State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

JOSEPH K. MINER, MD, MSPH, FACPM
Executive Director

Division of Medicaid and Health Financing

NATE CHECKETTS
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

July 31, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Verma:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the 1115 Primary Care Network (PCN) Demonstration Waiver. This amendment is a result of House Bill 219 "Mental Health Amendments", which passed during the 2020 General Session of the Utah State Legislature. Approval of this amendment will allow the State to claim federal financial participation (FFP) for payment of services to Medicaid beneficiaries, age 21 through 64, receiving inpatient psychiatric treatment or residential mental health treatment in an Institution for Mental Diseases (IMDs).

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's 1115 PCN Waiver.

Respectfully,

[redacted]

Emma Chacon
Operations Director
Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

288 North 1460 West · Salt Lake City, UT
Mailing Address: P.O. Box 143101 · Salt Lake City, UT 84114-3101
Telephone (801) 538-6689 · Facsimile (801) 538-6478 · www.health.utah.gov

Utah 1115 Primary Care Network Demonstration Waiver

Amendment Request

Behavioral Health Services for Adults with Serious Mental Illness

Demonstration Project No. 11-W-00145/8
21-W-00054/8

Contents

State of Utah

Section 1115 Demonstration Amendment
Behavioral Health Services for Adults with Serious Mental Illness
Amendment #22

Section I. Introduction

In SFY2019, Utah's public behavioral health system provided services to 20,327 youth and 36,326 adults. Of the youth served, 61.8% met the qualification for a serious emotional disturbance, and 52.4% of the adults served met the qualifications for a serious mental illness. Treatment of those with serious emotional disturbances and serious mental illness remains a priority for the State. Utah's Strategic Plan created by the Utah Division of Substance Abuse and Mental Health, outlines Utah's commitment to providing comprehensive behavioral health services.

Currently, Utah has approval through the State's 1115 Primary Care Network (PCN) Demonstration Waiver to cover the full continuum of substance use disorder treatment services. The State also has an extensive continuum of mental health services, and the Utah legislature invests millions annually across the state to cover inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing supports, and more.

During the Utah 2020 General Legislative Session, House Bill 219 "Mental Health Amendments", was passed. This bill directs the Utah Department of Health to "apply for a Medicaid waiver or a state plan amendment with CMS to offer a program that provides reimbursement for mental health services that are provided in an institution for mental diseases that includes more than 16 beds and to an individual who receives mental health services in an institution for mental diseases for a period of more than 15 days in a calendar month." Despite Utah's efforts, immediate access to inpatient psychiatric treatment beds and sufficient residential mental health treatment beds remains a concern.

Inpatient psychiatric beds remain hard to access due to the low numbers of beds and high census numbers on the psychiatric units. At times, non-psychiatric beds have to be temporarily used until an appropriate bed can be made available, or even worse, beneficiaries are waiting in emergency rooms for hours. In some cases, it takes days before a bed in a psychiatric unit is available.

Utah has four hospitals that have a total of 365 inpatient psychiatric beds that meet the regulatory definition of an Institutions for Mental Disease (IMD). Due to federal financial participation (FFP) not being available for these beds, beneficiaries needing inpatient psychiatric beds are unable to use them, and therefore end up waiting for the appropriate level of care, while there are available beds nearby that can't be used. Having access to FFP for these beds in an IMD hospital allows for beneficiaries to get the appropriate level of care in a timely manner.

In order to help fill the gap of available inpatient psychiatric beds, Utah has used the 2016 Managed Care Final Rule that allows up to 15 day stays in IMD hospitals for beneficiaries in managed care plans.

However, this has created issues with incentivizing discharge after 15 days instead of relying on medical necessity due to payment issues. Also, Utah's fee for service (FFS) beneficiaries, which are some of Utah's most vulnerable and needy, do not have access to this exception.

As part of Utah's extensive continuum of mental health care, Utah also has residential mental health treatment programs. Currently, the number of residential mental health treatment programs accessible to Medicaid beneficiaries remains artificially low because Medicaid cannot cover services in facilities with more than 16 beds, therefore programs are unable to grow beyond 16 beds. By allowing facilities to increase the number of beds on the same campus, the provider can benefit from economies of scale and will be able to achieve sustainability while expanding services to more beneficiaries. A recent University of Utah analysis of Utah's mental health system found that, "Federal rules do not allow Medicaid to reimburse mental health facilities with more than 16 beds, which limits the supply of available residential facilities (participants noted these facilities financially break even at about 30 beds). Utah currently has a waiver to reimburse SUD residential treatment facilities larger than 16 beds. Obtaining a similar waiver for mental health residential treatment facilities could improve the supply of mental health residential treatment options in the state".[1]

Section II. Program Description and Objectives

With this amendment, the State seeks to amend its 1115 PCN Demonstration Waiver, and is requesting waiver authority to claim federal financial participation (FFP) for payment of services to Medicaid beneficiaries, age 21 through 64, receiving inpatient psychiatric treatment or residential mental health treatment in an IMD. The State is also seeking the authority to make capitation payments to state contracted managed care entities to pay for services to Medicaid beneficiaries regardless of the length of stay in an IMD. Utah is requesting that the waiver authorities described in this amendment apply to Medicaid beneficiaries in both Utah's managed care and FFS service delivery systems. Application of the waiver to both systems would ensure equal access to this benefit for all Medicaid beneficiaries. Specifically, Utah seeks authority for the following:

1. Allow Utah to make capitated payments to managed care entities for Medicaid beneficiaries receiving inpatient or residential mental health treatment in an IMD. The average length of stays under this amendment will be no more than 30 days. Capitated payments may be used to pay for treatment in these settings and services provided before or after discharge from the facility during the calendar month.
2. To allow for FFP in expenditures for services provided to managed care and FFS Medicaid beneficiaries in inpatient psychiatric hospitals or residential mental health treatment facilities with more than 16 beds.

Maintenance of Effort Commitment

Utah is committed to a maintenance of effort (MOE) on funding for outpatient community-based mental health services as part of this amendment. Under the terms of this demonstration, the State assures that resources will not be disproportionately drawn into increasing access to treatment in inpatient or residential settings at the expense of community-based services. Utah understands the expectation under the demonstration is to maintain a level of state appropriations and local funding for outpatient

[1] Utah's Mental Health System: A collaborative endeavor of the Kem C. Gardner Policy Institute and the Utah Hospital Association. Final Report August 2019

community-based mental health services for Medicaid beneficiaries for the duration of this demonstration that is no less than the amount of funding provided at the beginning of the demonstration.

All beneficiaries will continue to have access to an array of mental health services throughout the state, including crisis stabilization services. Listed below are some of the available crisis stabilization services:

- Intensive Stabilization Services
- Statewide Crisis Line
- Mobile Crisis Outreach Teams
- Assertive Community Treatment
- Psychotherapy for Crisis

Additionally, Utah House Bill 32 "Crisis Services Amendments" (2020) requires Utah to establish Behavioral Health Receiving Centers in order to increase access for beneficiaries needing crisis stabilization services. These centers will closely follow the national guidelines put forth by SAMHSA.

Goals and Objectives

The objective of this demonstration is to allow Utah to expand access to inpatient psychiatric treatment and residential mental health treatment. The overall goal of this amendment request is to maintain and enhance the flexibility and availability of mental health treatment supports, and to supplement the comprehensive and integrated continuum of mental health treatments Utah provides.

Operation and Proposed Timeline

The demonstration will operate statewide. The State intends to implement the demonstration beginning January 1, 2021. The State requests to operate the demonstration through the end of the current waiver approval period, which is June 30, 2022.

Milestones

The demonstration will be implemented through a series of milestones outlined below and in greater detail in the State's Implementation Plan, which will be submitted at a later date.

Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings

1. Participating hospitals and residential settings are licensed by the state to primarily provide treatment for mental illnesses and are accredited by a nationally recognized accreditation entity including the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) prior to receiving FFP for services provided to beneficiaries;

2. 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;

Milestone 2: Improving Care Coordination and Transitions to Community-Based Care

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

2. Implementation of a process to assess the housing situation of individuals transitioning to the community from psychiatric hospitals and residential treatment settings and connect those who are homeless or have unsuitable or unstable housing with community providers that coordinate housing services where available;

3. 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 ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider the person was referred to;

4. Implementation of strategies to prevent or decrease the lengths of stay in emergency departments (EDs) among beneficiaries with serious mental illness (SMI) or serious emotional disturbance (SED) (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, substance use disorder (SUD), and mental health providers with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED;

Milestone 3: Increasing Access to Continuum of Care Including Crisis Stabilization Services

1. Annual assessments of the availability of mental health services throughout the state, particularly crisis stabilization services and updates on steps taken to increase availability;

2. Commitment to a financing plan approved by CMS to be implemented by the end of the demonstration to increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, coordinated community crisis response that involves law enforcement and other first responders, and observation/assessment centers as well as on-going community-based services, e.g., intensive outpatient services, assertive community treatment, xciii and services in integrated care settings such as the Certified Community Behavioral Health Clinic model described in Part I of State Medicaid Director letter #18--011 issued on November 13, 2018, as well as consideration of a self-direction option for beneficiaries;

3. 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;

4. 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 help determine appropriate level of care and length of stay;

Milestone 4: Earlier Identification and Engagement in Treatment Including Through Increased Integration

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with serious mental health conditions, in treatment sooner including through supported employment and supported education programs;

2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of serious mental health conditions sooner and improve awareness of and linkages to specialty treatment providers;

3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

4. Use of a utilization review entity (e.g., 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;

5. Participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements, and the state has a process for conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, states must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment 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);

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

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypotheses indicated below. Utah will identify validated performance measures that adequately assess the impact of the demonstration to beneficiaries. The State will submit the evaluation plan to CMS for approval.

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

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
The demonstration will reduce utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings	• All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care • Follow-Up After Emergency Department Visit for Mental Illness	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons
The demonstration will reduce preventable readmissions to acute care hospitals and residential settings	• 30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons
The demonstration will improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state	• Mental Health Services Utilization • Beneficiaries With SMI/SED Treated in an IMD for Mental Health • Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons
The demonstration will improve access to community-based services to address the chronic mental health care	• Access to Preventive/Ambulatory Health Services for	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include

needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care	Medicaid Beneficiaries With SMI ● Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) ● Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication		experimental or quasi-experimental comparisons
The demonstration will improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities	● Follow-up After Hospitalization for Mental Illness ● Medication Continuation Following Inpatient Psychiatric Discharge	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons

Section III. Demonstration Eligibility

This demonstration will include all Medicaid eligible individuals, age 21-64, approved for full Medicaid benefits under the Utah Medicaid State Plan and the State's 1115 Demonstration Waiver. The eligibility groups below will be excluded from this demonstration waiver, due to their limited Medicaid eligibility status:

- Qualified Medicare Beneficiaries (QMB);
- Special Low-Income Medicare Beneficiaries (SLMB);
- Qualified Individual Special Low-Income Medicare Beneficiaries (QI/SLMB2); and
- Non-citizens qualifying for emergency services only benefits.

Although eligible for the benefits available through this amendment, all beneficiaries receiving services through this amendment must meet medical necessity criteria. Utilization management procedures will ensure all eligible beneficiaries have access to the appropriate levels of care with appropriate lengths of stay in inpatient and residential settings based on defined clinical criteria for medical necessity.

Section IV. Demonstration Benefits and Cost Sharing Requirements

Under this demonstration, eligible individuals will have access to high quality, evidence-based SMI/SED treatment in short term residential and inpatient settings. The following services are currently covered under the Utah Medicaid State Plan:

- Crisis Stabilization Services
- Mobile Crisis Outreach Team

- Assertive Community Treatment
- Psychiatric Diagnostic Evaluation
- Mental Health Assessment
- Psychological Testing
- Psychotherapy
- ASAM LOC 1.0 - 4.0
- Therapeutic Behavioral Services
- Pharmacologic Management
- Psychosocial Rehabilitative Services
- Services Provided in Intensive Outpatient Treatment
- Peer Support Services
- Inpatient Psychiatric Services
- Treatment Provided in Residential Treatment Programs

Cost Sharing

This amendment does not impose new cost sharing requirements. Cost sharing will not differ from those provided under the state plan.

Section V. Delivery System

No modifications to the current Utah Medicaid FFS or managed care arrangements are proposed through this amendment; all enrollees will continue to receive services through their current delivery system.

Section VI. Enrollment and Implementation of Demonstration

Eligible individuals may receive services authorized under this demonstration as of the implementation date of this amendment.

Section VII. Demonstration Financing and Budget Neutrality

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

Projected Enrollment and Expenditures

Currently, Utah Medicaid provides inpatient and residential mental health treatment for all beneficiaries. This demonstration will expand the availability and access to needed treatment for all beneficiaries. The State anticipates the waiver amendment will have no impact on annual Medicaid enrollment.

Below is the projected enrollment and expenditures for each demonstration year.

	DY19 (SFY 21)*	DY 20 (SFY 22)
Member Months	8,400	17,300
Expenditures	$113,900,000	$245,800,000

*Represents half year estimate January 2021 - June 2021

Section VIII. Proposed Waiver and Expenditure Authority

The State requests expenditure authority for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment for a SMI who are short-term residents in facilities that meet the definition of an IMD. No additional waivers of Title XIX or Title XXI are requested through this amendment.

Section IX. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public Notice of the State's request for this demonstration amendment, and notice of Public Hearing were advertised in the newspapers of widest circulation and sent to an electronic mailing list (Attachment 2). In addition, the abbreviated public notice was posted to the State's Medicaid website at https://medicaid.utah.gov/1115-waiver.

Two public hearings to take public comment on this request were held. The first public hearing was held on June 18, 2020 from 4:00 p.m. to 6:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting (Attachment 3). The second public hearing was held on June 23, 2020 from 4:00 p.m. to 5:00 p.m. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings were held via video and teleconferencing.

Public Comment

The State accepted public comment during a 30-day public comment period held June 16, 2020 through July 16, 2020. The State received comments from one individual and one agency. The State reviewed and considered the comments received.

Comments

One commenter stated that while Utah needs additional residential beds for behavioral health issues, they are concerned that care provided in larger facilities will be less focused and less individualized. They also believe larger facilities can lead to "warehousing" and the removing of an individual's rights.

State Response: The purpose of the waiver request is to expand the continuum of care that is currently available in the state and increase the availability of residential treatment options for Medicaid members in need of mental health services. As there are currently several residential mental health treatment programs in the state, many of them are not accessible to Medicaid members due to the limited number of beds. This amendment would allow members to access these needed services at facilities with more than 16 beds. The average length of stay under this amendment will be no more than 30 days. The overall goal of the amendment request is to maintain and enhance the flexibility and availability of mental health treatment supports and to supplement the comprehensive and integrated continuum of mental health treatments in all Utah communities. This will be monitored through the following milestones that must be met or the waiver approval will be revoked:

- Earlier Identification and Engagement in Treatment
- Integration of Mental Health Care and Primary Care
- Improved Access to Services Across the Continuum of Care Including Crisis Stabilization Services

- Better Care Coordination and Transitions to Community-based Care
- Increased Access to Evidence-based Services that Address Social Risk Factors

One commenter stated the purpose of an 1115 demonstration waiver is to test novel approaches to improving medical assistance for low-income individuals. They believe this amendment request does not propose an actual experiment, with stated goals, hypothesis and measures, and it is not clear that this amendment will improve the currently inadequate mental health system for serious mental illness. They also believe CMS has granted states authority to waive the IMD exclusion, despite the illegality of these waivers. They state that it is no longer plausible for States to claim that providing FFP for IMD services is an experiment, after more than 25 years of these waivers.

State Response: As stated in State Medicaid Director letter #18-011 issued by CMS on November 3, 2018, section 12003 of the Cures Act requires CMS to provide for opportunities for "demonstration projects under section 1115(a) of the Act to improve care for adults with SMI and children with SED (referred to as this "SMI/SED demonstration opportunity"). Under section 1115(a) of the Act, the Secretary of HHS ("Secretary") or CMS, operating under the Secretary's delegated authority, may authorize a state to conduct experimental, pilot, or demonstration projects that, in the judgment of the Secretary, are likely to assist in promoting the objectives of title XIX of the Act. This SMI/SED demonstration opportunity will allow states, upon CMS approval of their demonstrations, to receive FFP for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as IMDs if those states are also taking action, through these demonstrations, to ensure good quality of care in IMDs and to improve access to community-based services…". This demonstration will require a focus on demonstrating improved outcomes for individuals with serious mental health conditions in inpatient and residential settings, as well as through improvements to community-based mental health care. The State will be required to demonstrate progress towards, and the accomplishment of several milestones listed in the SMD letter, as well as designing its evaluation of the demonstration according to the requirements set forth by CMS. The State included specific hypotheses in the demonstration amendment, as outlined in CMS guidance to meet these requirements.

One commenter stated that FFP for IMDs risks diverting resources away from community-based services and undermining community integration. They add that the State provides no plan to bolster the inadequate system of community-based supports for adults with SMI in Utah.

State Response: The 1115 waiver requires several milestones that support community integration and bolstering community-based programs. The details can be found in the State Medicaid Director letter that announced this 1115 opportunity, which can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf. The required milestones are listed below. Each milestone comes with extensive metrics and analysis that must be audited by an external party and reported to CMS. As part of the approval process, the State must create an implementation plan that outlines how each milestone will be accomplished. If the State is not accomplishing these milestones, CMS can revoke the 1115 waiver approval.

1. Earlier Identification and Engagement in Treatment
2. Integration of Mental Health Care and Primary Care
3. Improved Access to Services Across the Continuum of Care Including Crisis Stabilization Services
4. Better Care Coordination and Transitions to Community-based Care
5. Increased Access to Evidence-based Services that Address Social Risk Factors

The commenter also stated IMDs are residential settings where individuals with disabilities receive services, and decisions regarding funding for services in IMD's will inevitably have an impact on where people with disabilities receive services. They further state increasing services for adults with SMI in large institutional settings furthers discriminatory presumptions about the ability of individuals with disabilities to receive services in community-based settings and undermines the integration mandate articulated by the Supreme Court in *Olmstead v. LC.* They believe this request promotes the segregation of people with mental illness.

State Response: The purpose of the waiver request is to expand the continuum of care that is currently available in the state, and increase the availability of residential treatment options for Medicaid members in need of mental health services at a higher level of care, including members with disabilities. The amendment requests the opportunity to provide services for acute mental health treatment in facilities with greater than 16 beds with an average length of stay of no greater than 30 days. As part of the waiver approval process the state must meet several milestones including, better care coordination and transitions to community-based services.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver amendment. Normally because of this notification, DMHF would begin the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting to present this demonstration amendment. However, a UIHAB meeting was not held prior to August 1, 2020, the date of submittal required by House Bill 219. In response, the UDOH Indian Health Liaison sent a letter to Tribal Leaders and UIHAB Representatives informing them of this amendment and directing any questions or feedback to DMHF. A copy of this letter can be found in Attachment 4. No comments or feedback were received prior to this amendment being submitted to CMS. DMHF representatives will attend the UIHAB meeting on August 14, 2020 to present this amendment and discuss any questions or feedback.

The Tribal consultation process will include, but is not limited to:

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

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

Section X. Demonstration Administration

Name and Title: Nate Checketts, Deputy Director, Utah Department of Health
Telephone Number: (801) 538-6689
Email Address: ncheckets@utah.gov

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

UTAH DEPARTMENT OF HEALTH MEDICAID

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WOW
Current Eligibles					*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	0	377,866	0.0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	5.3%	0	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults with Children						*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**									
Eligible Member Months	5.9%	0	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	5.3%	0	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure					$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children								*Anticipated start of 9/1/20*		
Pop Type:	**Hypothetical**									
Eligible Member Months	34.9%	0	6,067	34.9%	8,182	11,034	14,881	16,723	27,064	
PMPM Cost	5.3%	0	$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 19,512,792	$ 33,251,572	$ 58,501,135
Demo Pop I - PCN Childless Adults						*PCN ends 3/31/19*				
Pop Type:	**Medicaid**									
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure					$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults								*Anticipated start of 9/1/20*		
Pop Type:	**Medicaid**									
Eligible Member Months	159	0		2.5%	163	167	171	146	180	
PMPM Cost	68.45	0		5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Targeted Adults							*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**				*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		0	0	2.5%	78,000	78,000	$ 126,000	172,200	176,505	
PMPM Cost		0	$ -	5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure					$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults						*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Pop Type:	**Expansion**									
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure					$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care							*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**									
Eligible Member Months		0			-		720	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	$ -		$ 2,100.00	$2,211.30	$2,328.50	
Total Expenditure					$ -		$ 1,512,000	$ 3,184,272	$ 3,353,038	$ 8,049,310
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure					$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged							*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**									
Eligible Member Months	2.5%	0	108,000				54,000	110,700	113,468	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WOW
Former Foster										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure					$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)										
Pop Type:	**Hypothetical**									
Eligible Member Months	6.9%	18	36,913	6.9%	39,456.31	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Started 5/1/19*				
Eligible Member Months	0.0%	0	4,018	0.0%		670	4,018	4,018	4,018	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations										
Pop Type:	**Hypothetical**							*Assumes start date of 7/1/21*		
Eligible Member Months	1.75%		3,200	1.75%	-			38,400	39,072	
PMPM Cost	3.0%			3.0%	-		$ -	$ 520.00	$ 535.60	
Total Expenditure					-		$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)										
Pop Type:	**Hypothetical**							*Assumes start date of 1/1/21*		
Eligible Member Months	2.5%		16,835	2.5%	-			8,418	17,256	
PMPM Cost	5.3%			5.3%	-		$ -	$ 13,527	$ 14,244	
Total Expenditure					-		$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		339,828	2.5%	-		169,914	348,324	357,032	
PMPM Cost	5.3%			5.3%	$ -		$ 671.61	$ 707.21	$ 744.69	
Total Expenditure					$ -		$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		400,973	2.5%	-		200,487	410,997	421,272	
PMPM Cost	5.3%			5.3%	-		$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure					-		$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								10,292	10,832	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiun*			
Eligible Member Months	5.25%		121,473	5.25%	-		58,671	123,503	129,987	
PMPM Cost	5.3%			5.3%	$ -		$ 656.90	$ 691.72	$ 728.38	
Total Expenditure					$ -		$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								32,570	34,280	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiun*			
Eligible Member Months	5.25%		384,418	5.25%	-		185,674	390,844	411,363	
PMPM Cost	5.3%			5.3%	-		$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure					-		$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715

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

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

Assumes start date of 7/1/21 (SFY22)

Anticipated start date of 9/1/20 (10 months of SFY21)

$ 6,618,271,791

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**						*Anticipated start date of 9/1/20*		
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 16,723	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 19,512,792	$ 33,251,572	$ 58,501,135
Demo Pop I - PCN Childless Adults					*PCN ends 3/31/19*				
Pop Type:	**Medicaid**								
Eligible Member Months		70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost	$	48.97	5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure				$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults									
Pop Type:	**Medicaid**						*Anticipated start date of 9/1/20*		
Eligible Member Months		159	4.9%	167	175	184	160	202	
PMPM Cost	$	68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Targeted Adults						*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months			2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults									
Pop Type:	**Expansion**				*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months			2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	
Total Expenditure				$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled									
Pop Type:	**Hypothetical**								
Eligible Member Months			0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost			3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure				$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months			0%	-	-	54,000	110,700	113,468	
PMPM Cost			3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure				$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/21*		
Eligible Member Months		1.75%	-	-	-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 1/1/21*		
Eligible Member Months		2.5%	-	-	-	8,418	17,256	
PMPM Cost		5.3%	-	$ -	$ -	$ 13,526.99	$ 14,243.92	
Total Expenditure				$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure			$ -	$ -	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure			-	$ -	$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	$ -	$ -	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure			$ -	$ -	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	-	$ -	$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure			-	$ -	$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
								$ 6,618,271,791

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

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

Assumes start date of 7/1/21 (SFY22)

Anticipated start date of 9/1/20 (10 months of SFY21)

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost		$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost		$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**						*Anticipated start date of 9/1/20*		
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 16,723	$ 27,064	
PMPM Cost		$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 19,512,792	$ 33,251,572	$ 58,501,135
Demo Pop I - PCN Childless Adults					*PCN ends 3/31/19*				
Pop Type:	**Medicaid**								
Eligible Member Months		70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost		$ 48.97	5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure				$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults									
Pop Type:	**Medicaid**						*Anticipated start date of 9/1/20*		
Eligible Member Months		159	4.9%	167	175	184	160	202	
PMPM Cost		$ 68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Former Targeted Adults						*Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility.* *PMPM will increase due to adding new managed care directed payments.* *PMPM will decrease due to removing the housing support benefit, and for non-medically frail individuals removing certain benefits from the traditional package.*			
Pop Type:	**Expansion**			*Started 11/1/17*					
Eligible Member Months			2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,281.14	$ 1,349.04	$ 1,420.54	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 155,909,778	$ 220,402,517	$ 237,885,946	$ 771,054,298
Dental - Targeted Adults					*Started 3/1/19*				
Pop Type:	**Expansion**								
Eligible Member Months			2.5%	-	12,000	18,450			
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 687,556	$ -	$ -	$ 1,087,556
System of Care						*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**								
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	
Total Expenditure				$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled									
Pop Type:	**Hypothetical**								
Eligible Member Months			0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost			3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure				$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged						*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**								
Eligible Member Months			0%	-	-	54,000	110,700	113,468	
PMPM Cost			3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure				$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2021*		
Eligible Member Months		1.75%	-		-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2021*		
Eligible Member Months		2.5%	-		-	8,418	17,256	
PMPM Cost		5.3%	-	$ -	$ -	$ 13,526.99	$ 14,243.92	
Total Expenditure				$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 640.57	$ 674.52	$ 710.27	
Total Expenditure			$ -	$ -	$ 108,841,789	$ 234,951,327	$ 253,588,841	$ 597,381,956
Expansion Adults w/out Dependent Children <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 899.03	$ 946.68	$ 996.85	
Total Expenditure			-	$ -	$ 180,242,854	$ 389,081,237	$ 419,945,107	$ 989,269,198
Expansion Parents 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**							
Eligible Member Months		5.25%	-	-	53,048	111,667	117,529	
PMPM Cost		5.3%	$ -	$ -	$ 625.86	$ 659.03	$ 693.96	
Total Expenditure			$ -	$ -	$ 33,200,871	$ 73,591,888	$ 81,560,602	$ 188,353,362
Expansion Adults w/out Dependent Children 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		5.25%	-	-	167,879	353,386	371,939	
PMPM Cost		5.3%	-	$ -	$ 882.60	$ 929.37	$ 978.63	
Total Expenditure			-	$ -	$ 148,169,813	$ 328,428,021	$ 363,991,028	$ 840,588,862

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

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

Assumes start date of 7/1/21 (SFY22)

Anticipated start date of 9/1/20 (10 months of SFY21)

$ 6,232,205,690

ATTACHMENT 2

Public Notice Requirements

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

Deseret News

Utah Media Group

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UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME, CRAIG DEVASHRAYEE PO BOX 143102 SALT LAKE CITY UT 84114	9001406923
	DATE: 6/22/2020

ACCOUNT NAME
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME,

TELEPHONE	ORDER # / INVOICE NUMBER
8015386641	0001292365 / 01292365-06162020

PUBLICATION SCHEDULE
START 06/16/2020 END 06/16/2020

CUSTOMER REFERENCE NUMBER
QAZ: Utah 1115 Waiver Amendment

CAPTION
PUBLIC NOTICE Utah 1115 Waiver Amendment The Utah Department of Health, Divisio

SIZE
72 LINES 2 COLUMN(S)

TIMES	TOTAL COST
3	246.92

PUBLIC NOTICE
Utah 1115 Waiver Amendment

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss an amendment to the State's 1115 Demonstration Waiver. The DMHF will also accept public comment regarding the demonstration amendment during the 30-day public comment period from June 16, 2020 through July 16, 2020.

With this amendment, the DMHF is requesting expenditure authority to claim federal financial participation (FFP) for services provided to Medicaid beneficiaries, age 21-64, who receive inpatient psychiatric services or residential mental health treatment in an Institution for Mental Disease (IMD). 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.

Public Hearings:
The DMHF will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing.

o Thursday, June 18, 2020 from 4:00 to 6:00 p.m. during the Medical Care Advisory Committee (MCAC) meeting
o Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/ahg-ngsm-ank
o Or join by phone: 1-608-879-0629
(PIN: 280 891 653#)

o Tuesday, June 23, 2020 from 4:00 to 5:00 p.m.
o Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/zho-xdbr-xeg
o Or join by phone: 1-561-614-0004
(PIN: 113 934 982#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4733 by 12:00 p.m. on Wednesday June 17, 2020.

Public Comment:
A copy of the public notice and proposed amendment are available online at:
https://medicaid.utah.gov/1115-waiver

The public may comment on the proposed amendment request during the 30-day public comment period from June 16, 2020 through July 16, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

1292365 UPAXLP

AFFIDAVIT OF PUBLICATION

AS NEWSPAPER AGENCY COMPANY, LLC dba UTAH MEDIA GROUP LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF **PUBLIC NOTICE Utah 1115 Waiver Amendment The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss** FOR **UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME,** WAS PUBLISHED BY THE NEWSPAPER AGENCY COMPANY, LLC dba UTAH MEDIA GROUP, AGENT FOR DESERET NEWS AND THE SALT LAKE TRIBUNE, DAILY NEWSPAPERS PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON Start 06/16/2020 End 06/16/2020

DATE 6/22/2020

SIGNATURE [redacted]

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 22ND DAY OF JUNE IN THE YEAR 2020

BY LENEA TAPUSOA.

LORIANE MARIE GUDMUNDSON
NOTARY PUBLIC - STATE OF UTAH
COMMISSION# 699563
COMM. EXP. 03-19-2024

[redacted]
NOTARY PUBLIC SIGNATURE

Department of Health:
Medicaid Expansion Workgroup

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendment

Notice Type: Notice, Hearing

Event Start Date & Time: June 18, 2020 04:00 PM

Event End Date & Time: June 18, 2020 06:00 PM

Description/Agenda:

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- Tuesday, June 23, 2020, from 4:00 to 5:00 p.m.
- Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/zha-xkbr-skg

Meeting Location:

Video/Teleconference
Salt Lake City ,

Map this!

Contact Information:

Jennifer Meyer-Smart
jmeyersmart@utah.gov (801)538-6338

Audio File Address

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- Or join by phone: 1-561-614-0004 (PIN: 113 934 982#)

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Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 12:00 p.m. on Wednesday June 17, 2020.

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Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

Notice of Special Accommodations:

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Jennifer Meyer-Smart at 801-538-6338.

Notice of Electronic or telephone participation:

- Thursday, June 18, 2020 from 4:00 to 6:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting - Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/qfg-ngsm-qnk - Or join by phone: 1-608-879-0629 (PIN: 280 891 653#)

Other Information

This notice was posted on: June 16, 2020 08:09 AM
This notice was last edited on: June 16, 2020 08:56 AM
Deadline Date: June 18, 2020 06:00 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

Department of Health:
Medicaid Expansion Workgroup

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendment

Notice Type: Notice, Hearing

Event Start Date & Time: June 23, 2020 04:00 PM

Event End Date & Time: June 23, 2020 05:00 PM

Description/Agenda:

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  meet.google.com/qfg-ngsm-qnk
- Or join by phone: 1-608-879-0629 (PIN: 280 891 653#)

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Meeting Location:

Video/Teleconference
Salt Lake City ,

Map this!

Contact Information:

Jennifer Meyer-Smart
jmeyersmart@utah.gov (801)538-6338

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Other Information

This notice was posted on: June 16, 2020 08:35 AM
This notice was last edited on: June 16, 2020 08:48 AM
Deadline Date: June 23, 2020 05:00 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

ATTACHMENT 3

Medical Care Advisory Committee

Public Hearing

UTAH DEPARTMENT OF HEALTH

Medical Care Advisory Committee Agenda

Meeting:	Medical Care Advisory Committee
Date:	June 18, 2020
Start Time:	4:00 p.m.
End Time:	6:00 p.m.
Location:	Google Hangout Meeting (only works in the Chrome web browser)
	meet.google.com/qfg-ngsm-qnk
	Or join by phone 1 608-879-0629 PIN: 280 891 653#

Agenda

1.	Welcome • Approve Minutes for May 2020 MCAC*	Dr. Cosgrove	5 minutes
2.	1115 Demonstration Waiver Amendment Public Hearing – • Behavioral Health Services Received in an IMD	Members of the Public	15 minutes
3.	Proposed Budget Cuts Update	Emma Chacon	10 minutes
4.	Budget Recommendations	Members of the Public	75 minutes
5.	Medicaid Expansion Updates and Director's Report	Emma Chacon	10 minutes
6.	Regular Reports as time allows: • New Rulemakings** • Eligibility Enrollment Update** • Medicaid Expansion Report and Update**	 Craig Devashrayee Jeff Nelson Jennifer Meyer-Smart	As Time Allows
7.	Additional Public Hearing Comments	Members of the Public	Time Remaining
8.	Adam Montgomery Resignation – Thank you Adam for your contributions to the MCAC	Dr. Cosgrove	

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
** Informational handout in the packet sent to Committee members

To get on the list to present budget recommendations, email ssteigerwalt@utah.gov.

Please note the following as you join the Google Hangout Meeting:

1. Mute your computer or phone and remain muted throughout the meeting.
2. The audience has the same authority as the presenter. Do not explore the bells and whistles of the Google Hangouts system during the meeting as you could accidentally take over the presentation. When an individual takes over the presentation, it usually causes all attendees to shift to that person's screen. If this occurs, the person will be removed from the meeting and will have to log back in. If this situation happens and you, as a participant, are inadvertently taken to another participant's screen, click on the main presenter again to return to view the seminar.

Next Meeting: July 16, 2020
2:00 p.m. – 4:00 p.m.
Vote on Budget Recommendations

Medical Care Advisory Committee

Minutes of June 18, 2020

Participants

Committee Members (via phone)

Dr. William Cosgrove (Chair), Jessie Mandle (Vice Chair) Jenifer Lloyd, Christine Evans, Muris Prses on behalf of Dale Ownby, Brian Monsen, Adam Cohen, Stephanie Burdick, Mark Brasher, Michael Hales, Pete Ziegler, Gina Tuttle, Adam Montgomery, and Mary Kuzel

Committee Members Absent

Sara-Carbajal-Salisbury, Dr. Robert Baird, Joey Hanna, Danny Harris, and Mike Jensen

DOH Staff (via phone)

Nate Checketts, Emma Chacon, Tonya Hales, Eric Grant, Brian Roach, Jeff Nelson, Jennifer Meyer-Smart, Craig Devashrayee, John Curless, Greg Trollan, Jennifer Strohecker, Kevin Bagley, Dean Weedon, Dave Lewis, Joel Hoffman, Matt Ohrenberger, Sarah Miles, David Wilde, Todd Neff, Tanya Edvalson , Suzanne Puckett, , Laurie Bird, Kim Michelson, Tracy Barkley, Joel Hoffman, Sharon Steigerwalt, and Dorrie Reese.

Guest (via phone)

Ashley Spatafore, Audry Wood, Barb Viskochil, Becky Gonzales, Beth Noyce, Drew Mingl, Ellen Maxfield, Joleen Huber, Kim Correa, Kory Holdaway, Matt Hansen, Matthew Mulligan, Maren Jacobsen, Merry Jane Lee, Michael Halligan, Robert "RJ" Key, Russ Kuzel, Sarah Hodson, Sarah Woolsey, Scott Horne, Sherri Wittwer, Stephanie Puffer, Teresa Brewer, and Todd Wood

Approval of Minutes

Jessie Mandle made the motion to approve the May 21, 2020 MCAC minutes. Brian Monsen seconded that motion. The group unanimously agreed.

Public Hearing for 1115 Waiver Amendment – Jennifer Meyer-Smart:

Jennifer Meyer-Smart discussed the Public Hearing for 1115 Waiver Amendment: Behavioral Health Services for Adults with Serious Mental Illness.

The document which was presented is embedded in this document

Public Hearing Overview-MH IMD-Fir

<u>Public Comments:</u>

Adam Montgomery: IMD good waiver there are certain residential treatment centers that are limited to that 16-bed, I am thinking right now Wasatch Mental Health has 16-bed residential unit I wonder why they don't open up another one, three or four that would help people transition out of places like the State Hospital. So, overall I am for it I have a few worries about it, your mention trying to match what we do for substance abuse disorder that's a little scary for me I think one of the benefits of having the 16-beds that it is more individualized treatment it is more focused and we have more space in those treatments then if you go to a substance use disorder treatment center where it is over 16-30 beds they will often cram people together a little to much for people with serious mental illness.

Proposed Budget Cuts Update – Emma Chacon:

Emma Chacon discussed the Proposed Budget Cuts.
Due to the impact of COVID the legislature asked agencies to identify 2%, 5% and 10% budget cuts, at that time projecting a gap in revenue anywhere from $587M-$1.2Billion. Appropriations Committee met and they voted on a list of cuts in certain priorities. When the EAC met to take final action of reduction recommendation from subcommittees and receive the most current revenue projections. LFA indicated that the revenue projections did not consider any impact if we experience another surge of COVID 19 in the fall.. . In the end the Legislature made some extreme effort to minimize cuts to health and human service programs and education by appropriating funds from rainy day and restricted accounts. However, some reduction will need to be taken out of the Medicaid and CHIP budgets..

Each year as we invite individuals to come to the MCAC and make their presentation regarding budget needs in Medicaid. This is the first phase of the budget or appropriations process for the new fiscal year. The MCAC is an advisory body. The MCAC will listen to your budget presentations and will then vote on their recommended budget priorities during the July meeting. Again, this is the first step of the budget process. We will take the MCAC's recommendation into consideration as we prepare our budget requests for the new year that we submit to the Department. The Department will determine priorities and will then submit those requests to GOMB. GOMD will then prepare the Governor's budget that is release in December. We need to be realistic about the fact there are many needs we are in a midst of a recession that we are not likely to come out of soon.

Question:
Jesse Mandle asked Emma can you clarify there was money that they talked about yesterday in Executive Committee meeting $56M from the Medicaid account that was being used, is that money being dedicated to fill the Medicaid cuts? Or is that money being used for other purposes? because there are significant Medicaid cuts that some of us will be seeking today, and yet means there are reserves in Medicaid that could be used to fill those cuts. Do you have a sense for that?

Emma Chacon response you know honestly Jesse I don't know for certain they did make the comment that they were going to tap into $56M, I don't recall hearing them say that they were only going to use it to take care of Medicaid cuts I will ask Nate or Michael if they will have some insight to that.

Nate Checketts response: I have not heard that it was going to be dedicated just to us for the Medicaid cuts

Michael Hales response I think it would be helpful for the Department knows of the funding used such as the Expansion fund, Medicaid Growth Reduction & Budget Stabilization, Restrictive account, and Medicaid restricted account. How much money of that money was used? and send that report to the MCAC after the meeting.

Emma Chacon we can send that information once we figure it out.

Jesse Mandle asked has the budget from the cuts yesterday been approved yet? Don't know where the bill stands at this time?

Emma Chacon response I have not seen the bill yet. They have the bill that basically addresses the core changes that needs to be made for the items that are on the list. I have not seen the actual appropriations bill yet that makes those reductions unless it came out in the last 30-40 minutes.

Budget Recommendations:

➢ CoMagine Health and Get Healthy Utah – Dr. Sarah Woolsey and Sarah Hodson

Dr. Sarah Woolsey and Sarah Hodson discussed Medicaid coverage for Women with a history of Gestational Diabetes.

The document which was presented is embedded in this document

Hodson - Medicaid Coverage for Women

Questions:
Stephanie Burdick asked who teaches the class?

Response: CDC evidence-based class. So, the CDC offers training program and so they are called lifestyle coaches, so once they go through the training then they offer it can be really PHW, nutritionist anyone in a Health Department.

Jessie Mandle asked do you have a list of the other States, Is it in the packets?

Response: Are you asking about Medicaid coverage in other States?

Jessie Mandle: Yes

Response: It's not in the packet, but I can tell you it's California, Minnesota, Montana, New Jersey, New York, Oregon, and Wyoming. On the CDC National DCP page it lists them.

➢ Catalyst Healthcare – Michael Halligan

Michael Halligan discussed Spencer-home medication dispense.

The documents which were presented are embedded in this document

Halligan - The Spencer.pdf

https://youtu.be/zxd_4oZSf5k https://youtu.be/onbrafYvytI

Questions:
Stephanie Burdick asked a question more for Nate and Emma to respond. Is this something that is needed or is already operating among our Medicaid recipients I just thought a lot of these things were being done already. Is this something needed more in the FFS population or is there a gap there? I am just trying to understand the need.

Emma Chacon responded we certainly don't have a lot of the ability to manage especially the FFS population, our assumption is that the ACO have the flexibility to implement these kinds of programs and likely in different ways particularly for individuals with complex situations they maybe are already doing some sort of oversite like this I don't know. Brian do you have any insight to what Molina or others are doing? This certain provides remote monitoring.

Stephanie Burdick response: So, you just partner with the providers office? If this was to be adopted, I guess how would you identify the population group that you would be trying to provide this service to.

Michael Halligan response: The way it's been done is looking at members are traditionally not refilling their prescriptions. They might be on five or more meds they are likely showing under claims data more expensive over the years than average so way to improve that again the quality of health outcomes they look at that factor with respect to Medicaid a lot of the engagement is based on the satisfaction of the member. Mental Health particularly has a very low engagement and other low satisfaction it's difficult to reach them. So, that is one area that has been looked at is diabetes and cardiovascular conditions.
Adam Montgomery response: I have to say that this would be pretty good for Mental Health clients, especially for medication management that we used to do in person changing to a system. Is this mainly for Mental Health clients? Or is it mainly for the elderly? What are you looking to implement this for?

Michael Halligan: It is actually both different use cases. Aging population doesn't really have access to home care often so this is a way so this is a way to ensure that they have it. Mental Health you are really accurate because mental health patients like the fact that device they are connecting with its not a person reminding them, it's not intrusive. It still allows them to move within the community because if they leave home a smart phone alerts them when to take their meds and then they do have access to the providers real time, so if they do have to reach out because they are feeling depressed or any other behavior health issues they can.

Pete Ziegler: I've seen people try to implement innovations like this in the FFS world in Medicare they are billing for I see am all-inclusive device here, I see remote patient monitoring with a blue tooth device, I see chronic care management with the text messaging type communication and I see a telehealth platform, and I am also seeing this medication management piece. Are you asking to have an FFS code like you get with Medicare to ask Medicaid to pay for an FFS similar to like Medicare does or are you looking more for a bundle payment kind of like you get with an alternative bundle payment model?

Michael Halligan response: The FFS Medicare they are still using this to deliver remote patient monitoring, transiting care, chronic care management, and also telemedicine. Those fee codes are available under Medicare. In Medicaid its actually a benefit that has been available for assist in technology close to 20 States that certain populations are able to use as an assisted technology device since it is connected and it is connected to providers. And providers under Medicaid can connect with the patients as well, we would like to see the fee codes available on the Medicaid side as well. The providers can go to CMS and have it approved. In Tennessee we have a system that has 4,000 patients on it.

Pete Ziegler: There was an ask last year for remote patient monitoring codes in addition to Utah has telehealth codes. There was an ask last year for the remote patient monitoring codes, but that would have covered the Bluetooth vital sign machine piece of this, but it wouldn't cover the medication management piece of this that seems like a critical piece of this to.

➢ Homecare and Hospice Association of Utah – Matt Hansen and Stephanie Puffer

Matt Hansen and Stephanie Puffer discussed Nursing Facility room and board reimbursement discrepancy for Hospice Agencies and Upper Payment Limit (UPL)v payment cessation for Nursing Facilities.

The documents which were presented are embedded in this document

Hansen - Contracted Hospice Room & Boa

Hansen - UPL Presentation.pdf

Questions:

Pete Ziegler: I represent the skilled nursing facilities here. The skilled facilities are required to provide the same services to patients whether hospice is there or not, so it would be inappropriate for payment to happen to ask hospice staff to do something that the skilled nursing staff are already receiving reimbursement for because there inside the facility hospice is in addition to not an instead of that just needs to be clear. I am glad we are all having this discussion making sure that every patient is getting the right care, at the right place, at the right time. I am glad you are talking to Dirk and the Utah Healthcare Association about this as well. It doesn't sound like you are seeking any budget request here more just a policy change if I am hearing your request correctly.

Matt Hansen response: Correct. As far as the state and the budget goes it is budget neutral. It does have an impact on the potential on facilities especially that is why we are trying to look for a solution as well, because we realize that there is an impact on how we look at it, that is why we are putting the beneficiary first.

➢ Alternative Behavioral Strategies (ABS) – RJ Keys

RJ Keys discussed Alternative Behavioral Strategies (ABS) Medicaid rates in Utah and the effects it has on Access to Care.

➢ The INN Between – Kim Correa

Kim Correa discussed Medicaid respite for persons experiencing homelessness

The documents which were presented are embedded in this document

Correa - The INN Between Proposal 6-1

Questions:

Jesse Mandle asked do you know if other states have an 1115 Waiver?

Kim Correa response: So far from all the research I have done no states have fully implemented it. I know that several other communities are trying to get an 1115 Waiver done, I know Colorado right now is probably the only one working the hardest on it. I think Utah could be on the four fronts of it and be a model for other states to follow. There are plenty other states that have larger homeless issues to deal with, but we still have quite an issue to deal with and we have an facility that is already operating whereas most of the other states don't have an actual facility, they are doing medical respite care out of hotels, and that is a very costly proposition, and it also does not provide the 24-hour care giver support because these folks are out on their own as far as a health concern it's not as productive.

➢ University of Utah Health – Michael Hales

Michael Hales discussed Restoring Hospital payments-outpatient reimbursement 2.7%.

Questions:

Stephanie Burdick asked are you asking on behalf of just the University of Utah hospital or are you asking for all the hospitals?

Michael Hales response: This is on behalf of all hospitals, so as the UHA representative to the MCAC I am speaking on behalf of all of the Utah hospitals saying that we would like to have these cuts restored and not fall further behind where we will plan to be after these cuts this week.

Stephanie Burdick response: So, the follow-up on that. Not all hospitals are created equally right? I am just trying to think through you have non-profit hospitals and then you have some of the for-profit hospitals one of which is problematic in some ways. I am just trying to think through like, what is your suggestion of how we try, like hospitals take up a big part of the budget in healthcare, the expenditures keep going up significantly over the past 20-years in a recession like if we don't try to adjust some of the spending especially in some of the areas where the spending is significant then it is just going to end up hurting the people who are eligible for Medicaid I feel like we cannot continually put it all on well income people to be the ones that suffer in economic times that suffer. There has got to be reserves in some of these hospitals. How do we make those types of decisions? I'm just curious what your thoughts are?

Michael Hales response you clearly raise a lot of broad questions for discussions that maybe we can discuss in some future MCAC meeting. I think we just recognize that the hospitals are looking for fair compensation if you look at all the impact on hospitals across the state over the last several months in terms of responding to the COVID-19 crisis we are a big percentage of the budget the in the commercial plan or the Medicaid it is where you are going to go if you need treatment. We need to make sure that we have hospitals that have adequate reimbursement for the services they provide. I recognize a lot of important priorities this is not going to be my number one vote when we vote next month, I think the presentation done by ABS and Mr. Key was very compelling that we are on the verge of a crisis, not saying that we are not at a crisis level I am just saying as we look to build the budget we need to make sure we adequately reimburse providers for core services on the program

➢ Disability Law Center – Andrew Riggle

Andrew Riggle discussed Individuals with disabilities.

The documents which were presented are embedded in this document

Riggle - DLC FY 22 MCAC Budget Comme

Questions:

Dr. Cosgrove ask what is the total ask?

Andrew Riggle response: I will have to go back and total up what Executive Appropriations did yesterday and the Legislature has done today and get that to you all.

➢ Voices for the Utah Children – Jessie Mandle

Jessie Mandle discussed Medicaid cuts restoring benefits

- 12-month Continuous Eligibility
- Rural Case Management
- Baby Watch

ACTION

Jesse Mandle will follow-up with funding and additional material

Public Hearing Comments for 1115 Waiver Amendment – Dr. Cosgrove:

Dr. Cosgrove asked if there were any public hearing comments for the IMD 1115 Waiver Amendment.

There were none.

New Rulemakings Information Rules/SPAs – Craig Devashrayee:

Craig Devashrayee discussed Rules.

R414-42: Telehealth (Emergency Rule)

R414-60-4: Program Coverage (Emergency Rule)

The document which was presented is embedded in this document

MCAC Rule Summary 6-18-20.pdf

Eligibility Enrollment Update – Jeff Nelson:

Jeff Nelson discussed Eligibility Enrollment.

The documents which were presented are embedded in this document

Medicaid Trends.pdf

Medicaid Expansion Updates and Director's Report:

Nate Checketts gave an update on COVID-19

As you all have probably noticed the number of cases that we are identifying have been up traumatically since May with Memorial Day, we continue to test at a similar level, but the number of positive cases we are finding continue to rise. We continue to work with messaging to the public related to social distancing and well as wearing masks as we have moved to a more open society hopefully allowing our economy to come back online with the proper use of a mask and social distancing it is an important way to try to reduce risk as we are moving into these new phases of overall risk with the state. The State early on in the crisis entered into an emergency contracts with Test Utah to provide testing for a significant number of individuals in the state. In late May and early June, we issued two solicitation to request for proposal to a place to be able to go out to contract for lab services and sample collection services that would be specifically dedicated for state priorities for testing. The solicitation period has closed on both of those and we are moving into the evaluation phase for those and are looking to have a contract on those early in July. Those are some of the key things we are working on in the testing area.

Nate Checketts gave an update on June 1st we opened testing providers to be able to bill for uninsured individuals using the Medicaid program and that portal that was opened up for Presumptive Eligibility so if an individual doesn't have any other insurance that those individuals could enroll to get Medicaid coverage and to get their testing costs covered through the Medicaid program.

Questions:

Stephanie Burdick asked what is the best way for community members who are in a vulnerable population group like farm workers, or meat processing plant workers, what is the best way for them to notify the State if they are worried about an outbreak in their area?

Nate Checketts response: Rebecca Fronberg from the Department of Health is heading up our Business activities a workplace response, she would be the best contact for that or they could work with their Local Health Department.

Andrew Riggle asked yesterday Senator Ramble in the presentation of SB511 mentioned that 30% of Long-Term Care facilities have refused testing for their residents. Does that number sound about right to you?

Nate Checketts response: No, not from what we have been seeing. So there have been two different efforts the State has been engaged with to reach out to long-term care facilities one is with the UHERT team, and help them assess their access and use of personal protective equipment and gone through and done a review to see if they are ready to see if they could handle an outbreak in their facility. There are approximately 350 facilities that the State is looking at on these types of activities between Nursing facilities, Immediate Care facilities, and Assisted Living facilities and as they have gone out and done their assessments they have completed 270, so far, they have had maybe 3-4 facilities that have refused to participate. The remaining 50 are still on the list to be done. That doesn't in my mind pointing to a 30% refusal rate the other activity that the State has been doing is that we have been reaching out to the same facilities and offering testing for their staff even if they are asymptomatic to come out and test the staff at the facility, I believe there are 80 facilities in that process I am not sure how far they are in that process. Again, I think they have recorded about 4-5 that have declined to participate and again it was set up for them as an opt-in option, so refusing to participate versus opt-in is a little different. So, again I am not seeing a 30% refusal rate. I have not spoken to Senator Bramble specifically about his concern and his information he obtained for that, but that doesn't match up with the experience we are seeing with those two team that have been going out at the nursing facilities.

Resignation of Adam Montgomery – Dr. Cosgrove

Dr. Cosgrove thanked Adam Montgomery for his Commitment and Service to the MCAC.

Adjourn

The meeting adjourned at 6:00pm

ATTACHMENT 4

Tribal Consultation

UTAH DEPARTMENT OF HEALTH MEDICAID

State of Utah

GARY R HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health
Executive Director's Office

Joseph K. Miner, M.D., M.S.P.H., F.A.C.P.M.
Executive Director

Marc E. Babitz, M.D.
Deputy Director

Nate Checketts
Deputy Director
Director, Medicaid and Health Financing

July 8, 2020

Dear Tribal Leaders and Utah Indian Health Advisory Board Representatives,

Due to the July Utah Indian Health Advisory Board (UIHAB) meeting not being held next week, Medicaid is not able to present for review and discussion two Utah Medicaid waiver documents. I have included each document and summary as attachments. Medicaid will submit these documents to the Centers for Medicare and Medicaid Service (CMS) on August 1, 2020. The two waiver documents are:

1. Behavioral Health Services for Adults with Serious Mental Illness (amendment to current 1115 waiver)
   - With this amendment, the State is seeking federal approval to claim federal financial participation (FFP) for payment of services to Medicaid beneficiaries, age 21 through 64, receiving inpatient psychiatric treatment or residential mental health treatment in an Institution for Mental Disease (IMD).

2. Utah Medicaid Prepaid Mental Health Plan (amendment to current 1915(b) waiver)
   - Tooele County has made the decision that Optum Health will replace Valley Behavioral Health as the Prepaid Mental Health Plan contractor for Tooele County. This change will take place on November 1, 2020.

As part of the initial Consultation process, please review each document and provide any impacts to your communities, concerns you may have, questions, or support for the waiver proposals to Ms. Jennifer Meyer-Smart at jmeyersmart@utah.gov on or before July 27, 2020. If you would like to request the Medicaid team to meet with you directly via teleconference, please let me know as soon as you are able and I can facilitate that request.

In addition, Ms. Meyer-Smart and Ms. Ford will be available during the August 14, 2020 UIHAB meeting to answer any additional questions or concerns you may have. They will be able to forward that information to CMS as additional feedback.
If you have any questions on this process or require any additional information, please contact me at mzito@utah.gov or 1-801-712-9346.

Best regards,

[redacted]

Melissa Zito, MS, RN
Office of AI/AN Health Affairs