                                     | X                     |                      | X         | See Expenditure Authority #8        |
| <b>Targeted Adults</b>                                                    | Hypo                                     | X                     |                      | X         | See Expenditure Authority #5        |
| <b>Dental – Targeted Adults</b>                                           | Hypo                                     | X                     |                      | X         | See Expenditure Authority #14       |
| <b>Dental – Blind &amp; Disabled Adults</b>                               | Hypo                                     | X                     |                      | X         | See Expenditure Authority #14       |
| <b>Dental - Aged</b>                                                      | Hypo                                     | X                     |                      | X         | See Expenditure Authority #14       |
| <b>Dental Services</b>                                                    | Hypo                                     | X                     |                      | X         | See Expenditure Authority #14       |
| <b>Dental Services – Comprehensive</b>                                    | Hypo                                     | X                     |                      | X         | See Expenditure Authority #14       |
| <b>Former Foster Care Youth From Another State</b>                        | Hypo                                     | X                     |                      | X         | See Expenditure Authority #4        |
| <b>SUD</b>                                                                | Hypo                                     | X                     |                      | X         | See Expenditure Authority #6        |
| <b>SMI</b>                                                                | Hypo                                     | X                     |                      | X         | See Expenditure Authority #9        |
| <b>ESI/COBRA</b>                                                          | Hypo                                     | X                     |                      | X         | See Expenditure Authority #2 and #3 |
| <b>In Vitro Fertilization and Genetic Testing Services</b>                | Hypo                                     | X                     |                      | X         | See Expenditure Authority #11       |
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Male</b>   | Hypo                                     | X                     |                      | X         | See Expenditure Authority #10       |
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Female</b> | Hypo                                     | X                     |                      | X         | See Expenditure Authority #10       |
| <b>Cryopreservation</b>                                                   | Hypo                                     | X                     |                      | X         | See Expenditure Authority #10       |
| <b>Reentry Initiative Services</b>                                        | Hypo                                     | X                     |                      | X         | See Expenditure Authority #12       |

| Table 7: Master MEG Chart                                     |      |   |   |   |                               |
|---------------------------------------------------------------|------|---|---|---|-------------------------------|
| Reentry Initiative Non-Services                               | Hypo |   | X | X | See Expenditure Authority #13 |
| HRSN Services                                                 | SHAC |   | X | X | See Expenditure Authority #15 |
| HRSN Infrastructure                                           | SHAC |   | X | X | See Expenditure Authority #16 |
| HRSN NMT                                                      | Hypo | X |   | X | See Expenditure Authority #17 |
| Extended Postpartum Coverage                                  | Hypo | X |   | X | See Expenditure Authority #18 |
| Family Planning Services and Family Planning Related Services | Hypo | X |   | X | See Expenditure Authority #19 |

15.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00145/8). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

- a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.
- b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

- c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.
- d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 16, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.
- e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 16, the state must report the actual number of “eligible member months” for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term “eligible member months” refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.
- f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state’s Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

**Table 8: MEG Detail for Expenditure and Member Month Reporting**

| MEG<br>(Waiver<br>Name) | Detailed<br>Description | Exclu<br>sions | CMS-64.9<br>Line(s) To<br>Use | How<br>Expend.<br>Are | MAP<br>or<br>ADM | Report<br>Member | MEG<br>Start<br>Date | MEG End<br>Date |
|-------------------------|-------------------------|----------------|-------------------------------|-----------------------|------------------|------------------|----------------------|-----------------|
|-------------------------|-------------------------|----------------|-------------------------------|-----------------------|------------------|------------------|----------------------|-----------------|

**Table 8: MEG Detail for Expenditure and Member Month Reporting**

|                                                     |                                        |     |                                                                      | Assigned<br>to DY  |     | Months<br>(Y/N) |          |            |
|-----------------------------------------------------|----------------------------------------|-----|----------------------------------------------------------------------|--------------------|-----|-----------------|----------|------------|
| <b>Current Eligibles</b>                            | See<br>Expenditure<br>Authority #1     | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>service | MAP | Y               | 7/1/2022 | 12/31/2023 |
| <b>Adult<br/>Expansion<br/>Population</b>           | See<br>Expenditure<br>Authority #7     | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>Service | MAP | Y               | 7/1/2022 | 6/30/2027  |
| <b>Mandatory<br/>ESI for Adult<br/>Expansion</b>    | See<br>Expenditure<br>Authority #8     | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>service | MAP | Y               | 7/1/2022 | 6/30/2027  |
| <b>Targeted<br/>Adults</b>                          | See<br>Expenditure<br>Authority #5     | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>service | MAP | Y               | 7/1/2022 | 6/30/2027  |
| <b>Dental –<br/>Targeted<br/>Adults</b>             | See<br>Expenditure<br>Authority<br>#14 | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>service | MAP | Y               | 7/1/2022 | 3/31/2025  |
| <b>Dental - Blind<br/>&amp; Disabled<br/>Adults</b> | See<br>Expenditure<br>Authority<br>#14 | N/A | Follow<br>CMS-64.9<br>Base<br>Category of<br>Service<br>Definitions  | Date of<br>service | MAP | Y               | 7/1/2022 | 3/31/2025  |
| <b>Dental - Aged</b>                                | See<br>Expenditure<br>Authority<br>#14 | N/A | Follow<br>CMS-64.10<br>Base<br>Category of<br>Service<br>Definitions | Date of<br>service | MAP | Y               | 7/1/2022 | 3/31/2025  |
| <b>Dental<br/>Services</b>                          | See<br>Expenditure<br>Authority<br>#14 | N/A | Follow<br>CMS-64.10<br>Base<br>Category of<br>Service<br>Definitions | Date of<br>service | MAP | Y               | 4/1/2025 | 12/31/2025 |
| <b>Dental<br/>Services –</b>                        | See<br>Expenditure                     | N/A | Follow<br>CMS-64.9<br>Base                                           | Date of<br>Service | MAP | Y               | 1/1/2026 | 6/30/2027  |



**Table 8: MEG Detail for Expenditure and Member Month Reporting**

| <b>Comprehensive</b>                                                      | <b>Authority #14</b>              |     | <b>Category of Service Definitions</b>                |                 |     |                                                                             |           |           |
|---------------------------------------------------------------------------|-----------------------------------|-----|-------------------------------------------------------|-----------------|-----|-----------------------------------------------------------------------------|-----------|-----------|
| <b>Former Foster Care Youth From Another State</b>                        | See Expenditure Authority #4      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of service | MAP | Y                                                                           | 7/1/2022  | 6/30/2027 |
| <b>SUD</b>                                                                | See Expenditure Authority #6      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of service | MAP | Y                                                                           | 7/1/2022  | 6/30/2027 |
| <b>SMI</b>                                                                | See Expenditure Authority #9      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of service | MAP | Y                                                                           | 7/1/2022  | 6/30/2027 |
| <b>ESI/COBRA</b>                                                          | See Expenditure Authority #2 & #3 | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of service | MAP | Y                                                                           | 7/1/2022  | 6/30/2027 |
| <b>In Vitro Fertilization and Genetic Testing Services</b>                | See STC 5.11                      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of Service | MAP | Y;<br>Each member month represents one user of the service in a given month | 2/29/2024 | 6/30/2027 |
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Male</b>   | See STC 5.10                      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of Service | MAP | Y                                                                           | 2/29/2024 | 6/30/2027 |
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Female</b> | See STC 5.10                      | N/A | Follow CMS-64.10 Base Category of Service Definitions | Date of Service | MAP | Y                                                                           | 2/29/2024 | 6/30/2027 |
| <b>Cryopreservation</b>                                                   | See STC 5.10                      | N/A | Follow CMS-64.10 Base                                 | Date of Service | MAP | Y                                                                           | 2/29/2024 | 6/30/2027 |

| Table 8: MEG Detail for Expenditure and Member Month Reporting       |                                                               |     |                                                         |                 |     |   |          |           |
|----------------------------------------------------------------------|---------------------------------------------------------------|-----|---------------------------------------------------------|-----------------|-----|---|----------|-----------|
|                                                                      |                                                               |     | Category of Service Definitions                         |                 |     |   |          |           |
| <b>Reentry Initiative Services</b>                                   | See Expenditure Authority #12                                 | N/A | Follow CMS-64.10 Base Category of Service Definitions   | Date of Service | MAP | Y | 7/2/2024 | 6/30/2027 |
| <b>Reentry Initiative Non-Services</b>                               | See Expenditure Authority #13                                 | N/A | Follow CMS-64.10 Base Category of Service Definitions   | Date of Service | ADM | Y | 7/2/2024 | 6/30/2027 |
| <b>HRSN Services</b>                                                 | See Expenditure Authority #15                                 | N/A | Follow CMS-64.10 Base Category of Service Definitions   | Date of Service | ADM | Y | 7/1/2025 | 6/30/2027 |
| <b>HRSN Infrastructure</b>                                           | See Expenditure Authority #16                                 | N/A | Follow CMS-64.10 Base Category of Service Definitions   | Date of Service | ADM | Y | 7/1/2025 | 6/30/2027 |
| <b>HRSN NMT</b>                                                      | Expenditures for non-medical transportation for HRSN services | N/A | Follow CMS-64.10 Base Category of Service Definitions   | Date of Service | ADM | Y | 7/1/2025 | 6/30/2027 |
| <b>Extended Postpartum Coverage</b>                                  | See Expenditure Authority #18                                 | N/A | Follow standard CMS-64.9 Category of Service Definition | Date of Service | MAP | Y | 1/1/2026 | 6/30/2027 |
| <b>Family Planning Services and Family Planning Related Services</b> | See Expenditure Authority #19                                 | N/A | Follow standard CMS-64.9 Category of Service Definition | Date of Service | MAP | Y | 1/1/2026 | 6/30/2027 |

15.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

| Table 9: Demonstration Years |
|------------------------------|
|------------------------------|

|                       |                               |           |
|-----------------------|-------------------------------|-----------|
| Demonstration Year 21 | July 1, 2022 to June 30, 2023 | 12 months |
| Demonstration Year 22 | July 1, 2023 to June 30, 2024 | 12 months |
| Demonstration Year 23 | July 1, 2024 to June 30, 2025 | 12 months |
| Demonstration Year 24 | July 1, 2025 to June 30, 2026 | 12 months |
| Demonstration Year 25 | July 1, 2026 to June 30, 2027 | 12 months |

- 15.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state’s regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the state to update this percentage to the more accurate figure, as supported by the state’s proposed methodology and data. CMS anticipates no increase in enrollment among individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) that are experiencing homelessness for the continuous eligibility period; therefore, no change in FMAP claiming is required for the homeless population.
- 15.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for “newly eligible” individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the “newly eligible” FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 15.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state’s regular Title XIX FMAP rate.
- 15.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the “Schedule C Report” for comparing the demonstration’s actual expenditures to the budget neutrality expenditure limits described in section 18. CMS will provide technical assistance, upon request.<sup>5</sup>

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<sup>5</sup> Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS’s current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained

- 15.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- 15.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:
- a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
  - b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

- 15.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated

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Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

- a. **Contents of Request and Process.** In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 15.18.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.
- b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:
  - i. Provider rate increases that are anticipated to further strengthen access to care;
  - ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;
  - iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;
  - iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;
  - v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;
  - vi. High cost innovative medical treatments that states are required to cover; or,
  - vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.
- c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

- i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,
- ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

## 16. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 16.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.
- 16.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 7, Master MEG Chart and Table 8, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.
- 16.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.
- 16.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal

government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration, and that federal Medicaid “savings” have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as “WOW Only” or “Both” are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The

| Table 10: Main Budget Neutrality Test |                      |                                        |               |               |               |               |               |               |
|---------------------------------------|----------------------|----------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| MEG                                   | PC<br>or<br>Agg<br>* | WOW<br>Only,<br>WW<br>Only, or<br>Both | Trend<br>Rate | DY 21<br>PMPM | DY 22<br>PMPM | DY 23<br>PMPM | DY 24<br>PMPM | DY 25<br>PMPM |
| Current<br>Eligibles                  | PC                   | Both                                   | 3.3%          | \$628.81      | \$649.69      | n/a           | n/a           | n/a           |
| *PC = Per Capita; Agg = Aggregate     |                      |                                        |               |               |               |               |               |               |

Composite Federal Share for this test is calculated based on all MEGs indicated as “Both.”

- 16.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be “hypothetical,” such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state’s WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

#### 16.6. Hypothetical Budget Neutrality Tests.

- a. **Hypothetical Budget Neutrality Test 1: Adult Expansion Population, Mandatory ESI for Adult Expansion, and Targeted Adults.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

| Table 11a. Hypothetical Budget Neutrality Test 1 |             |                            |            |            |            |            |            |            |
|--------------------------------------------------|-------------|----------------------------|------------|------------|------------|------------|------------|------------|
| MEG                                              | PC or Agg * | WOW Only, WW Only, or Both | Trend Rate | DY 21 PMPM | DY 22 PMPM | DY 23 PMPM | DY 24 PMPM | DY 25 PMPM |
| Adult Expansion Population                       | PC          | Both                       | 4.7%       | \$651.40   | \$682.02   | \$714.07   | \$747.63   | \$782.77   |
| Mandatory ESI for Adult Expansion                | PC          | Both                       | 5.3%       | \$266.22   | \$280.33   | \$295.19   | \$310.84   | \$327.31   |
| Targeted Adults                                  | PC          | Both                       | 5.5%       | \$1,177.22 | \$1,242.97 | \$1,310.28 | \$1,382.35 | \$1,458.38 |
| *PC = Per Capita; Agg = Aggregate                |             |                            |            |            |            |            |            |            |

- b. **Hypothetical Budget Neutrality Test 2: Dental Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

| Table 11b. Hypothetical Budget Neutrality Test 2 |             |                            |            |            |            |            |            |            |
|--------------------------------------------------|-------------|----------------------------|------------|------------|------------|------------|------------|------------|
| MEG                                              | PC or Agg * | WOW Only, WW Only, or Both | Trend Rate | DY 21 PMPM | DY 22 PMPM | DY 23 PMPM | DY 24 PMPM | DY 25 PMPM |
| Dental – Targeted Adults                         | PC          | Both                       | 5.3%       | \$40.57    | \$42.72    | \$44.98    | —          | —          |



|                                             |    |      |      |         |         |         |         |   |
|---------------------------------------------|----|------|------|---------|---------|---------|---------|---|
| <b>Dental – Blind &amp; Disabled Adults</b> | PC | Both | 4.8% | \$21.08 | \$22.09 | \$23.15 | —       | — |
| <b>Dental – Aged</b>                        | PC | Both | 3.4% | \$34.00 | \$35.16 | \$36.36 | —       | — |
| <b>Dental Services</b>                      | PC | Both | 5.9% | —       | —       | \$19.64 | \$20.80 | — |

- c. **Hypothetical Budget Neutrality Test 3: Former Foster Care Youth from Another State.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

| <b>Table 11c. Hypothetical Budget Neutrality Test 3</b> |                      |                                        |               |               |               |               |               |               |
|---------------------------------------------------------|----------------------|----------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| MEG                                                     | PC<br>or<br>Agg<br>* | WOW<br>Only,<br>WW<br>Only, or<br>Both | Trend<br>Rate | DY 21<br>PMPM | DY 22<br>PMPM | DY 23<br>PMPM | DY 24<br>PMPM | DY 25<br>PMPM |
| <b>Former Foster Care Youth from Another State</b>      | PC                   | Both                                   | 5.2%          | \$1,679.32    | \$1,766.64    | \$1,858.51    | \$1,955.15    | \$2,056.82    |

- d. **Hypothetical Budget Neutrality Test 4: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

| <b>Table 11d. Hypothetical Budget Neutrality Test 4</b> |                      |                                        |               |               |               |               |               |               |
|---------------------------------------------------------|----------------------|----------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| MEG                                                     | PC<br>or<br>Agg<br>* | WOW<br>Only,<br>WW<br>Only, or<br>Both | Trend<br>Rate | DY 21<br>PMPM | DY 22<br>PMPM | DY 23<br>PMPM | DY 24<br>PMPM | DY 25<br>PMPM |

|            |    |      |      |            |            |            |            |            |
|------------|----|------|------|------------|------------|------------|------------|------------|
| <b>SUD</b> | PC | Both | 5.2% | \$4,468.94 | \$4,701.32 | \$4,945.79 | \$5,202.97 | \$5,473.52 |
|------------|----|------|------|------------|------------|------------|------------|------------|

- e. **Hypothetical Budget Neutrality Test 5: SMI.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

| <b>Table 11e. Hypothetical Budget Neutrality Test 5</b> |                                |                                                   |                       |                       |                       |                       |                       |                       |
|---------------------------------------------------------|--------------------------------|---------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <b>MEG</b>                                              | <b>PC<br/>or<br/>Agg<br/>*</b> | <b>WOW<br/>Only,<br/>WW<br/>Only, or<br/>Both</b> | <b>Trend<br/>Rate</b> | <b>DY 21<br/>PMPM</b> | <b>DY 22<br/>PMPM</b> | <b>DY 23<br/>PMPM</b> | <b>DY 24<br/>PMPM</b> | <b>DY 25<br/>PMPM</b> |
| <b>SMI</b>                                              | PC                             | Both                                              | 5.3%                  | \$14,998.93           | \$15,793.87           | \$16,630.95           | \$17,512.39           | \$18,400.55           |

- f. **Hypothetical Budget Neutrality Test 6: ESI/COBRA.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

| <b>Table 11f. Hypothetical Budget Neutrality Test 6</b> |                                |                                                   |                       |                       |                       |                       |                       |                       |
|---------------------------------------------------------|--------------------------------|---------------------------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <b>MEG</b>                                              | <b>PC<br/>or<br/>Agg<br/>*</b> | <b>WOW<br/>Only,<br/>WW<br/>Only, or<br/>Both</b> | <b>Trend<br/>Rate</b> | <b>DY 21<br/>PMPM</b> | <b>DY 22<br/>PMPM</b> | <b>DY 23<br/>PMPM</b> | <b>DY 24<br/>PMPM</b> | <b>DY 25<br/>PMPM</b> |
| <b>ESI/COBRA</b>                                        | PC                             | Both                                              | 5.2%                  | \$247.15              | \$260.00              | \$273.52              | \$287.74              | \$302.70              |

- g. **Hypothetical Budget Neutrality Test 7: HRSN NMT.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are

designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 11g. Hypothetical Budget Neutrality Test 7**

| MEG      | PC<br>or<br>Agg<br>* | WOW<br>Only,<br>WW<br>Only, or<br>Both | Trend<br>Rate | DY 21<br>PMPM | DY 22<br>PMPM | DY 23<br>PMPM | DY 24<br>PMPM | DY 25<br>PMPM |
|----------|----------------------|----------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| HRSN NMT | PC                   | Both                                   | 5.2%          | —             | —             | —             | \$8.58        | \$9.03        |

- h. **Hypothetical Budget Neutrality Test 8: Fertility Preservation Services for Individuals Diagnosed with Cancer and In Vitro Fertilization and Genetic Testing.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 11h. Hypothetical Budget Neutrality Test 8**

| MEG                                                                       | PC<br>or<br>Agg<br>* | WOW<br>Only,<br>WW<br>Only, or<br>Both | Trend<br>Rate | DY 21<br>PMPM | DY 22<br>PMPM | DY 23<br>PMPM | DY 24<br>PMPM | DY 25<br>PMPM |
|---------------------------------------------------------------------------|----------------------|----------------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Male</b>   | PC                   | Both                                   | 5.3%          | —             | \$500         | \$526.50      | \$554.40      | \$583.79      |
| <b>Fertility Treatment for Individuals Diagnosed with Cancer – Female</b> | PC                   | Both                                   | 5.3%          | —             | \$9,375.00    | \$10,042.46   | \$10,574.71   | \$11,135.17   |

|                                                            |    |      |      |   |            |            |            |            |
|------------------------------------------------------------|----|------|------|---|------------|------------|------------|------------|
| <b>Cryopreservation</b>                                    | PC | Both | 5.3% | — | \$500      | \$526.50   | \$554.40   | \$583.79   |
| <b>In Vitro Fertilization and Genetic Testing Services</b> | PC | Both | 5.0% | — | \$7,421.38 | \$7,814.71 | \$8,228.89 | \$8,665.02 |

- i. **Hypothetical Budget Neutrality Test 9: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 9 are counted as WW expenditures under the Main Budget Neutrality Test.

| <b>Table 11i: Hypothetical Budget Neutrality Test 9</b> |                  |                                   |                   |              |              |                |                |                |
|---------------------------------------------------------|------------------|-----------------------------------|-------------------|--------------|--------------|----------------|----------------|----------------|
| <b>MEG</b>                                              | <b>PC or Agg</b> | <b>WOW Only, WW Only, or Both</b> | <b>Trend Rate</b> | <b>DY 21</b> | <b>DY 22</b> | <b>DY 23</b>   | <b>DY 24</b>   | <b>DY 25</b>   |
| Reentry                                                 | PC               | Both                              | 5.7%              | —            | —            | \$1,028.19     | \$1,086.80     | \$1,148.74     |
| Reentry Non-Services                                    | Agg              | Both                              | N/A               | —            | —            | \$2,847,829.00 | \$4,271,743.50 | \$4,271,743.50 |

- j. **Hypothetical Budget Neutrality Test 10: Extended Postpartum Coverage.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 10. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 10 are counted as WW expenditures under the Main Budget Neutrality Test.

**Table 11j: Hypothetical Budget Neutrality Test 10**

| MEG                          | PC<br>or<br>Agg | WOW<br>Only,<br>WW<br>Only,<br>or Both | Trend Rate | DY 21 | DY 22 | DY 23 | DY 24    | DY 25    |
|------------------------------|-----------------|----------------------------------------|------------|-------|-------|-------|----------|----------|
| Extended Postpartum Coverage | PC              | Both                                   | 5.7%       | —     | —     | —     | \$820.27 | \$867.03 |

- k. **Hypothetical Budget Neutrality Test 11: Family Planning Services and Family Planning Related Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 11. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 11 are counted as WW expenditures under the Main Budget Neutrality Test.

| Table 11k: Hypothetical Budget Neutrality Test 11             |                 |                                        |            |       |       |       |       |         |
|---------------------------------------------------------------|-----------------|----------------------------------------|------------|-------|-------|-------|-------|---------|
| MEG                                                           | PC<br>or<br>Agg | WOW<br>Only,<br>WW<br>Only,<br>or Both | Trend Rate | DY 21 | DY 22 | DY 23 | DY 24 | DY 25   |
| Family Planning Services and Family Planning Related Services | PC              | Both                                   | 5.2%       | —     | —     | —     | —     | \$42.92 |

- l. **Hypothetical Budget Neutrality Test 12: Dental Services – Comprehensive.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 12. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as

“WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 12 are counted as WW expenditures under the Main Budget Neutrality Test.

| Table 11l: Hypothetical Budget Neutrality Test 12 |                 |                                        |               |       |       |       |         |         |
|---------------------------------------------------|-----------------|----------------------------------------|---------------|-------|-------|-------|---------|---------|
| MEG                                               | PC<br>or<br>Agg | WOW<br>Only,<br>WW<br>Only,<br>or Both | Trend<br>Rate | DY 21 | DY 22 | DY 23 | DY 24   | DY 25   |
| Dental<br>Services –<br>Comprehe<br>nsive         | PC              | Both                                   | 5.1%          | —     | —     | —     | \$39.24 | \$41.24 |

- 16.7. **Supplemental HRSN Aggregate Ceiling (SHAC) Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in Section 14), CMS considers these expenditures to be “supplemental HRSN aggregate ceiling (SHAC)” expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state’s expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test’s expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state’s SHAC spending exceeds the Capped SHAC Budget Neutrality Test’s expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped SHAC.

- 16.8. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated “WOW Only” or “Both” are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as “WW Only” or “Both.” MEGs that are indicated as “WW Only” or “Both” are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

| Table 12: SHAC Budget Neutrality Test |                 |                                        |               |          |          |             |              |              |
|---------------------------------------|-----------------|----------------------------------------|---------------|----------|----------|-------------|--------------|--------------|
| MEG                                   | PC<br>or<br>Agg | WOW<br>Only,<br>WW<br>Only,<br>or Both | Trend<br>Rate | DY<br>21 | DY<br>22 | DY 23       | DY 24        | DY 25        |
| HRSN<br>Services                      | Agg             | Both                                   | N/A           | —        | —        | —           | \$94,157,357 | \$94,157,357 |
| HRSN<br>Infrastructure                | Agg             | Both                                   | N/A           | —        | —        | \$4,150,000 | \$16,600,000 | \$12,450,000 |

- 16.9. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration’s approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.
- 16.10. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 7/1/2022 to 6/30/2027. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.
- 16.11. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

| <b>Table 13: Main Budget Neutrality Test Mid-Course Correction Calculations</b> |                                          |                   |
|---------------------------------------------------------------------------------|------------------------------------------|-------------------|
| <b>Demonstration Year</b>                                                       | <b>Cumulative Target Definition</b>      | <b>Percentage</b> |
| DY21                                                                            | Cumulative budget neutrality limit plus: | 2.0 percent       |
| DY21 through DY22                                                               | Cumulative budget neutrality limit plus: | 1.5 percent       |
| DY21 through DY23                                                               | Cumulative budget neutrality limit plus: | 1.0 percent       |
| DY21 through DY24                                                               | Cumulative budget neutrality limit plus: | 0.5 percent       |
| DY21 through DY25                                                               | Cumulative budget neutrality limit plus: | 0.0 percent       |

## 17. EVALUATION OF THE DEMONSTRATION

- 17.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration's operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 14.1.
- 17.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.



- 17.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline, no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time services, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations.

The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 17.7 and 17.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

- 17.4. **Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.
- 17.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the

Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

- a. Hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose.
- b. Hypotheses for the SMI/SED component of the demonstration must relate to, for example, utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.
- c. Evaluation hypotheses for the HRSS and HRSN components of the demonstration must focus on areas such as assessing the effectiveness of the HRSS and HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' social needs and the provision of and beneficiary utilization of HRSS and HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

Hypotheses must be designed to help understand, in particular, the impacts of the HRSN services provided in the demonstration on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access to and, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports any other type of allowable HRSN services, change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis

to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

- d. For the Adult Expansion and employer-sponsored insurance (ESI) demonstration components, the state must analyze coverage, access to primary care, avoidance of inappropriate care utilization, reductions in uncompensated care, and health outcomes.
- e. For the other components of the demonstration, the state must—as applicable—develop and test hypotheses in alignment with program goals that support analyzing demonstration effects on enrollment rates, uninsurance rates, access to primary care, access to mental health care, rates of emergency department visits (emergent and non-emergent), and access to dental services. The evaluation must also provide an assessment of the state’s process for winding down the Current Eligibles population, and any potential lessons thereof.
- f. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual’s expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration’s evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they

develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

- g. Hypotheses for the family planning services and family planning related services component of the demonstration must focus on the impact of the demonstration in helping eligible beneficiaries access family planning services and family planning related services. Hypotheses must include, but not be limited to, outcomes such as beneficiary access to and utilization of family planning services (e.g., percentage of beneficiaries who utilized any contraception by method effectiveness) and family planning related services, and maternal health and birth outcomes (e.g., unintended pregnancies, teen birth rates, and the rate of preterm and low birthweight births).
- h. Hypotheses for the extended postpartum care component of the demonstration must cover outcomes related to primary and preventive care utilization, maternal and infant health, and if applicable, treatment for behavioral health.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not limited to, administrative costs of demonstration implementation and operation and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experience with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

- 17.6. **Evaluation Budget.** A budget for the evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses

and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

**17.7. Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

- a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.
- b. For demonstration authority or any component within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of the expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.
- c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
- d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any.
- e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

**17.8. Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

- a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.
- b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

- 17.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.
- 17.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.
- 17.11. **Public Access.** The state shall post the final documents (e.g., Annual Monitoring Report, Mid-Point Assessment Reports, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 calendar days of approval by CMS.
- 17.12. **Additional Publications and Presentations.** For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

## **18. PROVIDER RATE REQUIREMENTS**

- 18.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN expenditure authorities, as referenced in expenditure authorities 16 and 17.
- 18.2. As a condition of approval and ongoing provision of FFP for the HRSN expenditures over this demonstration period of performance, DY 23 through the fifth full demonstration year following the effective date of this amendment, the state will in accordance with these STCs analyze, increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's

Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

- a. Subject to CMS approval, in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY23 through DY 25) as otherwise authorized in STC 18.2, which is due to the HRSN expenditure authority being approved in the middle of the current period of performance, and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than the amount of time allowed by STCs 18.9, 18.10, and 18.11 as applicable to the state, beginning from this demonstration effective date into the subsequent period of performance.

- 18.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).
- 18.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.
- 18.5. No later than 90 days of the demonstration effective date, and if the state makes fee for service payments, the state must establish and report to CMS the state's average Medicaid to Medicare fee-for-service provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:
  - a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:
    - i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND
    - ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

- b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

- i. Service codes must be representative of each service category as defined in STC 18.4;
- ii. Medicaid and Medicare data must be from the same year and not older than 2019.
- iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

- 18.6. To establish the state's ratio for each service category identified in STC 18.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

- a. The average fee-for-service ratio as provided in STC 18.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or
- b. The data and methodology for any or all of the service categories as provided in STC 18.5(b) using Medicaid managed care provider payment rate and utilization data.

- 18.7. In determining the ratios required under STC 18.5 and 18.6, the state may not incorporate fee-for-service supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

- 18.8. If the state is required to increase provider payment rates for managed care plans per STC 18.2. and 18.6, the state must:

- a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and
- b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.



- 18.9. For the entirety of the third full demonstration year following the effective date of this amendment through the fifth full demonstration year following the effective date of this amendment, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 23, and such rate will be in effect on the first day of the third full demonstration year following the effective date of this amendment. A required payment rate increase shall apply to all services in a service category as defined under STC 18.4.
- 18.10. If the state uses a managed care delivery system for any of the service categories defined in STC 18.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from the third full demonstration year following the effective date of this amendment, through the fifth full demonstration year following the effective date of this amendment, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 23 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 18.4.
- 18.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of the third full demonstration year following the effective date of this amendment (or, as applicable, the first day of the first rating period that starts in the third full demonstration year following the effective date of this amendment), the state will provide an alternative effective date and rationale for CMS review and approval.
- 18.12. Utah will provide the information to document the payment rate ratio required under STC 18.5 and 18.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.
- 18.13. For demonstration years following the first year of provider payment rate increases, if any, Utah will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.
- 18.14. No later than 90 days following the demonstration effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 18.5 and 18.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment K.

**Table 14. Utah HRSN Related Provider Payment Increase Assessment – Attestation Table.**

|                                                                                                       |
|-------------------------------------------------------------------------------------------------------|
| The reported data and attestations pertain to HRSN related provider payment increase requirements for |
|-------------------------------------------------------------------------------------------------------|

the demonstration period of performance DY 23 through the fifth full demonstration year following the effective date of this amendment.

| <b>Category of Service</b>      | <b>Medicaid Fee-for-Service to Medicare Fee-for-Service ratio</b>                 | <b>Medicaid Managed Care to Medicare Fee-for-Service Ratio</b>                                                                                                                                               |
|---------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Primary Care Services           | [insert percent, or N/A if state does not make Medicaid fee-for-service payments] | [insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]                                                                         |
|                                 | [insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]          | [insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b), insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio] |
| Obstetric Care Services         | [insert percent, or N/A if state does not make Medicaid fee-for-service payments] | [insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]                                                                         |
|                                 | [insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]          | [insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]  |
| Behavioral Health Care Services | [insert percent, or N/A if state does not make Medicaid fee-for-service payments] | [insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]                                                                         |
|                                 | [insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]          | [insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]  |

In accordance with STCs 18.1 through 18.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on the **first day of the third full year following the effective date of this amendment**, and will not be lower than the highest rate for that service code in **DY 23** plus a two-percentage point increase relative to the rate for the same or similar

Medicare billing code through at least the fifth full demonstration year following the effective date of this amendment.

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 18.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

*[Select the applicable effective date, must check either a. or b. below]*

☐a. The effective date of the rate increases is the first day of the third full demonstration year following the effective date of this amendment and will be at least sustained, if not higher, through the fifth full demonstration year following the effective date of this amendment.

☐b. Utah has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of the third full demonstration year following the effective date of this amendment. Utah will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through the fifth full demonstration year following the effective date of this amendment.

Utah *[insert does or does not]* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than *[insert date]* for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than *[insert date]*.

Utah *[insert does or does not]* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 20.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date]*.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Per STC 18.2(a), in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY23 through the fifth full demonstration year following the effective date of this amendment) and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than period of time allowed by STC 18.9, 18.10, or 18.11, as applicable, beginning from this demonstration effective date into the subsequent period of performance. If the state intends to use this flexibility, the state will provide to CMS for CMS approval its plan to use this flexibility.</p> <p><input type="checkbox"/>a. The state will increase provider payment rates by the end of this demonstration period and will sustain use of these rate increases during the demonstration extension period.</p> <p><input type="checkbox"/>b. The state will not increase the provider payment rates by the end of this demonstration period and will use this flexibility to increase the provider payment rates during the next demonstration extension period. The state will provide CMS with its timeline for implementing these provider rate increases in the event that the HRSN expenditure authority is extended into a subsequent demonstration period.</p> <p>Proposed start date for provider rate increase: <i>[Provide date]</i></p> |
| <p>If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 18.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <p>Utah further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 18.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <p>I, <i>[insert name of SMD or CFO (or equivalent position)] [insert title]</i>, attest that the above information is complete and accurate.</p> <p><i>[Provide signature_____]</i> <i>[Provide date_____]</i> <i>[Provide printed name of signatory]</i></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |

**Attachment A: SUD Implementation Plan**

# State of Utah SUD 1115 Waiver Implementation Plan

Division of Medicaid and Health Financing  
Utah Department of Health



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### Overview

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

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

According to the annual report from the Division of Substance Abuse and Mental Health, Department of Human Services, State of Utah, 134,764 adults in the state were classified as needing treatment for alcohol and/or drug dependence or abuse in 2015. For youth in grades 6 through 12, 11,804 are in need of treatment for drug and/or alcohol dependence or abuse. Seventy four percent (74%) of all adults treated by the public system are Medicaid eligible. If amendment # 15 (Attachment 9) is approved by CMS the percentage of adults needing SUD services who are Medicaid eligible will increase. At the same time 46% of all youth receiving treatment in the public system are Medicaid eligible.

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

In 2014, 32.3% of Utah adults reported using at least one prescribed opioid pain medication during the preceding 12 months, an increase of 55.3% since 2008.

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

### **MILESTONE 1: Access to Critical Levels of Care for SUD Substance Use Disorder Delivery System**

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

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

### **Comprehensive Benefit Design**

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

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

| <b>ASAM Level of Care</b> | <b>Title</b>        | <b>Description</b>                                                                                                                                            | <b>Provider</b>                           | <b>Existing Medicaid Service Y/N</b> | <b>New Medicaid Service Y/N</b> |
|---------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------|---------------------------------|
| 0.5                       | Early Intervention  | Screening, Brief Intervention and Referral for Treatment (SBIRT)                                                                                              | Managed care or Fee for Services provider | Y as of July 1, 2017                 |                                 |
| 1                         | Outpatient Services | Less than 9 hours of services /week (adults);<br>Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM | DHS/OL Certified Outpatient Facilities    | Y                                    |                                 |

|     |                                                                            |                                                                                                                                                                                                                                                                                           |                                                               |   |  |
|-----|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|---|--|
| 2.1 | Intensive Outpatient Services                                              | 9 or more hours of service/week (adults); 6 or more hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM                                                                                                                                                            | DHS/OL Certified Outpatient Facilities                        | Y |  |
| 2.5 | Day Treatment/ Psychosocial Rehabilitation Services                        | 20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour care, MAT, TCM                                                                                                                                                                                  | DHS/OL Certified Outpatient Facilities                        | Y |  |
| 3.1 | Clinically Managed Low-Intensity Residential Services                      | 24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM                                                                                                                                                        | DHS/OL Licensed and DHS/ASAM Designated Residential Providers | Y |  |
| 3.3 | Clinically Managed Population Specific High Intensity Residential Services | 24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM | DHS/OL Licensed and DHS/ASAM Designated Residential Providers | Y |  |



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

**Table Two- ASAM Criteria for Withdrawal Services**

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

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

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

## **Residential treatment**

### **Services for Adolescents and Youth with an SUD**

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

#### **Level of Care: 0.5 (Early Intervention)**

##### **Current State:**

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

##### **Future State:**

No changes are expected.

##### **Summary of Actions Needed:**

None

#### **Level of Care: 1.0 (Outpatient Services)**

##### **Current State:**

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

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

##### **Future State:**

No changes are expected

##### **Summary of Actions Needed:**

None

#### **Level of Care: 2.1 (Intensive Outpatient Services)**

##### **Current State:**

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

Rehabilitative Mental Health and Substance Use Disorder Services.

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

**Future State:**

No changes are expected

**Summary of Actions Needed:**

None

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

**Current State:**

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

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

**Future State:**

No immediate changes are expected.

**Summary of Actions Needed:**

None

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

**Current State:**

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

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

**Future State:**

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

The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for both Level 3.1 and 3.5 residential services will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting. Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

**Summary of Action Items:**

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

**Action Implementation Timeline**

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

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

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

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

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

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

**Summary of Action Items:**

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

**Action Implementation Timeline**

- Develop rate methodology for residential treatment- COMPLETE
- MMIS system modifications (including finalizing coding)- November 1, 2017
- Provider notification and training- Beginning November 2, 2017
- Coverage and Reimbursement for ASAM levels of care 3.7 on a per diem basis will be available immediately upon approval the Utah’s SUD Implementation Plan.

- Update the Utah provider manual, “Rehabilitative Mental Health and Substance Abuse Disorder Services” to reflect coverage based on ASAM Levels of care for 3.1, 3.3, 3.5 and 3.7 by March 31, 2018.

**Future State:**

No changes are expected

**Summary of Actions Needed:**

None

**Sub Support Service – Addiction Recovery Management Services**

**Current State:**

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

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

**Future State:**

No changes are expected

**Summary of Actions Needed:**

None

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

**Criteria**

**Patient Assessments**

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following

(1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division

Directives: [https://dsamh.utah.gov/pdf/contracts\\_and\\_monitoring/Divison\\_Directives\\_FY\\_17\\_Final.pdf](https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY_17_Final.pdf).

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

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

(b) Biomedical conditions or complications;

- (c) Emotional, behavioral, or cognitive conditions;
  - (d) Readiness to change;
  - (e) Relapse, continued use or continued problem potential; and
  - (f) Recovery environment.
- (3) The assessment shall include relevant information on:
- (a) The individual's psychosocial function, substance use including tobacco/nicotine, mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;
  - (b) Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;
  - (c) Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;
  - (d) Cognitive, social, and affective development; family, peer, and intimate relationships; trauma; current or past emotional, physical or sexual abuse; suicidality; and safety;
  - (e) Collateral information from other sources that are relevant to the individual's situation and provides insight into the issues in Subsection R523-4-6(2)(a) through (2)(d).
- (4) The assessment shall include a diagnosis when clinically indicated.
- (5) Based on the screening and the assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs.
- (6) The levels of care and array of services shall be based on the ASAM.”

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

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

episodes of treatment may be necessary.

**Future State:**

All providers will be trained on ASAM criteria

**Summary of Actions Needed:**

Ongoing provider training on ASAM criteria

**Action Implementation Timeline**

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

**Independent Third Party**

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

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

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

**Future State:**

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

**Summary of Actions Needed:**

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

**Action Implementation Timeline:**

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

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

**Certification of Residential Facilities**

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



In addition, counties that contract for residential services have detailed contracts with providers based on ASAM Criteria.

The Office of Licensing audits to these guidelines. DSAMH conducts annual monitoring site visits to Local Authorities reviewing Policy and Procedures, licensures, schedules, clinical documents. Copies of DSAMH monitoring tools and reports can be found

at: <https://dsamh.utah.gov/provider-information/contracts-monitoring/>.

#### **Future State:**

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

#### **Summary of Actions Needed:**

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

#### **Action Implementation Timeline**

- Utah Medicaid will establish and implement a process to certify private residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than July 1, 2018.
- The Utah Division of Substance Abuse and Mental Health and the Office of Licensing will implement a process to certify public and private non-profit residential treatment facilities based on ASAM criteria who provide services to Medicaid fee for service members no later than December 31, 2018.
- PMHP contracts language regarding this requirement will be reviewed and modified if appropriate by July 1, 2018.
- Administrative rule making will be promulgated to support this milestone with an effective date of July 1, 2018.
- An addendum to the Utah Medicaid Provider Agreement will be implemented to gather information on ASAM levels of care provided by private residential treatment providers by March 31, 2018.

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

#### **Network Development Plan**

##### **Overall Strategy- Addiction Treatment Services Providers**

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

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

providers across the state who can provide treatment if the need arises.

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

#### **Future State:**

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

#### **Summary of Actions Needed:**

The DSAMH provider inventory needs to be updated to identify providers by ASAM level of care and whether or not providers are accepting new patients.

DMHF and DSAMH will continue to work together to assure Medicaid members in need of SUD treatment services have access to care.

#### **Action Implementation Timeline:**

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

### **Program Integrity Safeguards**

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

### **Risk-Based Screening**

Each provider is subject to pre-enrollment screening. Providers are categorized by risk level - limited, moderate, or high - using the Centers for Medicare & Medicaid Services (CMS) guidelines for risk determination. The risk level assignment of an individual provider may be increased at any time as a result of a payment suspension, an overpayment, Office of Inspector General (OIG) exclusion within the past 10 years, or at the discretion of the State pursuant to Utah Administrative Code R. In these instances, the provider is notified by the State, and the new risk level will apply to processing enrollment-related transactions. Providers who are enrolling (including changes of ownership) or revalidating are screened according to their assigned risk levels. Providers assigned to the high-risk category are required to pass a national fingerprint-based criminal background check in order to enroll or remain enrolled with the Utah Medicaid. All individuals who have at least 5% ownership or controlling interest in the enrolling business entity are required to have criminal background checks. The requirement also applies to individual practitioners who have been assigned to the high-risk category. The criminal background check requires affected individuals to submit to fingerprinting. When fingerprints are taken, a confirmation number is provided. Individuals being fingerprinted should be sure to record the confirmation number, as they will need this information when completing the IHCP provider enrollment application. Individuals who have had fingerprint-based federal criminal background checks for the IHCP within the last six months do not need to repeat the process for a new enrollment; the confirmation number of the prior fingerprinting is acceptable, as long as it was conducted within six months of submission. Individuals are responsible for the cost of the fingerprinting. It is important to follow instructions carefully, or it may be necessary to be fingerprinted.

Utah Medicaid may deny or terminate an individual's or entity's eligibility to participate as a Medicaid

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

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

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

### **Provider Revalidation**

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

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

After disenrollment, the provider will need to submit a new Utah Medicaid Provider Enrollment Application and all Documents to reenroll with Utah Medicaid.

Disenrollment with subsequent re-enrollment may result in a gap in the provider's eligibility.

### **Provider Agreements**

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

### **Billing and Compliance Issues**

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

are also contractually obligated to provide reports to Utah Medicaid on their activities. Providers can find out how to enroll with Utah Medicaid at <https://medicaid.utah.gov/become-medicaid-provider>

## Benefit Management

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

### Future State:

No changes are expected.

### Summary of Actions Needed:

None

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

Level of Care: OTS (Opioid Treatment Services)

### Current State:

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

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

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

Local Substance Abuse Authority treatment programs . . .

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

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

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

c. Refer the individual for MAT.

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

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

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

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by 7.6% in one

year <https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf>. DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevention abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence-based prevention programs. DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

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

Successful treatment may include:

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

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

A range of care with a tailored treatment program and follow-up options can be crucial to success.

Treatment should include both medical and mental health services as needed.

Follow-up care may include community- or family-based recovery support systems. Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid use and the risk of overdose.

Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a “whole-patient” approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities.

There are 14 OTP providers in the State of Utah. Utah's OTP's provide safe and effective treatment that includes regular counseling sessions, drug testing, and medication assisted treatment and recovery support. In 2015, 3,495 individuals sought assistance at the OTP clinics in Utah.

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

### Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

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

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

### Prior Authorization Criteria

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

### Prescribing Guidelines

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

## ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

Behavioral Health received funding from Intermountain Healthcare to provide medication assisted treatment and counseling for individuals with opioid dependence from prescription drugs that may have also led to current heroin use. Since its beginning, 120 clients have been served in the Opioid Community Collaborative. Currently, in Salt Lake County, a pilot project was legislatively funded in FY15 offering clients coming out of jail or prison with the option of using Vivitrol in coordination with treatment. Salt Lake County Behavioral Health Services launched this project in September 2015 and has served 205 clients to date. The average length of stay in the program is 3-4 months.

Salt Lake County anticipates ongoing growth and increased participation and length of stay in the program. Syringe Exchange Programs (SEP) also known as syringe services programs (SSPs), needle exchange programs (NEPs), and needle-syringe programs (NSPs), are community-based programs that provide access to sterile needles and syringes free of charge. The programs also facilitate safe disposal of used needles and syringes. SEPs are an effective component of a comprehensive, integrated approach to HIV and hepatitis C prevention among people who inject drugs. Most SEPs offer other prevention materials and services, such as HIV/HCV education; overdose prevention, including Naloxone distribution; referral to substance abuse treatment programs; and counseling and testing for HIV and hepatitis C.

Syringe exchange programs became legal in Utah in 2016, the day Utah Governor Gary Herbert signed House Bill 308 into law. The bill went into effect May 2016, and states that agencies in Utah "may



operate a syringe exchange program in the state to prevent the transmission of disease and reduce morbidity and mortality among individuals who inject drugs and those individuals' contacts." HB 308 does not fund syringe exchange programs in Utah, it only provides guidelines and reporting requirements and follows the restrictions of federal funding.

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

## **Drug Courts**

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

Drug courts are special court dockets designed to treat individuals with substance use disorders and provide them the tools they need to change their lives. The drug court judge serves as the leader of a multidisciplinary team of professionals, which commonly includes a program coordinator, prosecuting attorney, defense attorney, probation or community supervision officer, and treatment representatives. Drug Courts provide an alternative to incarceration. Eligible participants for these programs have a moderate-to-severe substance use disorder, are charged with non-violent, drug-related offenses, such as possession or sale of a controlled substance, or another offense caused or influenced by drug use, such as theft or forgery to support a drug addiction, and who are at substantial risk for reoffending, commonly referred to as high-risk and high-need offenders. To effectively work with this population, Drug Courts provide intensive supervision and treatment services in a community environment. Successful completion of the program results in expunged charges, vacated or reduced sentences, or rescinded probation.

DSAMH funds 45 drug courts throughout the state of Utah; 25 adult felony drug courts, 15 family dependency drug courts, and 5 juvenile drug courts. In fiscal year 2016, Utah's drug court program served 2084 individuals, the majority of whom participated in the adult felony drug court program. DSAMH and partner agencies (the Administrative Office of the Courts and the Department of Corrections) work to improve quality assurance and monitoring processes of the program. In addition to conducting annual site visits and biennial certifications of the courts, DSAMH has partnered with the National Center of State Courts to conduct process and outcome evaluations at select Utah Drug Courts, once completed new performance measurements will be developed and implemented throughout the state to help insure best practice standards are followed.

## **Future State:**

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

## **Summary of Actions Needed:**

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

## **Action Implementation Timeline**

- Draft policy and rule by March 1, 2018
- Notify providers and pharmacies in June and July 2018 Medicaid Information Bulletin

- Implement coverage policy that limits opioid prescriptions for dental procedures to three (3) days by July 1, 2018.

## **Milestone 6 Improved Care Coordination and Transitions between Levels of Care**

### **Transitions of Care**

#### **Current State**

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

#### **Future State:**

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

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

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

#### **Summary of Actions Needed:**

Utah will amend provider manuals and managed care contracts.

Providers and Managed Care Contractors will need to be notified and trained regarding the state's transitions of care requirement.

#### **Action Implementation Timeline**

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

## **ADDITIONAL INFORMATION**

### **Case Management**

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

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

DSAMH developed preferred practices for case management, including a training manual, and an



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

#### [Crisis Intervention Team \(CIT\)](#)

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

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

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

#### [Trauma-informed Approach](#)

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

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

1. Ongoing Organizational Evaluation,

Consultation, Training and Technical Assistance on the Trauma-Informed Approach, provided by Gabriella Grant, M.A., Director for the California Center of Excellence for Trauma-Informed Care for CABHI Grantees, Volunteers of America, DSAMH and other groups.

2. Utah Trauma Academy: October 31, November 4, 2016 for 110 public and provide providers. The Utah Trauma Academy was developed and provided by Gabriella Grant and several local trauma experts. The Utah Trauma Academy was based on the Victim Academy developed by the Office of Victims of Crimes at the Department of Justice.

3. Implementation of the Trauma-Informed Approach: DHS, DSAMH and several public and private providers have started the process for implementing a Trauma-Informed Approach in

their practices.

**Future State:**

No changes are expected.

**Summary of Actions Needed:**

None

**Grievances and Appeals**

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

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

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

**Future State:**

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

**Summary of Actions Needed:**

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

**Action Implementation Timeline**

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

## **Attachment B: SMI/SED Implementation Plan**

### **Section 1115 SMI/SED Demonstration Implementation Plan**

**Overview:** The implementation plan documents the state’s approach to implementing SMI/SED demonstrations. It also helps establish what information the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

**Implementation Plan Instructions:** This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on “Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]” over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are

encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.

The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

**Memorandum of Understanding:** The state Medicaid agency should enter into a Memorandum of Understanding (MOU) or another formal agreement with its State Mental Health Authority, if one does not already exist, to delineate how these agencies will work with together to design, deliver, and monitor services for beneficiaries with SMI or SED. This MOU should be included as an attachment to this Implementation Plan.

**State Point of Contact:** Please provide the contact information for the state's point of contact for the implementation plan.

Name and Title: Jennifer Meyer-Smart  
Telephone Number: 385-215-4725  
Email Address: [jmeyersmart@utah.gov](mailto:jmeyersmart@utah.gov)

**1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration**

*The state should complete this transmittal title page as a cover page when submitting its implementation plan.*

|                            |                                                                                                        |
|----------------------------|--------------------------------------------------------------------------------------------------------|
| <b>State</b>               | <i>Utah</i>                                                                                            |
| <b>Demonstration name</b>  | <i>Utah 1115 Primary Care Network Demonstration</i>                                                    |
| <b>Approval date</b>       | <i>Enter approval date of the demonstration as listed in the demonstration approval letter.</i>        |
| <b>Approval period</b>     | <i>Enter the entire approval period for the demonstration, including a start date and an end date.</i> |
| <b>Implementation date</b> | <i>Enter implementation date(s) for the demonstration.</i>                                             |

## 2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

| Prompts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| <b>SMI/SED. Topic 1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <p>To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk.</p> <p>To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p><b>Current State:</b><br/>In accordance with Utah Administrative Code R432-101 Specialty Hospital, all psychiatric facilities must be licensed and certified through the Utah Bureau of Health Facility Licensing and Certification. Residential Treatment Programs are required to be licensed through the Utah Office of Licensing.</p> <p><b>Hospitals:</b><br/>Utah's Bureau of Health Facility Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by the Bureau of Health Facility Licensing and Certification.</p> |

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|  | <p>Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division's external website.</p> <p><b>Residential Treatment Programs:</b><br/>The Utah Department of Human Services, Office of Licensing licenses residential treatment programs. R501-19 details the requirements a program must meet to be licensed and includes regulations for specialized treatment services for substance abuse treatment, services for children and youth, and services for people with disabilities.</p> <p><b>Future Status:</b><br/>Utah will continue operation of current requirements for hospitals. The State will develop methodologies for enrollment of residential treatment programs that include verification of accreditation by a national accreditation association.</p> <p><b>Summary of Actions Needed:</b><br/>The Medicaid Provider Enrollment process will be updated to require submission of verification of accreditation by a national accreditation association. In addition, all necessary system program changes needed in order to enroll residential treatment programs with the appropriate identifier.<br/>(Timeline: 6-12 months)</p> |
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| Prompts                                                                                                                                                                                      | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| <p>1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements</p> | <p><b>Current Status:</b><br/>Currently the Utah Department of Health Facility Licensing, Certification, and Resident Assessment may conduct administrative inspections on a routine basis for any licensed facility.</p> <p><b>Hospitals:</b><br/>R432-3-4 requires:</p> <ul style="list-style-type: none"> <li>(1) The Department (Utah Department of Health Facility Licensing, Certification, and Resident Assessment) or its designee may, upon presentation of proper identification, inspect each licensed health care facility or agency as necessary to determine compliance with applicable laws, rules and federal regulations.</li> <li>(2) Each licensed health care facility or agency must: <ul style="list-style-type: none"> <li>(a) allow authorized representatives of the Department immediate access to the facility or agency, including access to all staff and patients; and</li> <li>(b) make available and permit photocopying of facility records and documents by, or on behalf of, the Department as necessary to ascertain compliance with applicable laws, rules and federal regulations. Copies become the responsibility and property of the Department.</li> </ul> </li> </ul> <p>In addition, current state law allows for on site, unannounced visits to ascertain compliance with licensure requirements</p> <p><b>Residential Treatment Center:</b><br/>Utah code states:<br/>62A-2-118. Administrative inspections.</p> <ul style="list-style-type: none"> <li>(1) The office may, for the purpose of ascertaining compliance with this chapter, enter and inspect on a routine basis the facility of a licensee.</li> <li>(2) Before conducting an inspection under Subsection (1), the office shall, after identifying the person in charge: <ul style="list-style-type: none"> <li>(a) give proper identification;</li> <li>(b) request to see the applicable license;</li> <li>(c) describe the nature and purpose of the inspection; and</li> <li>(d) if necessary, explain the authority of the office to conduct the inspection and the penalty for refusing to permit the inspection as provided in Section 62A-2-116.</li> </ul> </li> <li>(3) In conducting an inspection under Subsection (1), the office may, after meeting the requirements of Subsection</li> </ul> |

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|                                                                                                                                                                   | <p>(2):</p> <ul style="list-style-type: none"> <li>(a) inspect the physical facilities;</li> <li>(b) inspect and copy records and documents;</li> <li>(c) interview officers, employees, clients, family members of clients, and others; and</li> <li>(d) observe the licensee in operation.</li> </ul> <p>(4) An inspection conducted under Subsection (1) shall be during regular business hours and may be announced or unannounced.</p> <p>(5) The licensee shall make copies of inspection reports available to the public upon request.</p> <p>(6) The provisions of this section apply to on-site inspections and do not restrict the office from contacting family members, neighbors, or other individuals, or from seeking information from other sources to determine compliance with this chapter.</p> <p><b>Future Status:</b><br/>Utah will continue operation of current requirements.</p> <p><b>Summary of Actions Needed:</b><br/>None</p>                                                                |
| <p>1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay</p> | <p><b>Current Status:</b><br/>Under Utah Administrative Code R432-101, Specialty Hospital-Psychiatric, psychiatric hospitals as well as residential treatment programs are to complete admission assessments to determine if the level of care provided is the least restrictive environment for the beneficiary. Discharge assessments are also to be performed in order to verify medical necessity and if the beneficiary no longer meets medical necessity criteria, discharge to a lower level of care should be completed.</p> <p><b>Hospitals:</b><br/>Prior to admission, Utah Medicaid’s managed care plans require an assessment of the beneficiary in order to appropriately place the beneficiary. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the hospital stay to ensure that the facility is the least restrictive setting appropriate for their needs.</p> |

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|                                                              | <p>Additionally, hospital must be in compliance with 42 CFR 482.30 which in part states, “The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.”</p> <p>Also, Utah Administrative Code R432-101-17 Admission and Discharge states:</p> <p>3(a) The facility shall assess and screen all potential patients prior to admission and admit a patient only if it determines that the facility is the least restrictive setting appropriate for their needs. The pre-screening process shall include an evaluation of the patient's past criminal and violent behavior.</p> <p>(4) The patient shall be discharged when the hospital is no longer able to meet the patient's identified needs, when care can be delivered in a less restrictive setting, or when the patient no longer needs care.</p> <p><b>Residential Treatment Programs:</b></p> <p>Prior to admission in a residential treatment facility, Utah Medicaid’s managed care plans require an assessment of the beneficiary to ensure the beneficiary is appropriately placed. Beneficiaries may be referred to a different level of care based on the information gathered in the assessment. The managed care plans then monitor treatment of the beneficiary throughout the residential stay to ensure that the facility is the least restrictive setting appropriate for their needs.</p> <p>Additionally, Utah Administrative Code R532-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment requires that an assessment be made “prior to admission to a clinical treatment level of care” and that the assessment uses a screening instrument that “has been evaluated and found reliable and valid by the scientific community”. Additionally, the assessment shall “provide the basis for a treatment plan, and establish a baseline measure for use in evaluating a patient's response to treatment”.</p> |
|                                                              | <p><b>Future Status:</b></p> <p>Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                              | <p><b>Summary of Actions Needed:</b></p> <p>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 1.d Compliance with program integrity requirements and state | <p><b>Current Status:</b></p> <p>In order to receive reimbursement under Medicaid, participating psychiatric hospitals and residential</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

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| compliance assurance process                                                                                                                                                                                                  | treatment programs must be enrolled to participate in Utah Medicaid. Provider enrollment processes fully comply with 42 CFR Part 455 Subparts B&E. Utah's managed care plans have been reimbursing IMDs as an in lieu of service and are only permitted to contract with Utah Medicaid screened and enrolled providers, the State is currently screening and revalidating this provider type.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                               | <b>Future Status:</b><br>Continued operation of current requirements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                               | <b>Summary of Actions Needed:</b><br>No action needed at this time.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions | <b>Current Status:</b><br>In accordance with 42 CFR 482.61, Utah Administrative Code requires both hospitals and residential treatment programs to screen and assess all beneficiaries for co-morbid conditions, including mental health disorders, suicidal ideations, physical health conditions, and substance use disorder screening.<br><br><b>Hospitals:</b><br>Utah Administrative Code R432-101-20 Inpatient Services requires that upon admission:<br><br>(a) A physician or qualified designee shall make an assessment of each patient's physical health and a preliminary psychiatric assessment within 24 hours of admission. The history and physical exam shall include appropriate laboratory work-up, a determination of the type and extent of special examinations, tests, or evaluations needed, and when indicated, a thorough neurological exam.<br>(b) A psychiatrist or psychologist or qualified designee shall make an assessment of each patient's mental health within 24 hours of admission. A written emotional or behavioral assessment of each patient shall be entered in the patient's record.<br><br>Additionally, hospitals must comply with 42 CFR 482.62(c). "Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available |

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|  | <p>within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.”</p> <p><b>Residential Treatment Programs:</b><br/> Utah Administrative Code R523-4-6 Standards for Substance Use and Mental Health Disorder Screening and Assessment, requires using screening instruments for mental health/substance use disorders. Additionally, the initial assessment is required to:</p> <p>(a) Determine the adult's eligibility for treatment, provide the basis for a treatment plan, and establish a baseline measure for use in evaluating a patient's response to treatment.<br/> (b) Identify comorbid medical and psychiatric conditions and diagnosis and to determine how, when and where they will be addressed;<br/> (c) Identify communicable diseases and address them as needed;<br/> (d) Evaluate the adult's level of physical, psychological and social functioning or impairment;<br/> (e) Assess the adult's access to social supports, family, friends, employment, housing, finances and legal problems; and<br/> (f) Determine the adult's readiness to participate in treatment.</p> |
|  | <p><b>Future Status:</b><br/> Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|  | <p><b>Summary of Actions Needed:</b><br/> None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

| Prompts                                                                                                                                                                                                                                                                                                                                                                                   | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| 1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.                                                                                                                                                                                                                                                                     | <b>Current Status:</b><br>According to Utah Administrative Code R432-101-11, both hospitals and residential treatment programs are required to “have a well-defined quality assurance plan designed to improve the delivery of patient care through evaluations of the quality of patient care services and resolution of identified problems”. This rule further requires all providers maintain a “Plan for Patient Care Services”, which is a “written plan that ensures the care, treatment, rehabilitation, and habitation services provided are appropriate to the needs of the patient population service and the severity of the disease, condition, impairment, or disability”. The Plan for Patient Care services must be kept up to date and all corrective actions and meeting minutes must be presentable upon request by the State. |
|                                                                                                                                                                                                                                                                                                                                                                                           | <b>Future Status:</b><br>Utah will continue operation of current requirements.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                           | <b>Summary of Actions Needed:</b><br>None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>SMI/SED. Topic 2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care</b>                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <i>Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Improving Care Coordination and Transitions to Community-based Care</b>                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.                                                                                                                                                                                                               | <b>Current Status:</b><br>Both residential treatment centers and hospitals are required by Utah administrative code to have transfer and discharge policy in place in order for beneficiaries to be provided with the necessary aftercare and follow up services following discharge.<br><br><b>Hospital:</b><br>All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes                                                                                                                                                                                                                                                                                         |

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|                                                                                                                                                                                                | <p>minimum discharge planning requirements aligned with this milestone. Additionally, Utah Administrative Code R432-101-17(4)(c) requires that, “Discharge planning shall be coordinated with the patient, family, and other parties or agencies (e.g. community-based providers) who are able to meet the patient's needs.”</p> <p><b>Residential Treatment Centers:</b><br/> R501-2-6(7) Transfer and Discharge<br/> a. a discharge plan shall identify resources available to consumer.<br/> b. the plan shall be written so it can be understood by the consumer or legally responsible party.<br/> c. whenever possible the plan shall be developed with consumers participation, or legally responsible party if necessary. The plan shall include the following:<br/> 1) reason for discharge or transfer,<br/> 2) adequate discharge plan, including aftercare planning,<br/> 3) summary of services provided,<br/> 4) evaluation of achievement of treatment goals or objectives,<br/> 5) signature and title of staff preparing summary, and<br/> 6) date of discharge or transfer.<br/> d. The program shall have a written policy concerning unplanned discharge.</p> |
|                                                                                                                                                                                                | <p><b>Future Status:</b><br/> Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                | <p><b>Summary of Actions Needed:</b><br/> None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <p>2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available.</p> | <p><b>Current Status:</b><br/> Utah’s psychiatric hospitals and mental health residential centers provide care of the highest quality, which includes a comprehensive discharge plan. Utah’s managed care plans work closely with psychiatric hospitals and mental health residential programs to ensure comprehensive discharge plans. The psychiatric hospitals and mental health residential programs, in coordination with Utah’s managed care plans, assess beneficiaries’ housing situations and coordinate with housing services providers when needed and available” as part of the best practices</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

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|  | for care coordination. The requirement for case management and care coordination is mandated in the managed care contracts between Utah Medicaid and its contracted managed care plans. |
|  | <b>Future Status:</b><br>Utah will continue operation of current requirements.                                                                                                          |
|  | <b>Summary of Actions Needed:</b><br>None                                                                                                                                               |



| Prompts                                                                                                                                                                                                                                   | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| 2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge | <b>Current Status:</b><br>Utah's managed care plans attempt to contact members as a follow up for all emergency departments and inpatient discharges within 72 hours. The care managers also reach out to members when they discharge from residential treatment programs to help the beneficiary arrange a follow up appointment. This effort is specifically done to improve the seven day follow up measure, but the care manager outreach will almost always happen within 72 hours                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                           | <b>Future Status:</b><br>Utah will add specific requirements in our managed care contracts to reflect this requirement                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                           | <b>Summary of Actions Needed:</b><br>Add this requirement to the next amendment to applicable managed care contracts<br>Timeline: July 2021 contract amendment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| 2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission                                                                                                                       | <b>Current Status:</b><br>Utah is committed to preventing or decreasing ED and inpatient stays. By providing beneficiaries the proper services and interventions when needed, beneficiaries receive better care and more cost effective services. This minimizes the need for more costly services such as ED visits. Utah Medicaid recently implemented several strategies to prevent or reduce ED visits and inpatient admission in psychiatric hospitals or residential treatment programs.<br><br>In the 2020 Utah General Session H.B. 32, Crisis Services Amendments was passed. H.B. 32 expanded the mobile crisis outreach team grant program, funded behavioral health receiving centers, and created the Behavioral Health Crisis Response Commission. Utah already has a statewide Crisis Line, Mobile Crisis Outreach Teams, and Assertive Community Treatment teams. These crisis services are designed to prevent ED and inpatient stays.<br><br>Utah also has the Clinically Managed Residential Withdrawal Pilot. This pilot allows for beneficiaries to receive social detoxification services, also known as withdrawal management, as a covered service. Many beneficiaries that access social detoxification services are dually diagnosed with a substance use disorder and a mental health disorder. Social detoxification prevents ED and inpatient psych stays by allowing beneficiaries to have a level of care appropriate for their current needs instead of going to an ED or inpatient stay to withdraw. Additionally, beneficiaries will have case managers at the detox center to assess them and guide them into outpatient mental health services appropriate for their needs. |

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|                                                                                                            | <p>Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well.</p>                                                                                                                                                                                                                                                        |
|                                                                                                            | <p><b>Future Status:</b><br/>Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                            | <p><b>Summary of Actions Needed:</b><br/>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 2.e Other State requirements/policies to improve care coordination and connections to community-based care | <p><b>Current Status:</b><br/>Utah Medicaid services are operated predominantly through Managed Care Plans. On January 1, 2020, Utah Medicaid implemented four new Integrated Managed Care Plans. The Utah Medicaid Integrated Care (UMIC) plans manage both physical and behavioral health benefits for the Adult Expansion population. Prior to this time, Utah had separate physical health and behavioral health plans only. The UMIC plans are able to provide more holistic care to the beneficiaries. By using integrated care, the care managers in the UMIC plans can help beneficiaries get needed care more easily and efficiently. Non-integrated care plans are unable to see the whole person. Since these plans are new to Utah, outcome data is still being gathered. However, nationally integrated care has proven to be a benefit to the beneficiary, reduced ED stays, and inpatient stays.</p> |
|                                                                                                            | <p><b>Future Status:</b><br/>Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                            | <p><b>Summary of Actions Needed:</b><br/>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

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| <b>SMI/SED. Topic 3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                 |
| <i>Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.</i> |                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Access to Continuum of Care Including Crisis Stabilization</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                 |
| 3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>Current Status:</b><br>In partnership with local partners, Utah Medicaid completed the initial assessment on September 30 <sup>th</sup> 2020. Some important results are the lack of IMD facilities available to beneficiaries, the need to increase crisis response in rural areas, and the need to increase crisis receiving centers throughout the state. |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <b>Future Status:</b><br>Utah Medicaid commits to conducting an availability assessment annually and will discuss any improvements that need to be made in ongoing assessments and reports.                                                                                                                                                                     |

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| <p>the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.</p> | <p><b>Summary of Actions Needed:</b><br/>Utah will complete the next annual assessment of the availability of mental health providers by September 30<sup>th</sup>, 2021.</p> |
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| Prompts                                                                                                                                    | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| 3.b Financing plan                                                                                                                         | <b>Current Status:</b><br>See Topic 5 for information on the State’s financing plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                            | <b>Future Status:</b><br>See Topic 5 for information on the State’s financing plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                            | <b>Summary of Actions Needed:</b><br>See Topic 5 for information on the State’s financing plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds                                        | <b>Current Status:</b><br>Currently each organization, with inpatient and crisis stabilization beds, manages their own bed availability and capacity. Anyone seeking a bed has to inquire with each organization individually.                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                                                                                            | <b>Future Status:</b><br>The Utah Behavioral Health Availability Platform is a search engine developed from the Juvare EMSResource© platform. Mental health inpatient bed availability will be the initial focus, followed by substance use disorder residential programs and social detoxification centers along the Wasatch front. Emergency room staff, participating inpatient units, call centers (including the University of Utah), and mobile crisis teams will be able to access the search engine, with bed availability updated twice per day.<br><br>The kickoff for the platform is planned for January 2021. |
|                                                                                                                                            | <b>Summary of Actions Needed:</b><br>Implementation of the platform – January 2021<br>Monitor with DSAMH the Utah Behavioral Health Availability Platform’s progress.<br>Timeline: Ongoing                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of | <b>Current Status:</b><br>Utah Medicaid uses InterQual Criteria, an evidence-based clinical decision support tool, to determine appropriate level of care and length of stays.<br><br>Utah Medicaid requires its managed care plans by contract to use evidence based practice guidelines consistent with                                                                                                                                                                                                                                                                                                                  |

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| care and length of stay | current standards of care. They are required to ensure decisions on utilization management are based on the best practice guidelines. Although managed care plans are already using a tool as discussed above, the contracts currently do not have a specific requirement to use an assessment tool.                                                                                                                                         |
|                         | <b>Future Status:</b><br>Add to contracts for managed care plans to use a “widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay”.                                                                                                                                                                                                                                         |
|                         | <b>Summary of Actions Needed:</b> <ol style="list-style-type: none"> <li>1. Modify managed contracts to include a requirement that they must use a “widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay”.</li> <li>2. Follow up with managed care plans to ensure they are requiring the utilization of a patient assessment tool<br/>(Timeline: 6-12 months)</li> </ol> |

| Prompts                                                                                                                                                                                                                                                                                                                                                           | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
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| 3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization                                                                                                                                                                                                                                                | <b>Current Status:</b><br>Utah Medicaid is currently working to implement a SAMHSA model of Crisis Receiving and Stabilization Services model called Utah Behavioral Health Receiving Centers. Utah Medicaid is working to add this service as part of the Medicaid State Plan.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                   | <b>Future Status:</b><br>Continue the State Plan amendment process. Pending CMS approval, the amendment will take affect 1/1/2021.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                   | <b>Summary of Actions Needed:</b><br>Follow through with needed action steps to ensure completion of the State Plan amendment process.<br>(Timeline: 3-6 months)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <i>Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <b>Earlier Identification and Engagement in Treatment</b>                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported employment and supported programs                                                                                                                                                                                               | <b>Current Status:</b><br>All of Utah's county behavioral health authorities are required to ask during intake if the individual is employed, unemployed, on disability etc. This includes use of the specific question - "Are you interested in looking for work/school". If the individual answers that they are interested, there is an automatic referral to the Individual Placement and Support (IPS) Supported Employment teams. Anyone can be referred whether they want full-time, part-time, volunteer, or education.<br><br>Additionally, all county behavioral health authorities have a functional assessment tool, usually given by a case manager, and generally provided within the first few treatment sessions. The needs assessment scale, usually the Daily Living Activities Functional Assessment (DLA-20). This tool reviews how well someone is functioning across multiple domains from self-care, independent activities of daily living, health practices, etc. It identifies strengths and weaknesses, and becomes part of a treatment plan with referrals to case management, skills training, peer support, day programs, and engagement of community resources when needed. |

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|                                                                                                                                                                     | <p>Utah's Division of Substance Abuse and Mental Health (DSAMH) requires that treatment plans are updated regularly, reviewing goals and determining if there are new or more emergent issues that should be the focus of treatment and care. DSAMH also has the ability to audit treatment plans to ensure quality of care.</p> <p>DSAMH also oversees First Episode Psychosis (FEP) programming targeting individuals ages 15-26 who are experiencing the first signs of psychosis. These programs are available in four areas throughout Utah, with additional training being offered across the State. FEP services focus on a Coordinated Specialty Care (CSC) model that allows for individuals who are seeking services to receive a range of necessary services including individual therapy, family therapy, medication management, case management, and peer support services. CSC services are also provided to individuals throughout their communities to ensure their services are more accessible.</p> <p>All of the county-based behavioral health authorities provide early intervention services for children and youth. These services included early childhood services, school based behavioral health, and family peer support services. Each of these services allow for earlier identification and access to care for children and their families.</p> <p><b>Future Status:</b><br/>Utah will continue operation of current requirements.</p> <p><b>Summary of Actions Needed:</b><br/>None</p> |
| <p>4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment</p> | <p><b>Current Status:</b><br/>On January 1, 2020 Utah Medicaid implemented integrated managed care plans. These plans, called Utah Medicaid Integrated Care (UMIC), combine physical and behavioral benefits under one payor. This allows for improved case management and care coordination. By having a more complete view of a member's needs the managed care plan's care coordinators can identify earlier SED/SMI concerns that may be arising for a member. After identifying a need for intervention, the care coordinators can help a member get the proper care for their unique needs.</p> <p>The Utah Division of Substance Abuse and Mental Health manages early intervention services for children and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |



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|  | <p>youth. These services are provided through the Local Authority Behavioral Health system and are focused on providing early access to care in non-traditional settings. These settings include partnerships with local education agencies and other health care providers. Through partnerships with schools, the local authority system is able to improve identification of SED and provides more access to services for children earlier in life.</p> <p>With support of a federal grant DSAMH is implementing the Utah- Promoting Integration of Primary and Behavioral Health Care (U-PIPBHC) Program. The U-PIPBHC program will provide mental and physical health services, substance abuse treatment and psychiatric consultation. In addition, DSAMH continues to work with the Association of Utah Community Health to integrate community health center services for physical health and local behavioral health centers services.</p> |
|  | <p><b>Future Status:</b><br/>Utah will continue operation of current requirements.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|  | <p><b>Summary of Actions Needed:</b><br/>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| Prompts                                                                                                                       | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| 4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI | <p><b>Current Status:</b><br/>Utah Department of Human Services (DHS) oversees the Stabilization and Mobile Response (SMR) program. This program provides children, youth, and family's specific crisis intervention and stabilization strategies. These crisis intervention and stabilization strategies help teach skills to improve family functioning, create plans that prepare for and prevent future challenges, prevent the need for out-of-home services, and equip families with ongoing resources and support in home and community based settings. SMR currently operates in two DHS regions of the state and is currently planning to expand to two more regions with the goal of becoming statewide.</p> <p>DHS also operates Juvenile Receiving Centers (JCR) under the Division of Juvenile Justice in twelve communities across the state in order to prevent at-risk youth from entering the justice or child welfare systems. JRCs operate in conjunction with the Division of Juvenile Justice Services' (DJJS) Youth Services Model and allow for a safe environment for adolescents to be taken when they are not appropriate for other services. Here they are assessed and referred for other services throughout the community, including those services provided by community based mental health centers.</p> |
|                                                                                                                               | <p><b>Future Status:</b><br/>DHS will continue to work to implement SMR statewide. It is anticipated that SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021. The expansion into the final parts of the state will occur when funding becomes available.</p> <p>DHS will continue to push integration and more robust behavioral health services into Juvenile Receiving Centers. DJJS recently partnered with a local county mental health provider to integrate services into a Juvenile Receiving Center and there are plans to expand this model into other counties across Utah to continue to provide more integrated behavioral health services to youth who are accessing services through these means.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                               | <p><b>Summary of Actions Needed:</b><br/>SMR will expand to the Salt Lake region by January of 2021 and into the Eastern region by mid-year 2021</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                               | <p><b>Current Status:</b><br/>The Utah Department of Human Services and Division of Substance Abuse and Mental Health oversees programming to</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 4.d Other state strategies to increase earlier                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

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| <p>identification/engagement, integration, and specialized programs for young people</p> | <p>increase early intervention strategies including preschool based programming for youth with co-occurring mental health and autism spectrum disorder needs. There are currently five programs operating throughout Utah. Each of these programs operates under different names. They provide services to youth ages 2-8 who are in need of co-occurring mental health and autism/developmental needs.</p> <p>Utah's Department of Human Services also uses the System of Care's High-Fidelity Wraparound (HFW) model, through this model and working with DSAMH, Utah is able to work with family advocacy and peer led organizations to provide high fidelity wraparound services and family and youth peer support services. These services are meant to provide early intervention for the youth and their families, and to help navigate the complex mental health system.</p> <p>Early childhood programs are also provided through Utah's Department of Child and Family Services with partnerships with local family support centers that provide mental health services and crisis nursery services. School based services are also provided in conjunction with county behavioral health authorities and schools to increase early engagement and access to services.</p> <p><b>Future Status:</b><br/>Early childhood training needs have been identified to help build out more robust mental health services and partnerships between agencies that serve children. These early childhood training needs include a consultation and competency model that will provide training to providers who serve younger children (0-5) throughout their communities. These trainings are meant for both clinical and non-clinical professionals and will increase the overall capacities throughout local communities.</p> <p>Ongoing efforts to increase partnerships and services with schools and Local Authorities. Currently there are partnerships with over 350 local schools throughout Utah. For the future, it is anticipated that these partnerships will continue to grow based on need in local areas with new schools being added yearly. Youth in Transition services and training opportunities are also being developed. DSAMH leads a State Youth In Transition team that meets monthly and are working on a health disparities project and creating a strategic plan.</p> <p><b>Summary of Actions Needed:</b><br/>Within the next 12 months, the Department of Human Services will enter into a contract for an early childhood competencies and consultation program that will include training for Local Authorities and their community partners.</p> |
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|  | Within 18 months, DSAMH and the Local Authorities will continue to partner with the Utah State Board of Education and Local Education Agencies to increase the local involvement for services, including increasing access to telehealth services and in person services that will be provided in local schools. A full school based implementation manual will also be completed in that timeframe. |
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| Prompts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| <b>SMI/SED.Topic 5. Financing Plan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <i>State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.                                                                                                                                                                                                                                                                                      | <p><b>Current Status</b></p> <p>Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well.</p> <p>Utah Medicaid recently added Assertive Community Treatment and Mobile Crisis Outreach Teams to the State Plan. Utah Medicaid also submitted a SPA to receive approval for bundled daily rates for services provided at a Crisis Receiving Center or a mental health residential treatment program.</p> <p>Utah currently either operates or is in the process of implementing several crisis services related initiatives.</p> <ol style="list-style-type: none"> <li>1. Crisis Line: Currently any individual in Utah can access crisis services via the Utah Crisis Line, which is funded by a mix of county and state funds.</li> <li>2. Mobile Crisis Outreach Team (MCOT): The four urban counties/Local Authorities in Utah have been operating MCOT teams. Seven additional rural/frontier Local Authorities will begin operating MCOT services in FY21. These are funded via a mix of state general funds, local funds, and Medicaid reimbursement.</li> <li>3. Stabilization and Mobile Response (SMR)- in three regions, currently in the works to expand to one additional region,</li> <li>4. Crisis Receiving Centers: Four Local Authorities will be standing up crisis receiving centers between FY 21 and</li> </ol> |

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|  | <p>FY23. These will be funded by state general funds with a plan to add a bundled rate to the Utah State Plan.</p> <p>5. Sub-Acute.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|  | <p><b>Future Status</b></p> <p>Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan</p> <ol style="list-style-type: none"> <li>1. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021.</li> <li>2. Expand MCOT statewide: Goal of even additional rural/frontier local Authorities will begin operating MCOT services by January 1, 2021 pending sustainable funding plan approved and adopted.</li> <li>3. Expand SMR statewide: Goal of SMR to be in four regions by Spring of 2021 dependent on funding.</li> <li>4. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22.</li> <li>5. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans.</li> <li>6. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system</li> <li>7. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce</li> </ol> |
|  | <p><b>Summary of Actions Needed</b></p> <ol style="list-style-type: none"> <li>1. On January 1, 2021, pending CMS approval, Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan.</li> <li>2. By December 2020, Utah will finalize administrative rule governing Crisis Receiving Centers.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

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|                                                                                                                                                                                                                                                         | <ol style="list-style-type: none"> <li>3. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021.</li> <li>4. Expand MCOT statewide: Goal of statewide MCOT by July 1, 2022 pending sustainable funding plan approved and adopted.</li> <li>5. Expand SMR statewide: Goal of SMR to be in four regions by Spring 2021 dependent on funding.</li> <li>6. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22.</li> <li>7. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. Ongoing.</li> <li>8. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system. Ongoing.</li> <li>9. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce. Ongoing.</li> </ol> |
| 5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified | <p><b>Current Status:</b></p> <p>Utah currently offers a comprehensive continuum of community-based mental health services. Outpatient, partial hospitalization, and residential mental health treatment services have been part of the Utah State Plan since 1987. The state continuously monitors access to mental health services through its managed care plans, external quality reviews, and through the Utah Department of Substance Abuse and Mental Health (DSAMH).</p> <p>Managed care plans are required to follow 42 CFR 438.68 Network adequacy standards. In accordance with 42CFR 438.358, Utah Medicaid contracts with an external quality organization to validate the managed care plans for network</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

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| Community Behavioral Health Clinic model. | <p>adequacy for the preceding 12 months.</p> <p>Utah Code 62A-15-103 assigns responsibility to DSAMH to work with the county behavioral health authorities to conduct annual program audits and reviews to ensure adequate plans and community based services are available throughout Utah. DSAMH is required to review the Local Authority Area Plans annually and audit each county behavioral health authority to these plans.</p> <p>In 2019, Utah Medicaid began reimbursing for the Assertive Community Treatment (ACT) model of care. Utah currently has one ACT team at SAMHSA fidelity with plans to expand to more teams.</p> <p>On January 1 2020, Utah Medicaid implemented four new integrated managed care plans. These plans cover both physical health behavioral health services. Through these new integrated plans, beneficiaries are able to receive care management in a more complete manner.</p> <p><b>Future Status</b><br/> DSAMH will continue to monitor county behavioral health authorities to ensure provision of mandated services including issuing Division Directives and requiring annual Area Plans as well as annual audits. DSAMH will work with key stakeholders to identify gaps in services including workforce shortages and partner on strategies to build out increased access to a continuum of community based services.</p> <p>DSAMH will continue to expand access to ACT services and AOT services. An additional ACT team in SLCO will launch FY21 (current year) and an AOT team will launch in Weber county</p> <p><b>Summary of Actions Needed</b><br/> 2020 Utah will finalize the Utah administrative rule governing ACT Teams.</p> <p>The state will require an annual plan by each Local Mental Health Authority that outlines the local plan for service delivery to high acuity clients and will provide support to build out AOT and/or ACT services when clinical need arises.</p> |
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| Prompts                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <b>SMI/SED. Topic 6. Health IT Plan</b><br><i>As outlined in State Medicaid Director Letter (SMDL) #18-011, “[s]tates seeking approval of an SMI/SED demonstration ... will be expected to submit a Health IT Plan (“HIT Plan”) that describes the state’s ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration’s goals.”<sup>1</sup> The HIT Plan should also describe, among other items, the:</i> <ul style="list-style-type: none"> <li>• <i>Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and</i></li> <li>• <i>Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.</i></li> </ul> <i>Please complete all Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state’s demonstration proposal.</i> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Statements of Assurance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>The State assures that it has a sufficient health IT infrastructure to achieve the goals of the demonstration. The State has an established health IT infrastructure that is based on the goal to improve interoperability across the continuum of care on behalf of all beneficiaries. The State’s health IT infrastructure includes achieving goals that will improve health outcomes, facilitate access, simplify care, and reduce the overall costs of healthcare. In order to achieve these goals, the State utilizes the State Medicaid Health Information Technology Plan (SMHP), an incentive based program that encourages hospitals and providers to utilize Electronic Healthcare Technology in order to improve outcomes for beneficiaries.</p> <p>Currently the state utilizes the Clinical Health Information Exchange (cHIE), which has been accredited through the Electronic Healthcare Network Accreditation Commission. The cHIE is the state-designated Health Information Exchange platform that allows providers and MCOs to collect and connect patient data within one main system throughout the state of Utah. <a href="https://uhin.org/solutions/use-cases/clinical-use-cases/">https://uhin.org/solutions/use-cases/clinical-use-cases/</a></p> |

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<sup>1</sup> See SMDL #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>.

| Prompts                                                                                                                                                                                                                                                                                         | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
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| Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period. | <p>Utah confirms that the State's Behavioral Health IT Plan aligns with the State's Broader State Medicaid Health IT Plan and other State health IT plans.</p> <p>Utah's Prescription Drug Monitoring Program (PDMP) is called the Controlled Substance Database (CSD). Utah's CSD is part of the PMP Interconnect (PMPi), in conjunction with Appriss Health and the National Association of Board of Pharmacy that enables the secure sharing of PMP data across states and systems. InterConnect includes a 'smart hub' routing methodology and rules engine to enforce interstate sharing permissions.</p> <p>Utah also has a contract with Utah Health Information Network (UHIN) as part of the SUD Health IT Plan goals. Through UHIN, the cHIE is utilized by providers and managed care plans as stated above. The goal of the cHIE is to decrease over utilization of services, reduce hospital readmissions, provide quality reports, track and monitor transient patient populations, identify gaps in care, and gather data for HEDIS measures.</p> |

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| <p>Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)<sup>2</sup> and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state’s Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.</p> | <p>Utah Medicaid will be in compliance with the standards set forth in 45 CFR 170 Subpart B.</p> <p>In addition, Utah Medicaid added this requirement as part of the July 1, 2020 amendments to the Managed Care Plan’s contracts requiring the plans to implement the standards referenced in the Interoperability Standards Advisory (ISA)<sup>2</sup> and 45 CFR 170 Subpart B by July 1, 2021.</p> |
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<sup>2</sup> Available at <https://www.healthit.gov/isa/>.

| Prompts                                                                                                             | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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|                                                                                                                     | <p>To assist states in their health IT efforts, CMS released <a href="#">SMDL #16-003</a> which outlines enhanced federal funding opportunities available to states “for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers.” For more on the availability of this “HITECH funding,” please contact your CMS Regional Operations Group contact.<sup>3</sup></p> <p>Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established “No Wrong Door System.”<sup>4</sup></p> |
| <b>Closed Loop Referrals and e-Referrals (Section 1)</b>                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider | <p><b>Current State:</b><br/>It is not a consistent practice to use the EHR to execute e-referrals and closed loop referrals between mental health providers.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                     | <p><b>Future State: Describe the future state of the health IT functionalities outlined below:</b><br/>The future state will be determined following feedback from surveys by providers and managed care plans to determine a need for closed loop referrals. Based on the results of the survey, the State will develop a plan for closed loop referrals if determined necessary.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                     | <p><b>Summary of Actions Needed:</b><br/>The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion.<br/>(Timeline: 18-24 months)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |

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<sup>3</sup> See SMDL #16-003, “Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers.” Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf>.

<sup>4</sup> Guidance for Administrative Claiming through the “No Wrong Door System” is available at <https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html>.

| Prompts                                                                                                        | Summary                                                                                                                                                                                                                                                                                                                                               |
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| 1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider | <b>Current State:</b><br>As stated above, there is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from an institution/hospital/clinic.                                                                                                                                                                  |
|                                                                                                                | <b>Future State:</b><br>The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.                                                                                                                                                                                          |
|                                                                                                                | <b>Summary of Actions Needed:</b><br>The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and managed care plans for completion.<br>(Timeline: 18-24 months)               |
| 1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports    | <b>Current State:</b><br>There is no current method or standard for closed loop referrals using the EHR to refer beneficiaries from physicians to community based providers.                                                                                                                                                                          |
|                                                                                                                | <b>Future State:</b><br>The State will conduct a survey to determine the number of mental health providers who utilize closed loop referrals or e-referrals.                                                                                                                                                                                          |
|                                                                                                                | <b>Summary of Actions Needed:</b><br>The State (DSAMH and UDOH) will develop a survey to assess the need for developing a standard process to conduct closed loop referrals. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion.<br>(Timeline: 18-24 months) |
| <b>Electronic Care Plans and Medical Records (Section 2)</b>                                                   |                                                                                                                                                                                                                                                                                                                                                       |



|                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| <p>2.1 The state and its providers can create and use an electronic care plan</p> | <p><b>Current State:</b><br/>Electronic care plans are used as a means to create a plan of care for beneficiaries by providers. While it is common practice for providers to utilize an electronic care plan for treatment, there is no standardized programming or reporting established by the State.</p> <p>According to ONC Health IT statistics from 2017, 97% of Utah’s acute care hospitals have adopted certified EHRs. In the physician community, 94% have adopted an EHR, with 85% using a certified EHR that meets the requirements for meaningful use. Almost 1200 unique providers participated in Utah’s Promoting Interoperability incentive program attesting that they have adopted a certified EHR. This encompasses a wide range of providers in major health systems, mid-size clinics, FQHCs and smaller independent practices. Particularly within the major health organizations in Utah, accessing shared care plans between different health providers in the same system should be fairly simple.</p> <p><b>Future State:</b><br/>Although EHR adoption levels in Utah are quite high, the state scores much lower when it comes to sending, receiving, and integrating patient health information from outside sources in settings beyond the hospital setting. There is room for improvement in these areas and providers need to understand the benefit of sharing this information outside of the walls of their own organizations (when clinically necessary.)</p> <p><b>Summary of Actions Needed:</b><br/>Partner with UHIN to understand what options are available to the behavioral health community. Conduct outreach and education to encourage the sharing of care plans and the efficiencies that are gained when everyone is on the same page.<br/>(Timeline: 18-24 months)</p> |
|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

| Prompts                                                                                                                                          | Summary                                                                                                                                                                                                                                                                                                                                                                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers                 | <b>Current State:</b><br>As mentioned previously, Utah has implemented Utah Medicaid Integrated Care (UMIC) to manage both physical and behavioral health for beneficiaries throughout the state. Under these managed care plans, the e-plans of care are available to all relevant providers, including behavioral health providers.                                     |
|                                                                                                                                                  | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <b>Summary of Actions Needed:</b><br>No further action needed at this time.                                                                                                                                                                                                                                                                                               |
| 2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications       | <b>Current State:</b><br>Currently in the Local Authority Behavioral Health system, transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email.                           |
|                                                                                                                                                  | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                  | <b>Summary of Actions Needed:</b><br>None                                                                                                                                                                                                                                                                                                                                 |
| 2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications | <b>Current State:</b><br>Currently in the Local Authority Behavioral Health system, electronic care plans for transitions of care for youth to adult records within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions from youth systems to adults systems outside of the agency are managed via secure email. |
|                                                                                                                                                  | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                                                                   |

|  |                                            |
|--|--------------------------------------------|
|  | <b>Summary of Actions Needed:</b><br>None. |
|--|--------------------------------------------|

| Prompts                                                                                                                                                                                                                                                                                                                 | Summary                                                                                                                                                                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.5 Transitions of care and other community supports are accessed and supported through electronic communications                                                                                                                                                                                                       | <b>Current State:</b><br>Currently in the Local Authority Behavioral Health system transitions of care for community supports within the agency are communicated by both EHR facilitated electronic communications and secured email. Transitions of care outside of the agency are managed via secure email.                                                                         |
|                                                                                                                                                                                                                                                                                                                         | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                         | <b>Summary of Actions Needed:</b><br>None                                                                                                                                                                                                                                                                                                                                             |
| <b>Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)</b>                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                       |
| <i>3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)</i> | <b>Current State:</b><br>Currently half of the local authority providers capture individual consent electronically in a way that is accessible to the care team in order to share protected health information.                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                         | <b>Future State:</b><br>The state will continue to assess the need for change and update Health IT functionalities as needed.                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                         | <b>Summary of Actions Needed:</b><br>The state will require an annual plan from each of the local authority providers that includes a plan for care coordination including communicating consent and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place.<br>(Timeline: 6-18 months) |
| <b>Interoperability in Assessment Data (Section 4)</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                       |
| 4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the                                                                                                                                                                 | <b>Current State:</b><br>Currently half of the Local Authority Behavioral Health providers utilize the cHIE and only one authority uses it to capture intake, assessment, and screening tools. However, all are able to capture within their organizations EHR.                                                                                                                       |

|               |                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| HIT ecosystem | <b>Future State:</b><br>The state will continue to assess the need for change and update Health IT functionalities as needed.                                                                                                                                                                                                                                                        |
|               | <b>Summary of Actions Needed:</b><br>The state will require an annual plan from each of the local authority providers that includes a plan for capturing intake, screening and assessment tools and will make changes as needed. DSAMH already implements the requirements for annual plans and UDOH will work with providers to ensure this is in place.<br>(Timeline: 6-18 months) |

| Prompts                                                                                                                                                                                                                                                                                                                                    | Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Electronic Office Visits – Telehealth (Section 5)</b>                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care                                                                                                                                                                                              | <b>Current State:</b><br>Telehealth technologies are available in all of the Local Authority Behavioral Health systems. These systems allow for better access to care and communication between providers for more integrated approaches. Multiple authorities involved in integrated healthcare systems also utilize telehealth technologies to ensure broader integrated care access.                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                            | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                                                            | <b>Summary of Actions Needed:</b><br>None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <b>Alerting/Analytics (Section 6)</b>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment <sup>5</sup> ) | <b>Current State:</b><br>It is not a common practice for the State to collect data and identify beneficiaries that are at risk for discontinuing engagement in treatment or have stopped engaging in treatment entirely. It is also not a practice of the State to notify care teams and managers of a beneficiary's disengagement in treatment.                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                            | <b>Future State:</b><br>The future state will be developed based on feedback from surveying enrolled Utah care providers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                            | <b>Summary of Actions Needed:</b><br>The State will work with DSAMH to develop a survey to identify a target population and assess the need for developing a standard process to identify patients who are at risk of disengagement from treatment and what roles the care teams may play in re-engaging the member in treatment. Once the survey has been developed, it will be distributed to the appropriate providers and community based support programs for completion. The State will then analyze the results and develop next steps based on the data.<br>(Timeline: 18-24 months) |

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<sup>5</sup> Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ismicc\\_2017\\_report\\_to\\_congress.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf)

| Prompts                                                                                                                                                                 | Summary                                                                                                                                                                                                                                                                                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 6.2 Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis                                        | <b>Current State:</b><br>In the Local Authority Behavioral Health system, the entire care team providing services for an individual experiencing a first episode of psychosis utilizes the EHR in accessing records to coordinate care among the team.                                                                               |
|                                                                                                                                                                         | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                              |
|                                                                                                                                                                         | <b>Summary of Actions Needed:</b><br>None                                                                                                                                                                                                                                                                                            |
| <b>Identity Management (Section 7)</b>                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                      |
| 7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records | <b>Current State:</b><br>Currently no organizations in the Local Authority Behavioral Health system link children's records with parent caregiver records.                                                                                                                                                                           |
|                                                                                                                                                                         | <b>Future State:</b><br>No actions have been planned around this activity.                                                                                                                                                                                                                                                           |
|                                                                                                                                                                         | <b>Summary of Actions Needed:</b><br>None                                                                                                                                                                                                                                                                                            |
| 7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient                                                                      | <b>Current State:</b><br>Currently all Local Authority Behavioral Health providers utilize an EHR that allows all services provided by employees of the agency which includes all types of providers, including prescriber, therapist and case management/Peer Support , etc...to capture all episodes of care of any given patient. |
|                                                                                                                                                                         | <b>Future State:</b><br>The State will continue with the current state.                                                                                                                                                                                                                                                              |



|  |                                           |
|--|-------------------------------------------|
|  | <b>Summary of Actions Needed:</b><br>None |
|--|-------------------------------------------|

**Section 3: Relevant documents**

*Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.*

### Attachment C: Non-Traditional Benefit Package

State Name:  Attachment 3.1-L-   
0938-1148 Transmittal Number: - -

| Benefits Description                                                                                                                                                                                   | ABP5 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| <p>The state/territory proposes a “Benchmark-Equivalent” benefit package. No <input type="text"/></p>                                                                                                  |      |
| <p><b>Benefits Included in Alternative Benefit Plan</b></p> <p>Enter the specific name of the base benchmark plan selected: PEHP Utah Basic Plus</p> <div><p>Adult Medicaid Expansion</p></div>        |      |
| <p>Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter “Secretary-Approved.”</p> <div><p>Secretary Approved 1115 Waiver</p></div> |      |

■ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Outpatient Hospital Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization

Benefit Provided:

Clinic Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes ambulatory surgical centers and dialysis

Benefit Provided:

Family Planning Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Physician Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Medical and Surgical Services by a Dentist

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Podiatry

Source:

Secretary-Approved Other

Remove

Authorization

:

None

Provider Qualifications:

Medicaid State Plan

Amount  
Limit:

Varies

Duration Limit:

Varies

Scope Limit:

For residents of long term care facilities: footcare performed by an employee of the facility is not covered, visits are limited to one visit every 60 days, debridement of mycotic toenails is limited to one every 60 days

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Optometry Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

1 exam

Duration Limit:

12 months

Scope Limit:

Eyeglasses are not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Services Provided by Licensed Nurse Practitioners

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Home Health Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Hospice

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Audiology

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Hearing evaluations or assessments for hearing aids are covered, hearing aids covered only if hearing loss is congenital.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Personal Care Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 hours

Duration Limit:

30 days

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Add



■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

|                                                                                                                                |                          |        |
|--------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| Benefit Provided:                                                                                                              | Source:                  | Remove |
| Emergency Hospital Services                                                                                                    | Secretary-Approved Other |        |
| Authorization:                                                                                                                 | Provider Qualifications: |        |
| None                                                                                                                           | Medicaid State Plan      |        |
| Amount Limit:                                                                                                                  | Duration Limit:          |        |
| None                                                                                                                           | None                     |        |
| Scope Limit:                                                                                                                   |                          |        |
| None                                                                                                                           |                          |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: |                          |        |
| <div></div>                                                                                                                    |                          |        |

|                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| Benefit Provided:                                                                                                                                                                                                                                                                                                                                                                                                      | Source:                  | Remove |
| Ambulance Transportation                                                                                                                                                                                                                                                                                                                                                                                               | Secretary-Approved Other |        |
| Authorization:                                                                                                                                                                                                                                                                                                                                                                                                         | Provider Qualifications: |        |
| None                                                                                                                                                                                                                                                                                                                                                                                                                   | Medicaid State Plan      |        |
| Amount Limit:                                                                                                                                                                                                                                                                                                                                                                                                          | Duration Limit:          |        |
| None                                                                                                                                                                                                                                                                                                                                                                                                                   | None                     |        |
| Scope Limit:                                                                                                                                                                                                                                                                                                                                                                                                           |                          |        |
| None                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:                                                                                                                                                                                                                                                                                         |                          |        |
| <div>Ambulance services (ground, air or water) are covered for transportation in the following circumstances:<br/><input type="checkbox"/> Life of the member is in immediate danger<br/><input type="checkbox"/> Life support equipment or medical care is required during travel<br/><input type="checkbox"/> Other means of transportation would endanger the member's health or be medically contraindicated</div> |                          |        |

Add

■ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.
2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.
4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.
5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.
6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.
7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).
8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.

Add

■ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Extended Services to Pregnant Women

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes Inpatient Hospital Services as defined in EHB3; Outpatient Hospital Services, Family Planning Services, Physician Services, Home Health Services, Services provided by a Pediatric and Family Nurse Practitioners as defined in EHB3; Medical Supplies and Equipment as defined in EHB7.

Benefit Provided:

Perinatal Care Coordination

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Benefit Provided:

Prenatal and Postnatal Home Visits

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

6 Visits

Duration Limit:

12-month period

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Benefit Provided:

Group Prenatal/Postnatal Education

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

8 Units

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Benefit Provided:

Prenatal and Postnatal Psychosocial Counseling

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

12 Visits

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Benefit Provided:

Nutritional Assessment Counseling

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

14 Visits

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Benefit Provided:

Freestanding Birthing Clinics

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

Benefit Provided:

Extended Services for Pregnant Women-Other Service

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

In accordance with 42 CFR 440.250, pregnant women may receive pregnancy related services and services for other conditions that might complicate the pregnancy.

Add

Collapse All

☐ 5. Essential Health Benefit: Mental health and substance use disorder services including

- behavioral health treatment

|                                                                                                                                               |                                                 |        |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--------|
| Benefit Provided:<br>Psychiatric Diagnostic Evaluation                                                                                        | Source:<br>Secretary-Approved Other             | Remove |
| Authorization:<br>None                                                                                                                        | Provider Qualifications:<br>Medicaid State Plan |        |
| Amount Limit:<br>None                                                                                                                         | Duration Limit:<br>None                         |        |
| Scope Limit:<br>None                                                                                                                          |                                                 |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:<br><div></div> |                                                 |        |
| Benefit Provided:<br>Mental Health Assessment                                                                                                 | Source:<br>Secretary-Approved Other             | Remove |
| Authorization:<br>None                                                                                                                        | Provider Qualifications:<br>Medicaid State Plan |        |
| Amount Limit:<br>None                                                                                                                         | Duration Limit:<br>None                         |        |
| Scope Limit:<br>None                                                                                                                          |                                                 |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:<br><div></div> |                                                 |        |
| Benefit Provided:<br>Psychological Testing                                                                                                    | Source:<br>Secretary-Approved Other             | Remove |
| Authorization:<br>None                                                                                                                        | Provider Qualifications:<br>Medicaid State Plan |        |
| Amount Limit:<br>None                                                                                                                         | Duration Limit:<br>None                         |        |
| Scope Limit:<br>None                                                                                                                          |                                                 |        |

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychotherapy

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Pharmacologic Management-Rehabilitative Mental Hea

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Nurse Medication Management

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Therapeutic Behavioral Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychosocial Rehabilitative Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Peer Support Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan



Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Inpatient Hospital-Mental Health

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Residential and Inpatient Treatment for SUD

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 days

Duration Limit:

12 months

Scope Limit:

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.

SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD.

These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.

Add

☐ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

- Prescription Drug Limits (Check all that apply.):
- ☒ Limit on days supply
  - ☐ Limit on number of prescriptions
  - ☒ Limit on brand drugs
  - ☒ Other coverage limits

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Physical Therapy and Occupational Therapy

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

16

Duration Limit:

12 months

Scope Limit:

Limitations are combined for physical therapy and occupational therapy visits

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization may be obtained if the limit of 16 visits combined needs to be exceeded due to medical necessity .

Benefit Provided:

Prosthetic Devices

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Durable Medical Equipment and Supplies

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

Varies

Scope Limit:

Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The following items are excluded from coverage as benefits of the Medicaid program:

1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.
9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.
  - a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.

Add

☐ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:

Other Laboratory and X-Ray Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☒ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

|                                                                                                                                                                                                                                                            |                          |        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| Benefit Provided:                                                                                                                                                                                                                                          | Source:                  | Remove |
| Diabetes Self-Management Training                                                                                                                                                                                                                          | Secretary-Approved Other |        |
| Authorization:                                                                                                                                                                                                                                             | Provider Qualifications: |        |
| Authorization required in excess of limitation                                                                                                                                                                                                             | Medicaid State Plan      |        |
| Amount Limit:                                                                                                                                                                                                                                              | Duration Limit:          |        |
| 10 hours                                                                                                                                                                                                                                                   | 12-month period          |        |
| Scope Limit:                                                                                                                                                                                                                                               |                          |        |
| Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients. |                          |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:                                                                                                                             |                          |        |
| Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.                                                                       |                          |        |

|                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------|
| Benefit Provided:                                                                                                                                                                                                                                                                                                                                                                                                                           | Source:                  | Remove |
| Tobacco Cessation                                                                                                                                                                                                                                                                                                                                                                                                                           | Secretary-Approved Other |        |
| Authorization:                                                                                                                                                                                                                                                                                                                                                                                                                              | Provider Qualifications: |        |
| None                                                                                                                                                                                                                                                                                                                                                                                                                                        | Medicaid State Plan      |        |
| Amount Limit:                                                                                                                                                                                                                                                                                                                                                                                                                               | Duration Limit:          |        |
| 7                                                                                                                                                                                                                                                                                                                                                                                                                                           | 12 months                |        |
| Scope Limit:                                                                                                                                                                                                                                                                                                                                                                                                                                |                          |        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                             |                          |        |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:                                                                                                                                                                                                                                                                                                              |                          |        |
| Within the State Plan this benefit is entitled "Face-to-face Tobacco Cessation Counseling Services for Pregnant Women." Tobacco cessation services are not only covered for pregnant women. The State provides tobacco cessation services under the State Plan benefits including Physician Services, Outpatient Hospital Services, Prescribed Drugs, and Clinic Services. Utah Medicaid offers a total of 7 sessions in a 12-month period. |                          |        |

Add

☐ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Remove

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Through age 20

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

11. Other Covered Benefits from Base Benchmark Collapse All

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Adoption: Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Adoption was removed and replaced in EHB 1 by substitution with the actuarial value of personal care services which are not covered in the Base Benchmark.

Base Benchmark Benefit that was Substituted:

Primary Care Visit to Treat an Injury: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Specialist Visit: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visit: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services (for Physician Assistants working under supervision) and Services Provided by Licensed Nurse Practitioners, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Outpatient Facility Fee: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Outpatient Surgery Physician/Surgical Services: Du

Source:

Base Benchmark

Remove



Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Outpatient Hospital Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Hospice Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Hospice Services, under EHB 1. Base Benchmark Plan: Limitation of 6 months per 3 years

Base Benchmark Benefit that was Substituted:

Urgent Care Centers: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations.

Base Benchmark Benefit that was Substituted:

Home Health Care: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Home Health Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Skilled Nursing Facility Services, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period

Base Benchmark Benefit that was Substituted:

Dialysis: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Chemotherapy and Radiation: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Infusion Therapy: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Outpatient Hospital Services, Clinic Services, and Home Health Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Reconstructive Surgery: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services, under EHB 1. Medicaid Limits: Covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention. Base Benchmark Plan: Covered when performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function.

Base Benchmark Benefit that was Substituted:

Emergency Room Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Emergency Hospital Services , under EHB 2. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Ambulance Transportation, under EHB 2. Medicaid Limitation: Medical emergencies only as defined by Utah Medicaid. Base Benchmark Plan: Limitation medical emergencies only, as determined by PEHP

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physical Therapy and Occupational Therapy under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 16 visits each per 12 months. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted:

Habilitation Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physical Therapy and Occupational Therapy under EHB7. Medicaid Limitations: Physical and Occupational Therapies limited to 16 visits each per 12 months. Prior authorization required for additional visits. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Base Benchmark Benefit that was Substituted:

Cardiac Rehabilitation: Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Cardiac rehabilitation was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Cardiac Rehabilitation, Phase 2, following heart attack, cardiac surgery, severe angina (chest pain), and Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment/Supply: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Durable Medical Equipment and Medical Supplies in EHB7. Medicaid Limitations: The following items are excluded from coverage as benefits of the Medicaid program:

1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.

9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.

a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.

Base Benchmark: Except for oxygen, DME over \$750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require preauthorization. Maximum limits apply on many items. Sleep Disorder equipment is not covered. TENS units, Neuromuscular stimulator, H-Wave electronic devices, Sympathetic therapy stimulators are not covered.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility/Rehabilitation:See Notes

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year. Requires preauthorization. This services is not detailed as a covered service for this benefit package.

Base Benchmark Benefit that was Substituted:

Inpatient Hospitalization: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Medicaid Limitations: 1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State

of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.

2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.

3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.

4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.

5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.

6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.

Base Benchmark: The following are Exclusions of the policy:

1. Ineligible Surgical Procedures or related Complications.

2. Treatment programs for enuresis or encopresis.

3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.

4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.

5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community

reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.

6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications., unless legally required and approved by PEHP.
12. Mastectomy for gynecomastia.
13. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
14. Breast reduction.
15. Tests and treatment for infertility.
16. Blepharoplasty (or other eyelid Surgery).
17. All facility claims related to a Hospital stay when the Member is discharged against medical advice.
18. Sclerotherapy of varicose veins.
19. Microphlebectomy (stab phlebectomy).
20. Blood clotting factor.
21. Inpatient or outpatient dental hospitalization.

Base Benchmark Benefit that was Substituted:

MH-Substance Facility and Hospital Services-Duplic

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Preauthorization required for many services. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed. Day treatment or intensive outpatient programs require Preauthorization. If approved, Benefit applied is the same as inpatient.

Base Benchmark Benefit that was Substituted:

MH-Substance Inpatient Provider Visits-Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Only one visit per Provider of the same specialty per day is payable.

1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.

5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
13. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted:

MH-Substance Outpatient Provider Visits-Duplicatio

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. Only one visit per Provider of the same specialty per day is payable.

1. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
2. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Wilderness programs.
4. Inpatient treatment for behavior modification, enuresis, or encopresis.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or Recreational Therapy.
7. Sodium amobarbital interviews.
8. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
9. Tobacco abuse.

Base Benchmark Benefit that was Substituted:

Lab, X-Ray, and Diagnostic Imaging: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Secretary Approved 1115 Waiver as Other Laboratory and X-Ray Services in EHB8. Base Benchmark:

1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to

the potential diagnosis.

2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.

3. Drug screening, up to 2 times in a 30-day period.

4. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.

The following are Exclusions of the policy:

1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.

2. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.

3. Sublingual or colorimetric allergy testing.

4. Charges in conjunction with weight loss programs regardless of Medical Necessity.

5. Epidemiological counseling and testing.

6. Probability and predictive analysis and testing.

7. Unbundling of lab charges or panels.

8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

9. Hair analysis, trace elements, or dental filling toxicity.

10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.

11. Sleep Studies for sleep disorders.

12. Services in conjunction with diagnosing infertility.

13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.

14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

15. Whole exome and whole genome sequencing for the diagnosis of genetic disorders.

16. Chromosomal Microarray Analysis (CMA) for Autism Spectrum Disorder.

Base Benchmark Benefit that was Substituted:

Preventive Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Extended Services for Pregnant Women and Prenatal and Postnatal Home Visits in EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted:

Delivery and All Inpatient for Maternity: Duplicat

Source:

Base Benchmark

Remove



Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Allergy Testing: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Diabetes Education-Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Diabetes Self-Management Education in EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Transplant-Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Speech Language Pathology-Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Speech Language Pathology Services was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Physical, Occupational, and Speech Therapy limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Add





Release All

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                           |               |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------|
| <p>Other 1937 Benefit Provided:<br/>Targeted Case Management for Tuberculosis</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <p>Source:<br/>Section 1937 Coverage Option Benchmark Benefit Package</p> | <p>Remove</p> |
| <p>Authorization:<br/>Other</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>Provider Qualifications:<br/>Medicaid State Plan</p>                   |               |
| <p>Amount Limit:<br/>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <p>Duration Limit:<br/>None</p>                                           |               |
| <p>Scope Limit:<br/>None</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                           |               |
| <p>Other:<br/>Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.</p> |                                                                           |               |

|                                                                                                                                                                                                                                                                                                                                                                               |                                                                           |               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------|
| <p>Other 1937 Benefit Provided:<br/>Routine Patient Cost in Qualifying Clinical Trials</p>                                                                                                                                                                                                                                                                                    | <p>Source:<br/>Section 1937 Coverage Option Benchmark Benefit Package</p> | <p>Remove</p> |
| <p>Authorization:<br/>Other</p>                                                                                                                                                                                                                                                                                                                                               | <p>Provider Qualifications:<br/>Medicaid State Plan</p>                   |               |
| <p>Amount Limit:<br/>None</p>                                                                                                                                                                                                                                                                                                                                                 | <p>Duration Limit:<br/>None</p>                                           |               |
| <p>Scope Limit:<br/>None</p>                                                                                                                                                                                                                                                                                                                                                  |                                                                           |               |
| <p>Other:<br/>This benefit is subject to the provisions set forth for qualifying clinical trials as found in the "Consolidated Appropriations Act, 2021" amendment to Section 1905 of the Social Security Act (42 U.S.C. 1396d). See Supplement to Attachment 3-A, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials in Utah's Medicaid State Plan.</p> |                                                                           |               |

Other 1937 Benefit Provided:  
Medication-Assisted Treatment (MAT)

Source:  
Section 1937 Coverage Option Benchmark Benefit  
Package

[Remove](#)

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Other

Scope Limit:

None

Other:

This benefit is subject to the provisions set forth for medication-assisted treatment pursuant to Section 1006(b) of the SUPPORT Act, an amendment to Section 1905(a)(29) of the Social Security Act (42 U.S.C. 1396d). MAT is provided as defined in the approved State Plan 3.1-A and, if applicable, 3.1-B pages. MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.



☐

15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

**Attachment D: Traditional Benefit Package**

☐

State Name:  Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number:        -        -

| Benefits Description                                                                                                                                                                                                  | ABP5 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|
| The state/territory proposes a “Benchmark-Equivalent” benefit package. <input type="text" value="No"/>                                                                                                                |      |
| <b>Benefits Included in Alternative Benefit Plan</b>                                                                                                                                                                  |      |
| <div><div>Enter the specific name of the base benchmark plan selected:</div><div>PEHP Utah Basic Plus<br/>Adult expansion population who are childless adults or non-custodial parent<br/>Targeted Adults</div></div> |      |
| <div><div>Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter “Secretary-Approved.”</div><div>Secretary-Approved</div></div>                     |      |

■ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided:

Outpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization. Reconstructive surgery is covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

Benefit Provided:

Clinic Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization. Services includes ambulatory surgical centers and dialysis.

Benefit Provided:

Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization. Reconstructive surgery is covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

Benefit Provided:

Services Provided by Licensed Nurse Practitioners

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization.

Benefit Provided:

Personal Care Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 hours

Duration Limit:

30-day period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Add



2. Essential Health Benefit: Emergency services

Collapse All

Benefit Provided: Emergency Hospital Services

Source:

Authorization: None

Amount Limit: None

Scope Limit: None

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None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Ambulance Transportation

Authorization: None

Amount Limit: None

Scope Limit: None

Source:

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None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:

1. Life of the member is in immediate danger
2. Life support equipment or medical care is required during travel
3. Other means of transportation would endanger the member's health or be medically contraindicated

■ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.
2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.
4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.
5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.
6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E in the Utah State Plan.
7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a) in the Utah State Plan.
8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.
9. Reconstructive surgery is covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

Benefit Provided:

Inpatient Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Transplant

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount

Limit: None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A

■ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided:

Extended Services to Pregnant Women

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization.

Benefit Provided:

Inpatient Care for Maternity and Newborn

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Physician Services for Maternity and Newborn

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Source:

Prenatal/Postnatal Care

State Plan

Authorization:

1905(a)

Authorization required in excess of limitation

Provider

Amount Limit: Varies

Qualificati

Scope Limit: Varies

ons:

Medicaid

State Plan

Duration

Limit:

Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include the following:

1. Prenatal and postnatal home visits, 6 visits in a 12-month period. This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.
2. Group prenatal/postnatal education, 8 units in a 12-month period. This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.
3. Prenatal/postnatal psychosocial counseling, 12 visits in a 12-month period. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.
4. Nutritional assessment counseling, 14 visits in a 12-month period. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Add

5. Essential Health Benefit: Mental health and substance use disorder services including

Collapse All



☒ behavioral health treatment

Benefit Provided:

Psychiatric Diagnostic Evaluation

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Benefit Provided:

Mental Health Assessment

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychological Testing

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None



Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychotherapy

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Pharmacologic Management-Rehabilitative Mental Hea

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Nurse Medication Management

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Therapeutic Behavioral Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Psychosocial Rehabilitative Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Peer Support Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Inpatient Hospital-Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services are not provided for members in Institutions for Mental Disease for those ages 21-64.

Benefit Provided:

Inpatient Treatment for SUD

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical detoxification only

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Residential Treatment

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 days

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.

SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD. These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.

☐ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

- Prescription Drug Limits (Check all that apply.):
- ☒ Limit on days supply
  - ☐ Limit on number of prescriptions
  - ☒ Limit on brand drugs
  - ☒ Other coverage limits
  - ☒ Preferred drug list

Authorization:

Yes

Provider Qualifications:

State licensed

Coverage that exceeds the minimum requirements or other:

The State of Utah's ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All ☐

Benefit Provided:

Skilled Nursing Facility Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Utah assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Rehabilitative and habilitative limits are combined, limits may be exceeded based on medical necessity.

Benefit Provided:

Physical Therapy-Rehabilitative and Habilitative

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Durable Medical Equipment and Supplies

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

Varies

Scope Limit:

Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include foot orthotics and prosthetics.

The following items are excluded from coverage as benefits of the Medicaid program:

1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.
9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.
  - a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.

Benefit Provided:

Occupational Therapy-Rehabilitative and Habilitati

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20

Duration Limit:

12-month period

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Speech Language Pathology-Rehab and Habilitative

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Varies

Duration Limit:

Varies

Scope Limit:

Varies

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Limitation:

1. One speech evaluation per client per year is a covered service.

Benefit Provided:

Home Health Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include home health nursing services and home health aide services.

Benefit Provided:

Physical Therapy in the Home

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:

Hospice

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None



Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services include the following:

1. Routine home care
2. Continuous home care
3. Inpatient respite care
4. Room and board
5. General inpatient care

☐ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Benefit Provided:

Other Laboratory and X-Ray Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Some services require prior authorization.

A

☒ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management

Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA’s Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

|                                                                                                                                                                                                                                                            |                 |                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------|
| <b>Benefit Provided:</b>                                                                                                                                                                                                                                   |                 | <b>Source:</b> |
| Diabetes Self-Management Training                                                                                                                                                                                                                          |                 | State Plan     |
| Authorization:                                                                                                                                                                                                                                             | 1905(a)         |                |
| Authorization required in excess of limitation                                                                                                                                                                                                             | Provider        |                |
| Amount Limit: 10 hours                                                                                                                                                                                                                                     | Qualificati     |                |
| Scope Limit:                                                                                                                                                                                                                                               | ons:            |                |
|                                                                                                                                                                                                                                                            | Medicaid        |                |
|                                                                                                                                                                                                                                                            | State Plan      |                |
|                                                                                                                                                                                                                                                            | Duration        |                |
|                                                                                                                                                                                                                                                            | Limit:          |                |
|                                                                                                                                                                                                                                                            | 12-month period |                |
| Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients. |                 |                |
| Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:                                                                                                                             |                 |                |
| Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.                                                                       |                 |                |
| <b>Benefit Provided:</b> Tobacco Cessation                                                                                                                                                                                                                 | <b>Source:</b>  |                |
| Authorization: None                                                                                                                                                                                                                                        | S               |                |
| Amount Limit: 7                                                                                                                                                                                                                                            | t               |                |
| Scope Limit: None                                                                                                                                                                                                                                          | a               |                |
|                                                                                                                                                                                                                                                            | t               |                |
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12-month period

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

☐ 10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All ☐

Benefit Provided:

Medicaid State Plan EPSDT Benefits

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Through age 20

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

A

|                                                               |
|---------------------------------------------------------------|
| 11. Other Covered Benefits from Base Benchmark   Collapse All |
|---------------------------------------------------------------|

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication

Collapse All ☐

Base Benchmark Benefit that was Substituted:

Source:

Remove

Inpatient Physician and Surgical Services: Duplication

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services and Inpatient Physician Services, under EHB3 and Physician Services, under EHB1.

Base Benchmark: The following are exclusions of the surgical policy:

1. Breast Reconstructive Surgery, augmentation or implants solely for cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes or any other complication(s) of cosmetic or non-covered breast surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future complications.
4. Any service or Surgery that is solely for cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
  - a. Breast Reconstructive Surgery as allowed under WHCRA for Cosmetic purposes: and
  - b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years and requires preauthorization.
6. Assisted reproductive technologies: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body.
- Any related services performed in conjunction with these procedures are also excluded.
7. Surgical treatment for correction of refractive errors.
8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible.
9. Reversal of sterilization.
10. Gender reassignment Surgery.
11. Rhytidectomy.
12. Dental services, except when the result of an accident, including surgery, care, and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia, periodontia, and orthodontia, including anesthesia or supplies used in such care.
13. Complications as a result of non-covered or ineligible Surgery, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
14. Injection of collagen, except as approved for urological procedures.
15. Lipectomy, abdominoplasty, panniculectomy, unless any of these procedures are medically necessary to treat an unintended adverse event of an eligible surgery.
16. Repair of diastasis recti.
17. Sperm banking system, storage, treatment, or other such services.
18. Non-FDA approved or experimental or investigational procedures, drugs and Devices.
19. Hair transplants or other treatment for hair loss or restoration.
20. Chemical peels.
21. Treatment for spider or reticular veins.
22. Liposuction.
23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.

26. Any Surgery solely for snoring.  
27. Otoplasty.  
28. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.  
29. Surgical treatment for sexual dysfunction.  
30. Subtalar implants.  
31. Additional fees charged because a robotic surgical system was used during surgery.  
32. Mastectomy for gynecomastia.  
33. Elective home delivery for childbirth.

Base Benchmark Benefit that was Substituted:

Primary Care Visit to Treat an Injury: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Specialist Visit: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visit: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services (for Physician Assistants working under supervision) and Services Provided by Licensed Nurse Practitioners, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Outpatient Facility Fee: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Outpatient Surgery Physician/Surgical Services: Du

Source:

Base Benchmark

Remove



Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Hospice Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Hospice Services, under EHB 7. Base Benchmark Plan: Limitation of 6 months per 3 years. The following are Exclusions of the policy:

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral nutrition, unless obtained through the pharmacy card.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations.

Base Benchmark Benefit that was Substituted:

Home Health Care: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Home Health Services under EHB 7, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period. The following are Exclusions of the policy:

1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to provider's offices or elsewhere, or food services.

7. Total Parenteral Nutrition through Hospice.  
8. Enteral Nutrition, unless obtained through the pharmacy card.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Skilled Nursing Facility Services under EHB 7. Base Benchmark Plan: Limitation 30 days per plan year

Base Benchmark Benefit that was Substituted:

Dialysis: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Chemotherapy and Radiation: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Infusion Therapy: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, Clinic Services, under EHB 1, and Home Health Services, under EHB7. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Reconstructive Surgery: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: Covered when performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function. While the Medicaid limitation language, found under Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services listed above in EHB 1 and EHB 3 is more succinct, the scope of the benefit is equal. Infection and tumors can be classified under disease and a developmental anomaly is a broad term used to define conditions which are

present at conception or occur before the end of pregnancy (also classified as congenital), those that occur after are due to things such as cerebral palsy and can be classified as disease-related.

Base Benchmark Benefit that was Substituted:

Emergency Room Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Emergency Hospital Services, under EHB 2. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Emergency Transportation/Ambulance: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Ambulance Transportation, under EHB 2. Base Benchmark Plan: Limitation medical emergencies only, as determined by PEHP

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted:

Habilitation Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted:

Cardiac Rehabilitation: Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Cardiac rehabilitation was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Cardiac Rehabilitation, Phase 2, following heart attack, cardiac surgery, severe angina (chest pain), and

Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment/Supply: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Durable Medical Equipment and Medical Supplies, under EHB7.

Base Benchmark: Except for oxygen, DME over \$750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require preauthorization. Maximum limits apply on many items. Sleep Disorder equipment is not covered. TENS units, Neuromuscular stimulator, H-Wave electronic devices, Sympathetic therapy stimulators are not covered.

The following are excluded:

1. Training and testing in conjunction with Durable Medical Equipment or prosthetics;
2. More than one lens for each affected eye following Surgery for corneal transplant;
3. Durable Medical Equipment that is inappropriate for the patient's medical condition;
4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit;
5. Equipment purchased from non-licensed Providers;
6. Used Durable Medical Equipment;
7. TENS Unit;
8. Neuromuscular Stimulator;
9. H-wave Electronic Device;
10. Sympathetic Therapy Stimulator (STS);
11. Limb prosthetics;
12. Machine rental or purchase for the treatment of sleep disorders;
13. Support hose for phlebitis or other diagnosis.
14. Foot orthotics.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility and Rehabilitation: Dupli

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Skilled Nursing Facility Services in EHB7. Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year.

Base Benchmark Benefit that was Substituted:

Inpatient Hospitalization: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Inpatient Hospital Services in EHB3.

Base Benchmark:

The following are Exclusions of the policy:

1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP

plan, and the transplant is eligible.

9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.

10. Custodial Care and/or maintenance therapy.

11. Take-home medications., unless legally required and approved by PEHP.

12. Mastectomy for gynecomastia.

13. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.

14. Breast reduction.

15. Tests and treatment for infertility.

16. Blepharoplasty (or other eyelid Surgery).

17. All facility claims related to a Hospital stay when the Member is discharged against medical advice.

18. Sclerotherapy of varicose veins.

19. Microphlebectomy (stab phlebectomy).

20. Blood clotting factor.

21. Inpatient or outpatient dental hospitalization.

Base Benchmark Benefit that was Substituted: Lab, X-Ray,

Source:

and Diagnostic Imaging: Duplication

Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Other Laboratory and X-Ray Services, under EHB8. Base Benchmark:

1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.

2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.

3. Drug screening, up to 2 times in a 30-day period.

4. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.

The following are Exclusions of the policy:

1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.

2. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.

3. Sublingual or colorimetric allergy testing.

4. Charges in conjunction with weight loss programs regardless of Medical Necessity.

5. Epidemiological counseling and testing.

6. Probability and predictive analysis and testing.

7. Unbundling of lab charges or panels.

8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.

9. Hair analysis, trace elements, or dental filling toxicity.

10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.

11. Sleep Studies for sleep disorders.

12. Services in conjunction with diagnosing infertility.

13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.

14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted:

Preventive Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Extended Services for Pregnant Women and Prenatal/Postnatal Care under EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted:

Delivery and All Inpatient for Maternity: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3 and Inpatient Care for Maternity and Newborn in EHB4. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:

Allergy Testing: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physician Services, under EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Diabetes Education: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Diabetes Self-Management Education, under EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Transplant: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Transplant Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 20 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted:

Imaging (CT/PET Scans, MRIs)

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Other Laboratory and X-Ray Services in EHB8. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted:

Nutritional Counseling: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Utah Medicaid State Plan as Physician Services and Services Provided by Licensed Nurse Practitioners in EHB1. Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted:

Inherited Metabolic Disorder-Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under Physician Services and Outpatient Hospital Services in EHB1 and Inpatient Hospital Services in EHB3. Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted:

MH-Substance Outpatient Provider Visits-Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication



Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5 Tobacco Cessation, under EHB9. Base Benchmark Plan: 8 visits per plan year combined mental health and substance abuse disorder outpatient services. Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. Only one visit per Provider of the same specialty per day is payable.

1. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
2. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Wilderness programs.
4. Inpatient treatment for behavior modification, enuresis, or encopresis.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or Recreational Therapy.
7. Sodium amobarbital interviews.
8. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
9. Tobacco abuse.

Base Benchmark Benefit that was Substituted:

MH-Substance/Facil and Hospital Svcs-Duplic/Substi

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, Inpatient Treatment for SUD, and Peer Support Services, under EHB5. The base benchmark benefit for inpatient treatment for SUD has a greater scope than the Medicaid benefit, therefore, the State submits Residential Treatment, under EHB5 as a substitution for the difference in scope. Base Benchmark Plan: 30 days per plan year combined mental health and substance abuse disorder services. Preauthorization required for many services. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed. Day treatment or intensive outpatient programs require Preauthorization. If approved, Benefit applied is the same as inpatient.

Base Benchmark Benefit that was Substituted:

MH-Substance/Inpatient Provider Visits-Dupl/Substi

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, Inpatient Treatment for SUD, and Peer Support Services, under EHB5. The base benchmark benefit for inpatient treatment for SUD has a greater scope than the Medicaid benefit, therefore, the State submits Residential Treatment, under EHB5 as a substitution for the difference in scope.

Base Benchmark Plan: Only one visit per Provider of the same specialty per day is payable.

1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan.



2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.
5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
13. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted:

Adoption: Substitution

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Adoption was removed and replaced in EHB 1 by substitution with the actuarial value of personal care services which are not covered in the Base Benchmark.

Base Benchmark Benefit that was Substituted:

MH-Substance for Tobacco Abuse: Duplication

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Covered under the Utah Medicaid State Plan as Tobacco Cessation, under EHB 9. Base Benchmark: Covered under Mental Health and Substance Abuse Disorder Treatment, outpatient visits are limited to 8 per plan year.

Add

|                                                               |
|---------------------------------------------------------------|
| 13. Other Base Benchmark Benefits Not Covered    Collapse All |
|---------------------------------------------------------------|

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All ☐

Other 1937 Benefit Provided:

Family Planning Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Targeted Case Mgmt - Chronically Mentally Ill

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Specialized services for mentally ill individuals means the services from an individualized plan of care that:

- a. Are prescribed only for persons experiencing an acute episode of serious mental illness, which necessitates supervision of trained mental health personnel;
- b. Are developed and supervised by an interdisciplinary team, which includes a physician and qualified mental health professionals;
- c. Are directed toward reducing behavioral symptoms and improving his or her level of independent functioning level that permits reduction in the intensity of mental health services; and
- d. Are usually limited to inpatient psychiatric hospital care and care in an institution for mental diseases. Certain individuals, as applicable, are not precluded from receiving such services in a nursing facility

Other 1937 Benefit Provided:

Nursing Facility Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:  
Prior Authorization

Amount Limit:  
None

Scope Limit:  
Long term custodial care

Other:  
Must meet institutional level of care

Provider Qualifications: Medicaid  
State Plan

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Other 1937 Benefit Provided:  
Targeted Case Management for Tuberculosis

Authorization: Other  
Amount Limit: None  
Scope Limit: None  
Other:

Source:  
Section 1937 Coverage Option Benchmark  
Benefit Package  
Provider Qualifications: Medicaid  
State Plan

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Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete

treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

Other 1937 Benefit Provided: Optometry Services

Source:

Section 1937 Coverage Option  
Benchmark Benefit Package

Authorization:

Other

Amount Limit:

None

Scope Limit:

None

Other:

Prior authorization is not required.

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Other 1937 Benefit Provided:

Medical and Surgical Services by a Dentist

Authorization: Other

Amount Limit: None

Scope Limit: None

Other:

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Services include emergency dental. Emergency dental services are the treatment of a sudden and acute onset of a dental condition that requires immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

|                                       |                              |
|---------------------------------------|------------------------------|
| Other 1937 Benefit Provided: Podiatry | Source:                      |
|                                       | Section 1937 Coverage Option |
|                                       | Benchmark Benefit Package    |
| Authorization: Other                  | P                            |
| Amount Limit: Varies                  | r                            |
| Scope Limit: None                     | o                            |
| Other:                                | v                            |
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For residents of long term care facilities: footcare performed by an employee of the facility is not covered, visits are limited to one visit every 60 days, debridement of mycotic toenails is limited to one every 60 days.



Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Varies

Other:

Hearing aids are non-covered.

Other 1937 Benefit Provided:

Perinatal Care Coordination

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Other 1937 Benefit Provided:

Freestanding Birthing Clinics

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk

and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

Other 1937 Benefit Provided:

Long Term Acute Care-Rehabilitative

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Routine Patient Cost in Qualifying Clinical Trials

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

This benefit is subject to the provisions set forth for qualifying clinical trials as found in the "Consolidated Appropriations Act, 2021" amendment to Section 1905 of the Social Security Act (42 U.S.C. 1396d). See Supplement to Attachment 3-A, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials in Utah's Medicaid State Plan.

Other 1937 Benefit Provided:

Medication-Assisted Treatment (MAT)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

Other

Scope Limit:

None

Other:

This benefit is subject to the provisions set forth for medication-assisted treatment pursuant to Section 1006(b) of the SUPPORT Act, an amendment to Section 1905(a)(29) of the Social Security Act (42 U.S.C. 1396d). MAT is provided as defined in the approved State Plan 3.1-A and, if applicable, 3.1-B pages. MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

#### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

### Attachment E: Modified Adjusted Gross Income (MAGI) Conversion Table

|                               | Population Group                                                                                                                       | SIPP results used? (Yes/No) | Time Period selected                                   | Sampling (Yes/No) | Net Income Standard                                                                                                                                                                                                                                                                                                                                                                                                              | Income band used in conversion*                                                                                                                                                                                                                                                                                                                                                                                   |  | Converted Standard                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                               | A                                                                                                                                      | B                           | C                                                      | D                 | E                                                                                                                                                                                                                                                                                                                                                                                                                                | F                                                                                                                                                                                                                                                                                                                                                                                                                 |  | G                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Conversions for FMAP Claiming |                                                                                                                                        |                             |                                                        |                   |                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 1                             | Parents/Caretaker Relatives<br>(Expand number of rows for family size as needed for larger family size standards defined by the state) | <b><u>NO</u></b>            | <b><u>Converted in Part 1 and described there.</u></b> | <b><u>NO</u></b>  | % FPL<br><br>Fixed dollar standards<br>Family size<br>1 <u>\$382</u><br>2 <u>\$468</u><br>3 <u>\$583</u><br>4 <u>\$682</u><br>5 <u>\$777</u><br>6 <u>\$857</u><br>7 <u>\$897</u><br>8 <u>\$938</u><br>9 <u>\$982</u><br>10 <u>\$1023</u><br>11 <u>\$1066</u><br>12 <u>\$1108</u><br>13 <u>\$1150</u><br>14 <u>\$1192</u><br>15 <u>\$1236</u><br>16 <u>\$1277</u><br>Add-on for additional family members if relevant <u>\$42</u> | % FPL<br><br><b>or</b><br>FPL% by family size (Fixed dollar standards)<br>1 – 16.0-41.0%<br>2 – 12.1-37.1%<br>3 – 11.6-36.6%<br>4 – 10.5-35.5%<br>5 – 9.5-34.5%<br>6 – 8.2-33.2%<br>7 – 5.8-30.8%<br>8 – 3.9-28.9%<br>9 – 2.5-27.5%<br>10 – 1.2-26.2%<br>11 – 0.2-25.2%<br>12 – 0-24.3%<br>13 – 0-23.5%<br>14 - 0-22.8%<br>15 - 0-22.3%<br>16 - 0-21.7%<br>Add-on for additional family members if relevant _____ |  | % FPL<br><br>Fixed dollar standards<br>Family size<br>1 <u>\$438</u><br>2 <u>\$544</u><br>3 <u>\$678</u><br>4 <u>\$797</u><br>5 <u>\$912</u><br>6 <u>\$1012</u><br>7 <u>\$1072</u><br>8 <u>\$1132</u><br>9 <u>\$1196</u><br>10 <u>\$1257</u><br>11 <u>\$1320</u><br>12 <u>\$1382</u><br>13 <u>\$1443</u><br>14 <u>\$1505</u><br>15 <u>\$1569</u><br>16 <u>\$1630</u><br>Add-on for additional family members if relevant <u>\$62</u> |
| 2                             | Non-institutionalized disabled adults                                                                                                  | <b><u>YES</u></b>           | <b><u>N/A</u></b>                                      | <b><u>N/A</u></b> | % FPL <u>100%</u><br><br>% SSI FBR<br><br>Dollar Standards<br>Single _____<br>Couple _____                                                                                                                                                                                                                                                                                                                                       | %FPL _____<br><br>% SSI FBR<br><br>Dollar Standards<br>Single _____<br>Couple _____                                                                                                                                                                                                                                                                                                                               |  | % FPL <u>102%</u><br><br>% SSI FBR<br><br>Dollar Standards<br>Single _____<br>Couple _____<br><br>Conversion based on:<br><br>Average disregard<br>Median disregard                                                                                                                                                                                                                                                                  |

|   | Population Group                                                                              | SIPP results used? (Yes/No) | Time Period selected | Sampling (Yes/No) | Net Income Standard                                                                                                                                                                                              | Income band used in conversion*                                                                                                                                                                                  |  | Converted Standard                                                                                                                                                                                               |
|---|-----------------------------------------------------------------------------------------------|-----------------------------|----------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|   | A                                                                                             | B                           | C                    | D                 | E                                                                                                                                                                                                                | F                                                                                                                                                                                                                |  | G                                                                                                                                                                                                                |
| 3 | Institutionalized disabled adults<br>(This is a gross income category: fill in column G only) |                             |                      |                   |                                                                                                                                                                                                                  |                                                                                                                                                                                                                  |  | % FPL _____<br><br>% SSI FBR <u>300%</u><br><b>or</b><br>Dollar Standards<br>Single _____<br>Couple _____                                                                                                        |
| 4 | Children age 19 and/or 20<br><b>Specify age limit as of 12/1/09 (19 or 20):</b><br>_____<br>- | <u>N/A</u>                  |                      |                   | % FPL _____<br>_____ or _____<br>Fixed dollar standards<br>Family size<br>1 _____<br>2 _____<br>3 _____<br>4 _____<br>5 _____<br>6 _____<br>7 _____<br>_____<br>Add-on for additional family members if relevant | % FPL _____<br>_____ or _____<br>Fixed dollar standards<br>Family size<br>1 _____<br>2 _____<br>3 _____<br>4 _____<br>5 _____<br>6 _____<br>7 _____<br>_____<br>Add-on for additional family members if relevant |  | % FPL _____<br>_____ or _____<br>Fixed dollar standards<br>Family size<br>1 _____<br>2 _____<br>3 _____<br>4 _____<br>5 _____<br>6 _____<br>7 _____<br>_____<br>Add-on for additional family members if relevant |
| 5 | Childless Adults                                                                              | <u>N/A</u>                  |                      |                   | % FPL _____                                                                                                                                                                                                      | % FPL _____                                                                                                                                                                                                      |  | % FPL _____                                                                                                                                                                                                      |

## Attachment F: Claiming Methodologies

### METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

#### Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on December 20, 2019. In general, and subject to any adjustments described in this attachment, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

**Table 1: Adult Group Eligibility Standards and FMAP Methodology Feature**

| Covered Populations Within New Adult Group |                                                                                                                                                                                                  | Applicable Population Adjustment                                                                                                                                                                        |                |                       |                   |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------|-------------------|
| Population Group                           | Relevant Population Group Income Standard                                                                                                                                                        | Resource Proxy                                                                                                                                                                                          | Enrollment Cap | Special Circumstances | Other Adjustments |
|                                            | For each population group, indicate the lower of:                                                                                                                                                |                                                                                                                                                                                                         |                |                       |                   |
|                                            | <ul style="list-style-type: none"><li>• The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or</li><li>• 133% FPL.</li></ul> |                                                                                                                                                                                                         |                |                       |                   |
|                                            | If a population group was not covered as of 12/1/09, enter “Not covered”.                                                                                                                        |                                                                                                                                                                                                         |                |                       |                   |
|                                            |                                                                                                                                                                                                  | Enter “Y” (Yes), “N” (No), or “NA” in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments. |                |                       |                   |
| A                                          | B                                                                                                                                                                                                | C                                                                                                                                                                                                       |                | D                     |                   |
| Parent/Caretaker Relatives                 | Attachment 1, Column C, line 1 of part 2 of the CMS approved MAGI Conversion Plan                                                                                                                | No                                                                                                                                                                                                      | No             | No                    | No                |
| Non-institutionalized Disabled Persons     | Attachment 1, Column C, line 2 of part 2 of the CMS approved MAGI Conversion Plan                                                                                                                | No                                                                                                                                                                                                      | No             | No                    | No                |
| Institutionalized Disabled Person          | Attachment 1, Column C, line 3 of part 2 of the CMS approved MAGI Conversion Plan                                                                                                                | No                                                                                                                                                                                                      | No             | No                    | No                |
| Children Age 19-20                         | Not covered                                                                                                                                                                                      | n/a                                                                                                                                                                                                     | n/a            | n/a                   | n/a               |
| Childless Adults                           | Attachment 1, Column C, line 5 of part 2 of the CMS approved MAGI Conversion Plan                                                                                                                | No                                                                                                                                                                                                      | No             | No                    | No                |

**Part 2 – Population-based Adjustments to the Newly Eligible Population  
Based on Resource Test, Enrollment Cap or Special Circumstances**

**A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))**

1. The State:

- ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.
- ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment 2.

2. Data source used for resource proxy adjustments:

The State:

- ☐ Applies existing state data from periods before January 1, 2014.
- ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment 2.

3. Resource Proxy Methodology: Attachment 2 describes the sampling approach or other methodology used for calculating the adjustment.

**B. Enrollment Cap Adjustment (42 CFR 433.206(e))**

1.

- ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).
- ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment 3 describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009, that are applicable to populations that the State covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in



alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The State applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

- ☐ Yes. The combined enrollment cap adjustment is described in Attachment 3  
☐ No.

4. Enrollment Cap Methodology: Attachment 3 describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

**C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology**

1. The State:

- ☐ Applies a special circumstances adjustment(s).  
☒ Does not apply a special circumstances adjustment.

2. The State:

- ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).  
☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment 4 describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

**Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group**

**A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group**

- ☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment 5, and where applicable, is subject to any special circumstances or other adjustments described in Attachment 4.
- ☐ The State does not have any relevant populations requiring such transitions.

**Part 4 - Applicability of Special FMAP Rates**

### **A. Expansion State Designation**

The State:

- ☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)
- ☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated \_\_\_\_\_

### **B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.**

The State:

- ☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).
- ☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated \_\_\_\_\_. The State will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

## **Part 5 - State Attestations**

The State attests to the following:

- A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
- B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

### **ATTACHMENTS**

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this attachment:

- ☒ Attachment 1 – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment 2 – Resource Criteria Proxy Methodology
- ☐ Attachment 3 – Enrollment Cap Methodology

☐ Attachment 4 – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

☒ Attachment 5 – Transition Methodologies

**Attachment 1: Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan\*\***

|   | Population Group                       | Net Standard as if 12/1/09                  | Converted Standard for FMAP Claiming        | Same as Converted Eligibility Standard? | Source of Information in Column C        | Data Source for Conversion (SIPP or State Data) |
|---|----------------------------------------|---------------------------------------------|---------------------------------------------|-----------------------------------------|------------------------------------------|-------------------------------------------------|
|   | A                                      | B                                           | C                                           | D                                       | E                                        | F                                               |
| 1 | Parent/Caretaker Relatives             | 1 - \$382                                   | 1 - \$438                                   | no                                      | Table 1 of Approved MAGI Conversion Plan | State Data – Standardized Methodology           |
|   |                                        | 2 - \$468                                   | 2 - \$544                                   |                                         |                                          |                                                 |
|   |                                        | 3 - \$583                                   | 3 - \$678                                   |                                         |                                          |                                                 |
|   |                                        | 4 - \$682                                   | 4 - \$797                                   |                                         |                                          |                                                 |
|   |                                        | 5 - \$777                                   | 5 - \$912                                   |                                         |                                          |                                                 |
|   |                                        | 6 - \$857                                   | 6 - \$1,012                                 |                                         |                                          |                                                 |
|   |                                        | 7 - \$897                                   | 7 - \$1,072                                 |                                         |                                          |                                                 |
|   |                                        | 8 - \$938                                   | 8 - \$1,132                                 |                                         |                                          |                                                 |
|   |                                        | 9 - \$982                                   | 9 - \$1,196                                 |                                         |                                          |                                                 |
|   |                                        | 10 - \$1,023                                | 10 - \$1,257                                |                                         |                                          |                                                 |
|   |                                        | 11 - \$1,066                                | 11 - \$1,320                                |                                         |                                          |                                                 |
|   |                                        | 12 - \$1,108                                | 12 - \$1,382                                |                                         |                                          |                                                 |
|   |                                        | 13 - \$1,150                                | 13 - \$1,443                                |                                         |                                          |                                                 |
|   |                                        | 14 - \$1,192                                | 14 - \$1,505                                |                                         |                                          |                                                 |
|   |                                        | 15 - \$1,236                                | 15 - \$1,569                                |                                         |                                          |                                                 |
|   |                                        | 16 - \$1,277                                | 16 - \$1,630                                |                                         |                                          |                                                 |
|   |                                        | Add-on for additional family members - \$42 | Add-on for additional family members - \$62 |                                         |                                          |                                                 |
| 2 | Non-institutionalized Disabled Persons | 100%                                        | 102%                                        | n/a                                     | New SIPP conversion                      | SIPP                                            |
| 3 | Institutionalized Disabled Person      | 300%                                        | 300%                                        | n/a                                     | ABD conversion template                  | n/a                                             |
| 4 | Children Age 19-20                     | n/a                                         | n/a                                         | n/a                                     | n/a                                      | n/a                                             |
| 5 | Childless Adults                       | 150%                                        | \$0                                         | no                                      | n/a                                      | n/a                                             |

\*Parent/Caretaker Relative group is a fixed income standard.

\*\*The numbers in this summary chart will be updated automatically in the case of modification in the CMS

approved MAGI Conversion Plan.

## Attachment 5

### Utah Adult Medicaid FMAP, Eligibility and Transition Plan Populations Transitioning from Utah's 1115 Waiver to the New Adult Group

| Population and MAGI Eligibility Levels                                                                | Enhanced FMAP Post Transition | Traditional FMAP Post Transition |
|-------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------|
| Adult Expansion up to 95% FPL                                                                         | X                             |                                  |
| Non-institutionalized Disabled Persons up to 102% FPL                                                 |                               | X                                |
| Targeted Adults up to 5% FPL and up to 133% FPL during continuous eligibility period                  | X                             |                                  |
| Targeted Adults above 133% FPL during continuous eligibility period                                   |                               | X                                |
| Demonstration Population III & V (Utah's Premium Partnership for Health Insurance-UPP) up to 133% FPL | X                             |                                  |
| Targeted Adults Dental ("TAD") up to 5% FPL and up to 133% FPL during continuous eligibility period   | X                             |                                  |
| Targeted Adults Dental ("TAD") above 133% FPL during continuous eligibility period                    |                               | X                                |
| Mandatory Employer Sponsored Insurance for Adult Expansion up to 95% FPL                              | X                             |                                  |
| Mandatory Employer Sponsored Insurance for Non-institutionalized Disabled Persons up to 102% FPL      |                               | X                                |

|                                                                                                                                                     |   |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| Withdrawal Management for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL                                                          | X |   |
| Withdrawal Management for non-Adult-Expansion; non-Targeted Adults groups; and Targeted Adults above 133% FPL during continuous eligibility period  |   | X |
| Substance Use Disorder for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL                                                         | X |   |
| Substance Use Disorder for non-Adult Expansion; non-Targeted Adults groups; and Targeted Adults above 133% FPL during continuous eligibility period |   | X |

Under the 1115 Waiver, Utah covers seven demonstration populations that will transition to the new adult group.

- Adult Expansion individuals with income at or below 95% of FPL who are not part of the 1115 “Current Eligibles Demonstration Population” - These individuals currently receive a traditional or non-traditional state plan benefits equivalent to the ABPs.
- Targeted Adult (TAM) individuals with income at or below 5% of FPL and income at or below 133% of FPL during continuous eligibility period - These individuals currently receive traditional state plan benefits equivalent to the ABP. They will retain 12-month continuous eligibility, as allowed under the 1115 waiver.
- Targeted Adults Dental (“TAD”) with income at or below 5% of FPL and income at or below 133% of FPL during continuous eligibility period.
- Demonstration Population III & V (UPP) with income at or below 133% FPL- These individuals currently receive premium assistance to help pay for the individual’s or family’s share of the monthly premiums costs of employer sponsored insurance or COBRA. These individuals will receive a traditional or non-traditional state plan benefits equivalent to the ABPs.
- Mandatory Employer Sponsored Insurance for Adult Expansion up to 95% FPL.
- Withdrawal Management for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL
- Substance Use Disorder for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL

This eligibility transition will be completed administratively and will be effective January 1, 2020. Eligibility under the 1115 Waiver had already been determined using MAGI methodology so no MAGI conversion is necessary. The transition will be seamless for the member and there will be no disruption in coverage. Members will be sent a notice advising them of the change in their coverage to the more robust benefit package under the ABP, when applicable. Members will be advised of their appeal rights.

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## **Attachment G: Reentry Demonstration Initiative Implementation Plan**

**[To be incorporated after CMS Approval]**

## **Attachment H: Reentry Demonstration Initiative Reinvestment Plan**

**[To be incorporated after CMS approval]**

## **Attachment I: Protocols for HRSN Infrastructure and HRSN Services**

### **HRSN Infrastructure Protocol**

**HRSN Infrastructure.** In accordance with the state's section 1115 demonstration and Special Terms and Conditions, this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 12.9. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to \$33,200,000 on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

### **HRSN Infrastructure**

#### **I. Implementation Timeline and Approach**

##### **a. Timeline for Disbursement of Infrastructure Funding**

- i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than April 1, 2025. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity.
- ii. Eligible entities can apply for capacity building funding on an ongoing basis.

##### **b. Approach to Infrastructure Funding Applications and Disbursements**

- i. The state will conduct the HRSN infrastructure application and funding disbursement activities either directly or through a contracted vendor based on experience operationalizing the HRSN Infrastructure program.
- ii. Either directly or through a contacted vendor, the state will conduct the following activities:
  1. Develop the infrastructure funding application and budget template
  2. Conduct outreach and education to eligible entities regarding infrastructure funding opportunities
  3. Review applications against minimum entity eligibility criteria
  4. Review funding request budget templates to ensure compliance with requirements
  5. Award infrastructure funding to eligible entities
  6. Disburse funding to awarded entities



7. Monitor infrastructure funding uses amongst eligible entities to prevent fraud, waste and abuse
8. Develop reporting templates for awardees to report on funding uses
9. Review and analyze reports from awardees on funding uses

**c. Monitoring and Oversight**

- i. The state will ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:
  1. **Participating in audit processes.** The state will conduct spot audits to ensure that infrastructure funds are being spent on permissible uses and are being documented and reported on appropriately.
  2. **Taking action to address non-compliance.** The state will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.
  3. **Ensuring non-duplication of funds.** Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state will monitor for funding irregularities and potential duplication of funds.
  4. **Monitoring for fraud, waste and abuse.** The state will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. The state will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste and/or abuse. The state reserves the right to recoup funding as necessary.

**II. Eligible Entities.** The following entities may be eligible to apply for and receive HRSN infrastructure funding:

- a. Providers of HRSN services, including, but not limited to:
  - i. Tribal government and tribal providers
  - ii. Community-based organizations (CBOs)
  - iii. Social-services agencies
  - iv. Housing agencies and providers

- v. Case management providers
- vi. Child welfare providers
- vii. City, county, and local governmental agencies
- viii. Outreach and engagement providers

In addition, entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:

- a. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state of Utah.
- b. The entity intends to contract to serve as an HRSN provider for at least one HRSN service.
- c. The entity has attested to being financially stable, as defined by the state.

**III. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding.** The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.

- a. Technology
- b. Development of business or operational practices
- c. Workforce development
- d. Outreach, education and stakeholder convening

The State intends to provide infrastructure funding to eligible entities for the following activities:

- a. Technology.** Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities.
  - i. Procuring IT infrastructure/data platforms/systems needed to enable, for example:
    - 1. Authorization of HRSN services
    - 2. Documentation of eligibility for HRSN services and track enrollment
    - 3. Closed loop referral to HRSN services
    - 4. Record plans of care
    - 5. HRSN service delivery
    - 6. HRSN service billing
    - 7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program)

8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC)
- ii. Modifying existing systems to support HRSN
- iii. Development of an HRSN eligibility/services screening tool
- iv. Integration of data platforms/systems/tools
- v. Onboarding to new, modified or existing systems
- vi. Training for use of new, modified or existing systems
- b. Development of business or operational practices**
  - i. Development of policies/procedures related to:
    1. HRSN referral and service delivery workflows
    2. Billing/invoicing
    3. Data sharing/reporting
    4. Program oversight/monitoring
    5. Evaluation
    6. Privacy and confidentiality
  - ii. Training/technical assistance on HRSN program and roles/responsibilities
  - iii. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HRSN operations)
  - iv. Procurement of administrative supports to assist implementation of HRSN
- c. Workforce development**
  - i. Cost of recruiting, hiring and training new staff to provide HRSN
  - ii. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities, time limited to a period of 18 months.
  - iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care)
  - iv. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery
  - v. Production costs for training materials and/or experts as it pertains to the HRSN program
- d. Outreach, education and stakeholder convening**
  - i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.
  - ii. Translation of materials

- iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services
- iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN
- v. Community engagement activities necessary to support HRSN program implementation and launch (e.g., roundtable to solicit feedback on guidance documents)
- vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.

**IV. Projected Expenditure Amounts:** The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the state's STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

| <b>Allowable Use Category</b>                    | <b>% of Spend</b> | <b>Estimated Amount</b> |
|--------------------------------------------------|-------------------|-------------------------|
| Technology                                       | 30%               | \$9,960,000             |
| Development of Operational or Business Practices | 25%               | \$8,300,000             |
| Workforce Development                            | 30%               | \$9,960,000             |
| Outreach, Education and Stakeholder Convening    | 15%               | \$4,980,000             |
| <b>Total</b>                                     | <b>100%</b>       | <b>\$33,200,000</b>     |

| <b>Demonstration Year (DY)</b>        | <b>DY23</b> | <b>DY24</b>  | <b>DY25</b>  |
|---------------------------------------|-------------|--------------|--------------|
| HRSN Infrastructure Estimated Amounts | \$4,150,000 | \$16,600,000 | \$12,450,000 |

## HRSN Services Protocol

In accordance with the Special Terms and Conditions (STCs) of Utah’s Section 1115 Demonstration, this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program. It outlines the covered HRSN services, a process for identifying eligible individuals, a process for determining the services medically appropriate, and a description of the process for developing care plans based on assessment of need.

### 1. Member Eligibility

- a. **Covered Populations.** The following covered populations will be eligible to receive HRSN services provided that they also satisfy the applicable clinical and social risk criteria and the HRSN service is determined to be medically appropriate:

**Table 1: Covered Populations**

| Covered Population                       | Population Description                                                                                                                                                                                                                                                                                                                                                             | Covered Service                                                                                                                                                                                                                                                                              |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Recently Incarcerated Individuals</b> | <ol style="list-style-type: none"> <li>The individual must be released from incarceration within the past 12 months.</li> <li>The individual must be 18 years of age or older.</li> <li>Eligibility must be determined within 12 months of release from incarceration.</li> <li>The individual must have received the Medicaid Justice Benefit Plan while incarcerated.</li> </ol> | <ul style="list-style-type: none"> <li>Pre-Tenancy Navigation Services<sup>6</sup></li> <li>Tenancy and Sustaining Services</li> <li>One-time transition and moving costs other than rent</li> <li>Home accessibility modifications and remediations that are medically necessary</li> </ul> |
| <b>Adult Expansion (AE)</b>              | <ol style="list-style-type: none"> <li>The individual must be 19-64 years old.</li> <li>The individual must be covered under the Adult Expansion program.</li> </ol>                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>Pre-Tenancy Navigation Services</li> <li>Tenancy and Sustaining Services</li> <li>One-time transition and moving costs other than rent</li> <li>Home accessibility modifications and remediations that are medically necessary</li> </ul>             |

<sup>6</sup> Pre-tenancy navigation services, as well as tenancy and sustaining services, one-time transition and moving costs other than rent, and home accessibility modifications and remediations that are medically necessary were previously covered under the state’s Housing Related Services and Supports (HRSS) program. These services are now covered under the HRSN program.

|                                      |                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                          |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                      |                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>• Short-Term Rental Assistance</li> <li>• Short-Term Recuperative Care</li> </ul>                                                                                                                                                                                                                                                 |
| <b>Targeted Adult Medicaid (TAM)</b> | <ol style="list-style-type: none"> <li>1. The individual must be 19-64 years old.</li> <li>2. The individual must be covered under the Targeted Adult Medicaid program.</li> </ol> | <ul style="list-style-type: none"> <li>• Pre-Tenancy Navigation Services</li> <li>• Tenancy and Sustaining Services</li> <li>• One-time transition and moving costs other than rent</li> <li>• Home accessibility modifications and remediations that are medically necessary</li> <li>• Short-Term Rental Assistance</li> <li>• Short-Term Recuperative Care</li> </ul> |

- b. **Medical Appropriateness.** To ensure the services are medically appropriate, the state will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for a HRSN service, a member must:
- Meet the eligibility criteria for one or more of the covered populations (described above in Section I.a);
  - Have at least one of the clinical risk factors. The HRSN clinical risk factors for housing are listed in the table below.
  - Meet the following social risk criteria: Be experiencing homelessness or at risk of homelessness, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5, except the annual income requirement in 24 CFR 91.5 (1)(i) ;
  - Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.
- c. **Clinical Risk Factors.** In order to receive services, individuals must meet one of the clinical risk factors listed below.

**Table 2: Clinical Risk Factors**

| Clinical Risk Factors     |                                                       |
|---------------------------|-------------------------------------------------------|
| HRSN Clinical Risk Factor | Risk Factor Description                               |
| 1. Complex Behavioral     | Requires improvement, stabilization, or prevention of |

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Health Need                                                                  | deterioration of functioning (including ability to live independently without support) resulting from the presence of diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment or behavioral impairment resulting from dementia, brain injury or other medically-based behavior condition/disorder.                                                                                                                                                                                  |
| 2. Needs Assistance with ADLs/IADLs or Eligible for LTSS                     | Requires assistance with one or more activities of daily living (ADLs), one of which may be body care, verbal queuing or hands-on assistance.                                                                                                                                                                                                                                                                                                                                                                                          |
| 3. Pregnant/Postpartum                                                       | An individual who is currently pregnant or up to 12 months postpartum.                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| 4. Adults 65 years of age or older                                           | <p>An adult who is 65 years of age or over and currently has at least one of the following:</p> <ul style="list-style-type: none"> <li>• Two or more chronic health conditions</li> <li>• Social isolation placing the individual at risk for early death, neurocognitive disorders, sleep disruption, cardiovascular disease, and elder abuse</li> <li>• A health condition, including behavioral health and developmental syndromes, stemming from trauma, child abuse, or neglect</li> </ul>                                        |
| 5. Recent hospitalization for a Chronic Health Condition                     | <p>In the last 12 months, at least 1 inpatient claim for one of the following:</p> <ul style="list-style-type: none"> <li>• Cancer</li> <li>• Diabetes</li> <li>• Hypertension</li> <li>• Heart Disease</li> <li>• Heart Failure</li> <li>• Kidney Disease</li> <li>• Kidney Transplant Failure</li> <li>• Liver Disease</li> <li>• Multiple Sclerosis</li> <li>• Necrotizing Fasciitis</li> <li>• Renal Failure</li> </ul> <p>Utah Medicaid's Medical Director may approve additional chronic conditions on a case-by-case basis.</p> |
| 6. At-risk of or transitioning from ED/hospitalization or institutional care | Must have an acute medical condition that can be safely managed in a recuperative care program setting, and Medical respite care is necessary to provide the conditions to support recovery from the acute medical condition and meet one of the following:                                                                                                                                                                                                                                                                            |

|  |                                                                                                                                                                                                                                                                             |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <ul style="list-style-type: none"> <li>• Are at-risk of Emergency Department (ED), hospitalization or institutional care as determined by a qualified healthcare professional, or</li> <li>• Are in the ED/hospitalized, or</li> <li>• Are in institutional care</li> </ul> |
|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|



## 2. HRSN Services

- a. **Use of a Third-Party Contractor or Other Contracted Vendor.** The state may contract with a third-party contractor or other entity to perform service approval, care management, and other functions related to the administration of HRSN services for members covered under the FFS program. The state will work with Tribal Government on a culturally responsive and specific HRSN service delivery approach for American Indian/Alaska Native (AI/AN) members.
- b. **Providing culturally and linguistically appropriate services.** All HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services.
- c. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state or federally funded service or other HRSN service the member is already receiving.
- d. **Covered HRSN Services.** The state will cover the following HRSN services as defined in the table below:

**Table 3: Covered HRSN Services**

| Service                                | Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Eligibility Criteria                                                                                                                                                                                                                                                                                        |
|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Pre-Tenancy Navigation Services</b> | <p>The following service includes:</p> <ol style="list-style-type: none"> <li>1. Tenant screening and housing assessment to identify housing preferences (e.g., housing type, location, living alone or with someone else, roommate identification, type of accommodations needed, etc.) barriers to successful tenancy, identification of housing transition and retention barriers.</li> <li>2. Development of an individualized housing support plan to address identified barriers and establish goals to address each issue, identification of providers/services required to meet the established goal.</li> <li>3. Assistance with the housing application process, including application/documentation completion and submission.</li> <li>4. Assistance with completing reasonable accommodation requests.</li> <li>5. Assistance with the housing search process.</li> <li>6. Identification of resources to cover housing expenses (e.g., rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses,</li> <li>7. Ensuring, through coordination, that the living environment is safe and move-in ready.</li> </ol> | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE;</li> <li>2. TAM; or</li> <li>3. Recently Incarcerated Individuals</li> </ol> <p>Clinical Risk Factors:<br/>At least one of the clinical risk factors 1-5 in Table 2</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p> |

|                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        | Beneficiaries with Serious Mental Illness (SMI) have access to Targeted Case Management (TCM) services under Utah's Medicaid State Plan. Targeted Adults with a serious mental illness who receive benefits on a fee for service basis and are not enrolled in a Prepaid Mental Health Plan (PMHP) will have access to Tenancy Support Services if they cannot otherwise access Targeted Case Management services. To ensure there is no duplication of services, the state will review and authorize requests for tenancy support services through the demonstration only after verifying that Targeted Case Management services are not being provided.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                    |
| <b>Tenancy and Sustaining Services</b> | <p>The following service includes:</p> <ol style="list-style-type: none"> <li>1. Development of a housing support crisis plan to identify prevention and early intervention services when housing is jeopardized.</li> <li>2. Participation in planning meetings to assist beneficiaries with the development of a housing support and crisis plan to address existing or recurring housing retention barriers.</li> <li>3. Assistance with completing reasonable accommodation requests.</li> <li>4. Connecting beneficiaries to education and training on tenant and landlord rights, and responsibilities.</li> <li>5. Providing eviction risk reduction services (e.g., conflict resolution skills, coaching, role playing, and communication strategies targeted towards resolving disputes with landlords and neighbors). <ol style="list-style-type: none"> <li>a. Communicating with landlords and neighbors to reduce the risk of eviction.</li> <li>b. Addressing biopsychosocial behaviors that put housing at risk. through coordination and referrals to other services</li> <li>c. Providing ongoing case management support with activities related to household management.</li> <li>d. Assistance with the housing voucher/subsidy application and recertification processes.</li> </ol> </li> </ol> | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE;</li> <li>2. TAM; or</li> <li>3. Recently Incarcerated Individuals</li> </ol> <p>Clinical Risk Factors:<br/>At least one of the clinical risk factors 1-5 listed in Table 2</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p> |
| <b>One-time transition and</b>         | Services provided to assist eligible beneficiaries to secure, establish, and maintain a safe and healthy living environment.,. Services include:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE;</li> <li>2. TAM; or</li> </ol>                                                                                                                                                                                                                    |

|                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                  |
|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>moving costs<br/>other than rent</b></p>     | <ol style="list-style-type: none"> <li>1. One-time purchase of essential household items and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; moving expenses; and activities to assess, arrange and procure necessary resources. Services needed to establish basic living arrangements in a community setting, including kitchen, bathroom and cleaning equipment/goods.</li> <li>2. Payment of a security deposit when a member moves into a new residence and it is required for a beneficiary to obtain a lease. To address the complex social determinants of health needs of individuals enrolled in the Targeted Adult Population, the State will impose a maximum of no more than two security deposit payments per beneficiary during the five-year demonstration approval period to help individuals who have transitioned into a community-based living arrangement and subsequently lose the community residence.</li> <li>3. One-time non-refundable fees including submit rental applications, <ol style="list-style-type: none"> <li>a. application and inspection fees,</li> <li>b. utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments),</li> <li>c. movers and relocation expenses,</li> <li>d. pest eradication,</li> <li>e. cooking supplies, and</li> <li>f. the purchase of household goods and furniture.</li> </ol> </li> </ol> <p>Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services that are essential to the operation of the residence.</p> <p>Services will be furnished when determined reasonable and necessary, when identified in a member's housing support plan, and when the beneficiary is unable to secure funding/items from other sources.</p> | <p>3. Recently Incarcerated Individuals</p> <p>Clinical Risk Factors:<br/>At least one of the clinical risk factors 1-5 listed in Table 2</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p> |
| <p><b>Home accessibility modifications and</b></p> | <p>The provision of medically necessary home accessibility modifications and remediation services to eliminate known home-based health and safety risks and ensure the occupants' health and safety in the living environment.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE;</li> <li>2. TAM; or</li> </ol>                                                                                                                  |

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Remediations that are medically necessary</b> | <ol style="list-style-type: none"> <li>1. Home/environmental accessibility modifications including, for example, wheelchair accessibility ramps, handrails, and grab bars.</li> <li>2. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <ol style="list-style-type: none"> <li>3. Recently Incarcerated Individuals</li> </ol> <p>Clinical Risk Factors:<br/>At least one of the clinical risk factors 1-5 listed in Table 2</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p>    |
| <b>Short-term rental assistance</b>              | <p>Payment for rent and/or short-term, temporary stays for up to six months in a 5-year period.</p> <p>Payments include:</p> <ul style="list-style-type: none"> <li>• Rent payments for apartments, single room occupancy (SRO) units, single-family homes, multi-family homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes; manufactured home lots, motel or hotel when it is serving as the member's primary residence, transitional and recovery housing including bridge, site-based, population specific, and community living programs that may or may not offer supportive services and programming.</li> </ul> <p>Eligible costs include:</p> <ul style="list-style-type: none"> <li>• Rent payment (past due or forward rent)</li> <li>• Storage fees</li> <li>• Renter's insurance if required by the lease</li> <li>• Landlord paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments.</li> </ul> <p>Payments must only be provided in connection with dwellings that meet maintenance regulation code within the local jurisdiction for safety, sanitation, and habitability.</p> | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE; or</li> <li>2. TAM</li> </ol> <p>Clinical Risk Factors:<br/>At least two of the clinical risk factors 1-5 listed above</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p> |

|                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                             |
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|                                                                                                      | <p>Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.</p> <p>Rent/temporary housing is only available to individuals who are transitioning out of institutional care or congregate settings such as nursing facilities, large group homes, congregate residential settings, Institutions for Mental Diseases (IMDs), residential mental health and substance use disorder facilities, or inpatient psychiatric units, correctional facilities, and acute care hospitals</p> <p>Room and board-only interventions are limited to a combined 6 months per household per demonstration period.</p> <p>All section 1115 demonstration HRSN housing interventions with room and board are limited to the global HRSN housing cap of a combined 6 months per rolling 12-month period.</p> |                                                                                                                                                                                                                                             |
| <p><b>Short Term<br/>Recuperative<br/>Care<br/>(Also referred<br/>to as Medical<br/>Respite)</b></p> | <p>Short-term recuperative care where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care.</p> <p>Maximum benefit period: 60 days in a 365-day period. Assessed based on a rolling year.</p> <p>Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.</p> <p>All section 1115 demonstration HRSN housing interventions with room and board are limited to the global HRSN housing cap of a combined 6 months per rolling 12-month period.</p>                                                                                                                                                                                                       | <p>Population:<br/>1. AE; or<br/>2. TAM</p> <p>Clinical risk factor 6:<br/>At-risk of or<br/>transitioning from<br/>ED/hospitalization or<br/>institutional care</p> <p>Social Risk Factor:<br/>Homeless or at Risk of<br/>Homelessness</p> |

|                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                |
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| <b>Short-term post transition housing</b> | <p>Short-term post-transition housing (e.g., post-hospitalization), where integrated clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.</p> <p>Services may include:</p> <ul style="list-style-type: none"> <li>a. Rent or lease payments for dwellings that are an individual's primary residence. Dwellings must meet local zoning guidelines and local housing and building codes for safety, sanitation, and habitability.</li> <li>b. Hotel or motel costs, if being used as the individual's primary residence</li> <li>c. Renter's insurance if required by the lease.</li> </ul> <p>Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space are excluded from the demonstration.</p> <p>All section 1115 demonstration HRSN housing interventions with room and board are limited to global HRSN housing cap of a combined 6 months per rolling 12-month period.</p> | <p>Population:</p> <ol style="list-style-type: none"> <li>1. AE; or</li> <li>2. TAM</li> </ol> <p>Clinical risk factor 6:<br/>At-risk of or transitioning from ED/hospitalization or institutional care</p> <p>Social Risk Factor:<br/>Homeless or at Risk of Homelessness</p> |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

### 3. Provider Qualifications

- a. Service providers will be required to meet the following minimum qualification requirements:
  - i. Demonstrate the capacity and experience to provide HRSN services as described below:
    1. Housing services providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver, or comparable services meant to support individuals in obtaining and maintaining stable housing.
    2. Pre-tenancy Navigation Services must be provided by Medicaid enrolled providers certified by the State per Administrative rule R523-7-4.
    3. Tenancy and Sustaining Services must be provided by Medicaid enrolled providers certified by the State per Administrative rule R523-7-4.
    4. One-time transition and moving cost providers must meet the following criteria. Entities coordinating the purchase of equipment or supplies or paying deposits or other set-up fees for Medicaid members must be enrolled Medicaid providers that are:
      - a. Housing authorities,
      - b. public or private not-for-profit service organizations,
      - c. faith-based organizations,
      - d. state or local departments and agencies,
      - e. units of local governments, or
      - f. homeless services providers who provide housing/homeless services to individuals and/or families who are experiencing homelessness or are at risk of becoming homeless.
  - ii. **HRSN Provider Experience and Expertise:** All HRSN services providers are expected to meet certain qualifications that ensure they are capable of providing high-quality services to qualifying members as well as have culturally specific expertise to connect with members of priority populations. Qualifications may include, for example:
    1. Maintain sufficient hours of operation and staffing to serve the needs of HRSN participants.
    2. Demonstrate their capabilities and/or experience with effectively serving at least one “priority population,” as determined by the state. HRSN providers may demonstrate these capabilities and/or experience through, for example:
      - a. Providing letter(s) of support from community members being served or other entities in the community, describing the HRSN provider’s presence in the community and impact on individual community members and/or the community as a whole.

- b. Submitting an annual report or similar document that describes the HRSN provider's relevant capabilities and activities.
  - c. Other methods deemed appropriate by the state.
  - d. Demonstrate that it has qualified service delivery and administrative staff, as determined by the state.
- 3. The ability to comply with applicable federal and state laws.
- 4. The capacity to provide culturally and linguistically appropriate, responsive and trauma-informed service delivery, including by ensuring their ability to:
  - a. Adhere to federal and state laws and requirements related to ensuring communication and delivery of services to Members with diverse cultural and ethnic backgrounds.
  - b. Meet cultural needs of the community for whom it provides services.
  - c. Provide documentation of how cultural responsiveness and trauma informed care trainings are impacting organizational policies and staff practices.
  - d. Document efforts to recruit and employ staff who reflect the HRSN provider's Medicaid population, including individuals with similar demographics, lived experience, background and language fluency to the greatest extent possible.

#### 4. **Member Identification and Assessment of Service Need**

- a. **Member Identification.** The state will ensure individuals can be identified for HRSN services through many different pathways.
  - i. The state will ensure multiple pathways for individuals to be identified as being enrolled in Medicaid, belonging to an HRSN Covered Population, and potentially having one or more HRSN Service needs. Pathways for Member identification must include:
    - 1. The state proactively identifying Members through a review of encounter and claims data;
    - 2. Contracting with HRSN Service Providers to conduct HRSN Outreach and Engagement to identify Members and make HRSN Recommendations;
    - 3. Engaging with and receiving HRSN Recommendations from organizations other than HRSN Service Providers (called "HRSN Connectors"); and
    - 4. Accepting Members' self-referral.
  - ii. The following are examples of individuals and entities that may serve as HRSN Connectors and will have a pathway to identify individuals in need of HRSN services:
    - 1. Private and public housing service agencies and housing providers
    - 2. Correctional institutions



3. Health care providers including but not limited to primary care providers, behavioral health providers, hospitals, and long-term services and supports (LTSS) providers
4. State, local, and federal agencies who engage with Medicaid members
5. Traditional health workers
6. Child welfare workers and other case managers
7. Community partners and housing agencies will be required to estimate the number of individuals they expect to serve each year with HRSN services, as well as report to the state on the actual number of individuals they do serve.

**b. HRSN Requests**

- i. The state will provide an HRSN Request Template that contains necessary information about individuals identified with a service need for an approval decision. HRSN Connectors that recommend individuals to receive HRSN services must use the State-developed HRSN Request Template.
- ii. Other information that may be documented in the HRSN Request includes confirmation of Medicaid enrollment as well as any other information regarding the individual's potential HRSN eligibility. All HRSN Recommendations must include a statement that the recommended individual desires to take part in further HRSN eligibility determination process.
- iii. The transmission of the information in the HRSN Request Template to the state can occur through a variety of delivery methods including, but not limited to email, fax, mail personal delivery or any other reasonable delivery method. These pathways must be made clear and accessible to members, Community-Based Organizations (CBOs), and other potential entry points through information posted on the state's website and through other means.

**5. Eligibility Determination and Services Approval**

- a. Upon receipt of the information regarding the individual's HRSN needs, the state will use reasonable efforts to obtain all other information necessary to determine whether the individual is eligible for HRSN.
- b. If, after completing the HRSN eligibility determination and documenting all the required information in, the Member meets all of the criteria for being HRSN eligible, the state will authorize the identified HRSN Services needed as expeditiously as possible. The service approval will be based on the following criteria:
  - i. Confirmation that the member is enrolled in Utah Medicaid;
  - ii. Determination that the individual meets the eligibility criteria for one of the HRSN covered population groups;
  - iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
  - iv. Assessment of the individual's clinical and social needs (described above in Section I.b) that justify the medical appropriateness of the service.
- c. The HRSN provider will be required to:

- i. Notify the individual of approval or denial of the service and provide information about appeals and hearing rights.
  - 1. The HRSN provider shall notify all individuals who have undergone an HRSN Service authorization or denial as expeditiously as the circumstances require, not to exceed fourteen (14) calendar days from the date of, as applicable and appropriate, authorization or denial. The HRSN provider will follow individual preferences for methods of communication (e.g., e-mail, phone call, etc.)
  - 2. Individuals who are denied HRSN Services or are authorized for HRSN Services but such authorization is limited in scope, amount, or duration, have Grievance and Appeal rights.
- ii. Document the approval or denial of services through the closed loop referral technology; or chosen alternative system by the referring entity, ensuring a closed loop of the referral.
- iii. A determination of non-eligibility for the HRSN program will be sent by the State and include Grievance and Appeal rights.
- d. HRSN service approvals shall have the duration of up to 12 months. To ensure continuity of care, an HRSN provider shall rescreen for HRSN eligibility and service needs at least 60 days before the expiration of the current service authorization and submitted to the state for eligibility redetermination as described above in items 5.a and b, at least 30 days before the expiration of the current service authorization. This process will reassess any changes in the individual's circumstances, clinical and social needs, and service utilization. Subsequent re-screenings will follow this timeline annually, or sooner if significant changes in the individual's condition or circumstances are reported.

## **6. Care Management and Service Plans**

- a. The HRSN provider will conduct care management for individuals approved for HRSN services. The care management will include:
  - i. Developing the care plan with the member and review as needed;
  - ii. Identifying other HRSN services the member may need and referring to alternative providers if needed;
  - iii. Determining what other services the individual is receiving or may be eligible to receive under Medicaid or other programs;
  - iv. Coordinating with other social support services and care management the member is already receiving or becomes eligible for while receiving the HRSN service;
  - v. Conducting reassessment for services prior to the conclusion of the service; and
  - vi. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

- b. The case manager and the member will create the care plan for the individual to obtain the HRSN service as approved by the community partner or housing agency. The care plan will be in writing and developed with and agreed upon by the member.
  - i. The care plan will include:
    - 1. The recommended HRSN service;
    - 2. The service duration;
    - 3. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
    - 4. The goals of the service(s);
    - 5. The follow-up and transition plan;
    - 6. The care management team responsible for managing the member's HRSN services.
- c. The case manager is required to have one meeting with the individual, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the case manager is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

## **7. Payment**

- a. After providing HRSN services to members who satisfy HRSN eligibility requirements, HRSN service providers will submit a claim to the state.
- b. The state will reimburse HRSN service providers according to a fee schedule for HRSN services to be developed by the state.
- c. The state may also pay HRSN service providers in advance for select services, with the intent of conducting a reconciliation no less than annually to ensure services were rendered.

## **8. Conflict of Interest**

- a. The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

## **Attachment J: HRSN Implementation Plan**

**[To be incorporated after CMS approval]**

**Attachment K: Provider Payment Rate Increase Assessment – Attestation Table**

**[To be incorporated after CMS approval]**

## **Attachment L: Postpartum Proxy Methodology**

As established in [SHO# 21-007](#) RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP), CMS recognizes that states may use a proxy methodology to account for the proportion of individuals covered under the extended postpartum coverage option who would otherwise be eligible for coverage in the adult group and for the newly eligible FMAP under section 1905(y) of the Act.

Utah proposes the following methodology to estimate a percentage for claiming the enhanced FMAP for Medicaid members eligible for extended postpartum coverage. The State estimates this percentage to be 9.43%. Utah proposes to apply the percentage to the entire prenatal and postpartum period as described in the Application section below.

### **Methodology**

#### **Time Frame and Population**

The methodology uses data from members who had deliveries paid for by the Medicaid program between April 1, 2021, and March 31, 2022. Utah identified these members based on specific aid codes for pregnant women and diagnosis codes associated with delivery services. This time frame has been selected as the most representative period for analysis. During this time, Medicaid members could neither be disenrolled nor could they move to non-pregnant eligibility groups until 60 days after their pregnancy ended.

#### **Metrics**

On average, these members received prenatal care for approximately 6.27 months and postpartum care for 11.64 months, beginning the month following the delivery. Additionally, 17.53% of these members transitioned to an expansion aid group post-delivery.

#### **Calculation**

Utah arrived at the proposed 9.43% figure using the following methodology:

1. The State queried all Medicaid claims and encounters in the Medicaid data warehouse with a delivery (identifiable based on presence of ICD-10-CM code of O80\* or O82\*) in a given month between 4/1/2021 through 3/31/2022. This totaled 6,018 deliveries.
  - a. This is data gathered while the PHE was still active. Had Utah been able to, the State would have used data from months outside of the PHE. However, Utah is constrained by the fact that Utah's Adult Expansion program began in January 2020. This was three months prior to the start of the maintenance of effort (MOE) period
  - b. Utah recognizes that this data has the anomaly of the PHE, but does not have an alternative time period to measure the movement from the pregnant program to adult expansion. This time frame simulated the effect of a 12-month postpartum coverage policy due to the fact that individuals would only be disenrolled from Medicaid due to death, moving out of state, or requesting case closure.
2. Of the 6,018 deliveries, the State queried the members' new aid category four months after the delivery month.
  - a. Although the MOE required Utah Medicaid to keep members eligible except under special circumstances (death, move out of state, request closure, etc.), the member could transition to other aid categories after their delivery pursuant to 85 FR 71142.

- b. Utah chose to look four months after the delivery month because the State wanted to ensure that the member in question was actually outside of the 60-day postpartum coverage period. Due to the fact that the 60-day coverage policy covered individuals through the end of the month that contained the 60th day after the end of the pregnancy, there were some end-of-month deliveries that could result in three postpartum months of coverage. This is why Utah queried the fourth month after delivery.
  - c. Following this evaluation, it was found that 17.53% (1,055 members) transitioned into adult expansion categories. 41.54% transitioned to parent/caretaker relative categories, 39.37% were still in a pregnant category, 1.43% were no longer Medicaid eligible (due to moving out of state, requesting closure, death, etc.), and the remaining members were eligible on child Medicaid or Blind/Disabled Medicaid.
3. For the 6,018 members who delivered between 4/1/2021 through 3/31/2022, the State calculated the total months before the delivery that each client was eligible for a pregnant aid category.
  - a. This is the prenatal period. Utah includes this period in the calculation so that the State may apply the proxy methodology to the entire prenatal and postnatal period. This allows Utah to avoid a constant process of prior period adjustments as the State often learns of the end of pregnancy a few months after the fact.
  - b. The prenatal months were calculated on average to be 6.27.
4. Of the 6,018 deliveries, Utah calculated the average duration of eligibility in the year after delivery.
  - a. Utah acknowledges again that this analysis occurs during the months of the PHE. This calculation recognizes that certain exceptional circumstances, such as relocating out of state, voluntary account closure, or death, could lead to the termination of a member's eligibility prior to completing the 12-month period.
  - b. The purpose of this calculation is to recognize that even with a coverage policy that would grant members 12 months of eligibility after the end of the pregnancy, some members do not experience the full 12 months.
  - c. This number was calculated on average to be 11.64 months.
5. Utah calculated the “new postpartum months” as a percentage of the whole prenatal and postpartum period.
  - a. This is calculated as 4.c (11.64 months) minus 2 months (to account for the postpartum period already covered as a state) divided by 4.c (11.64) + 3.b (6.27).
    - i.  $(11.64-2)/(11.64+6.28) = 53.79\%$
6. Multiply 5.a by 2.c – the percentage of members who transitioned to expansion categories four months after delivery.
  - a.  $53.79\% * 17.53\% = 9.43\%$

## Application

If approved, Utah would report 9.43% of all Medicaid expenditures with the criteria below as Group VIII Newly Eligible expenditures:

- Medicaid recipient aged 19-64; and
- service date occurs when the recipient is pregnant or within 12 months after the end of a pregnancy.

## Claiming Methodology

When Utah Medicaid reports expenditures on CMS-64 forms, they will be reported as follows:

| Coverage Group & Period                                | Type of Expenditure                 | 64.9 Form Pre-Allocation                              | 64.9 Form Post-Allocation                       |
|--------------------------------------------------------|-------------------------------------|-------------------------------------------------------|-------------------------------------------------|
| Prenatal through 60 days postpartum                    | FFS claims                          | 90.57% of total computable (TC) reported on 64.9 Base | 9.43% of TC reported on 64.9VIII Base           |
|                                                        | Capitations under 1915(b) authority | 90.57% of TC reported on 64.9 Waiver 1915(b)          | 9.43% of TC reported on 64.9VIII Waiver 1915(b) |
| Beyond 60 days postpartum through 12 months postpartum | FFS claims                          | 90.57% of TC reported on 64.9 Waiver 1115             | 9.43% of TC reported on 64.9VIII Waiver 1115    |
|                                                        | Capitations under 1915(b) authority | 90.57% of TC reported on 64.9 Waiver 1115             | 9.43% of TC reported on 64.9VIII Waiver 1115    |

### Department Assurances

The State assures that all individuals enrolled in the 12-month postpartum eligibility group will receive a package of services comparable to the state's Section 1937 Alternative Benefit Plan benefit package in accordance with Section 1903(i)(26) of the Social Security Act, including but not limited to:

- a. Services that could be categorized under the 10 essential health benefit categories, plus federally qualified health centers/rural health clinic services, family planning services and supplies, non-emergency medical transportation and early and periodic screening diagnostic and treatment requirements;
- b. Habilitative services;
- c. No application of cost sharing on preventive services;
- d. Adherence to mental health services parity requirements for fee-for-service (parity is required under managed care).