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## Section 1: Extension Request

Utah is seeking a three-year extension of the Primary Care Network Demonstration Waiver pursuant to Section 1115(f) of the Social Security Act. The State is requesting several amendments to its existing 1115 waiver. They are as follows:

- Removal of High-Risk Pregnant Woman Demonstration Group (Demonstration Population II).
- Providing the same benefit available to current eligible parents to newly eligible parents up to 55 percent of the federal poverty level (FPL).
- Implementation of Mental Health Parity for the Non-Traditional Medicaid group.
- Termination of the EPSDT Waiver of Section 1902(a)(43).
- Waiver of the Medicaid Institutions for Mental Diseases (IMD) exclusion under Section 1905(a)(29)(B) of the Social Security Act to allow for medically necessary Residential Treatment Services for individuals with substance use disorders.
- Implementation of new Medicaid eligibility covering specific groups of adults without dependent children, ages 19-64.

All amendments above are discussed further in the amendment section below and/or in applicable attachments.

## Section 2: History of Utah's 1115 Waiver

In the first few months of Governor Michael Leavitt's first term, Governor Leavitt introduced HealthPrint, a step by step incremental plan for reducing the uninsured rates in Utah. Under HealthPrint, Utah implemented initiatives targeted at very specific populations to increase coverage for children, seniors and the disabled. These initiatives were very successful in reducing the number of uninsured individuals in Utah. However, there was still a need to address the health care access needs of thousands of low income adults who had no health care coverage. In some cases, these were individuals with health issues not severe enough to qualify them as disabled for purposes of Medicaid, but clearly significant enough to interfere with their ability to find and maintain employment at a level that would also provide them with access to health care coverage.

Utah's Primary Care Network (PCN) was designed to serve adults in this low-income category, by offering limited benefits to cover their day-to-day needs, and to encourage them to use the health care system appropriately. The PCN program provides eligible individuals with ongoing access to primary care, pharmacy (up to four prescriptions per month) and emergency room coverage, as well as other limited services.

In order to fund the cost of providing services to a portion of uninsured adults, parent and care taker relatives with incomes below 40 percent FPL receive a slightly reduced benefit package. While reduced, the benefit package is still comprehensive and meets essential benefit requirements. According to the 2014 Health Insurance Analysis from the Behavioral Risk Surveillance System, 18.7 percent of all Utahns, age 19-64, declared that they were uninsured in 2011. During that same year (CY 2011), 41.3 percent of Utahns with a household income below 150 percent FPL were uninsured. Overall, uninsurance rates have improved in CY 2014, the percent of uninsured among all Utahns, age 19-64, dropped 4.0 points to 14.7 percent; the uninsured rate dropped 13.5 points for Utahns age 19-64 with a household income below 150 percent FPL to 27.8 percent.

During the past ten years (SFY 2006 to SFY 2015), Utah’s PCN has served 93,319 distinct individuals, with an average of 25,785 lives being covered each year. Although the Affordable Care Act removed the need for PCN to cover adults above 95 percent FPL, interest in the program has remained strong.

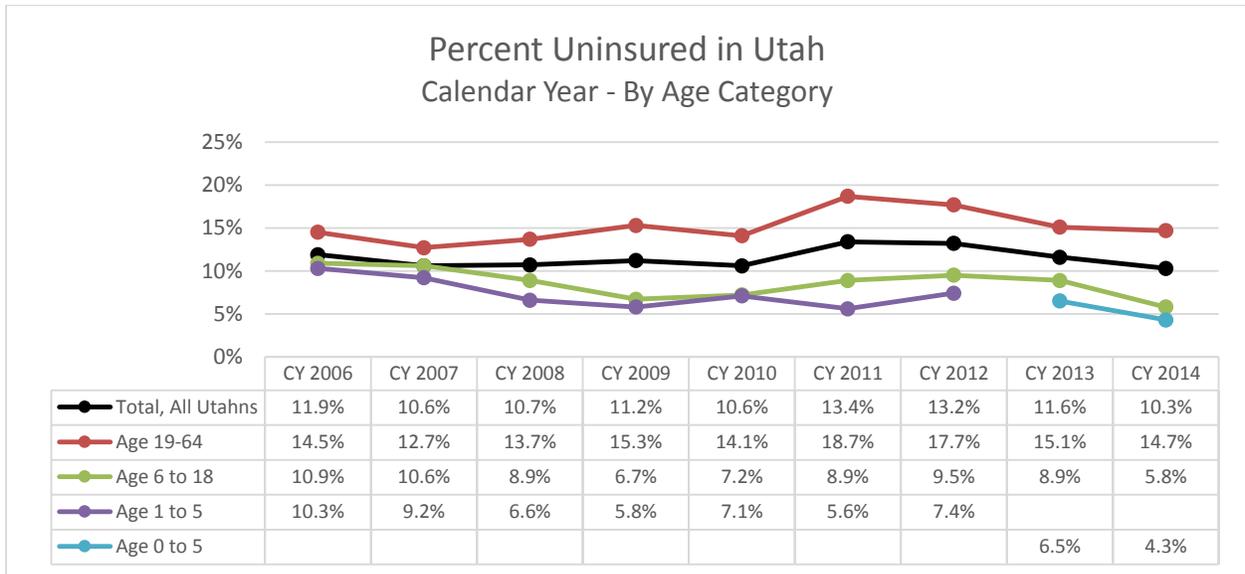


Figure 1. Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS): [https://ibis.health.utah.gov/pdf/oph/publication/ins/InsHighlights\\_2014.pdf](https://ibis.health.utah.gov/pdf/oph/publication/ins/InsHighlights_2014.pdf).

## Amendments

- The Utah PCN 1115 Demonstration Waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- **Amendment #1** - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those age 19 and above who are eligible through Sections 1925 and 1931) in the Demonstration who become pregnant get the full Medicaid State Plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to changes to the benefits available under the State Plan. Finally, it increased the co-payment for hospital admissions from \$100 to \$220, again to conform with changes to the State Plan. (Approved on August 20, 2002, effective on July 1, 2002.)
- **Amendment #2** - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidizes the employee's portion of the premium for up to five years. The employer-sponsored insurance must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over five years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the employer-sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the \$50 fee was prohibitive as they earn less than \$260 per month. For this population, the State reduced the enrollment fee to \$15. (Approved on May 30, 2003, effective on May 30, 2003.)
- **Amendment #3** - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50

percent of the FPL had their enrollment fee reduced from \$50 to \$25. (Approved on July 6, 2004, effective on July 6, 2004.)

- **Amendment #4** - This amendment changed the way the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the "Current Eligibles" ("Non-Traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the State provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005.)
- **Amendment #5** - This amendment implemented the adult dental benefit for the "Current Eligibles" population (Section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005.)
- **Amendment #6** - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006.)
- **Amendment #7** - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from \$2.00 per prescription to \$3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006.)
- **Amendment #8** - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in PCN. (Approved on October 25, 2006, effective on November 1, 2006.)
- **Amendment #9** - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (ESI) (dated June 23, 2006, and change #1 dated September 5, 2006). Also,

this amendment suspends Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006.)

This amendment provides the option of ESI premium assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least 5 percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to \$150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP-eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is \$140 per month; otherwise, it drops to \$120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the title XXI out-of-pocket cost sharing limit of 5 percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well-baby/well-child visits, age appropriate immunizations, dental services, physician visits, hospital inpatient and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

- **Amendment #10-** This amendment enables the State to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees,

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

During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) worked in tandem with the subsidy provided under the American Recovery and Reinvestment Act of 2009 (ARRA) for the purchase of COBRA coverage. Specifically, ARRA provided a federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008 through May 31, 2010. As long as the individual received the ARRA subsidy, the State provided the family with premium assistance based on the number of eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under the STCs.

The ARRA COBRA subsidy was of limited duration and eligibility and ended May 31, 2010. Once the ARRA subsidy ended, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP continues to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage. Under the Utah program, the amount of premium assistance available to a family will be based on the number of eligible individuals in the household. However,

as with the existing ESI program, the State will use various administrative databases to ensure that it does not exceed the individual/family's share of the cost of the COBRA premium.

The Utah CPAP program will provide premium assistance to eligible individuals and families with existing COBRA coverage. Individuals and families, who are COBRA-eligible but uninsured, may also apply for enrollment in the Utah CPAP. The State may provide premium assistance for up to three months of retroactive eligibility. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the State under these STCs. CMS originally approved this amendment on December 18, 2009.

- **Amendment #11**-This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150 percent FPL to 200 percent FPL. This amendment was approved by CMS on September 28, 2012.
- **Amendment #12**- This amendment reduced the income eligibility for Demonstration population I from 100 percent FPL to 95 percent FPL. This amendment was approved by CMS on December 10, 2014.

## New Amendments

- **Amendment #13**- Remove High Risk Pregnant Women Group

This demonstration allowed pregnant women with assets over the asset limit to pay an asset co-pay to be eligible for Medicaid. Due to the Affordable Care Act, and removal of the asset test, this demonstration group is no longer needed. Pregnant women previously in this group are now eligible for Medicaid without a co-pay.

- **Amendment #14- Mental Health Parity**

This amendment will allow changes to be made to Non-Traditional Medicaid benefits to comply with mental health parity. This applies to recipients referred to as Current Eligibles.

The changes being made to comply with mental health parity are:

- Removing the 30 day limit for inpatient treatment and the 30 visit outpatient limit
- Adding coverage of targeted case management for substance abuse treatment
- Removing the 30 visit limit for targeted case management for the Chronically Mentally Ill.

- **Amendment #15- Termination of EPSDT Waiver**

This amendment will terminate the EPSDT waiver of Section 1902(a)(43) for individuals aged 19 and 20, for all Title XIX populations affected by this waiver. The State will cover certain services required to treat a condition identified during an EPSDT screening for this age group.

- **Amendment #16- New Medicaid Program- Adults Without Dependent Children**

This amendment will allow the State to implement Medicaid eligibility for adults without dependent children, ages 19-64, who meet targeted eligibility criteria. Approval of this amendment will allow the State to implement provisions of a Utah law enacted in March 2016. The details of this request are outlined in **Attachment 9**.

- **Amendment #17- Residential Treatment for Substance Use Disorder**

This amendment will waive the IMD exclusion found in Section 1905(a)(29)(B) that prohibits the use of federal Medicaid funds for care provided to most patients in substance use disorder residential treatment facilities larger than 16 beds. The details of this request are outlined in **Attachment 10**.

## Extensions

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

**Section 1115(f) Extension**- On February 3, 2010, the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a three year extension from July 1, 2010, through June 30, 2013.

**Section 1115 Extension**- On December 19, 2012 the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration was set to expire on June 30, 2013. The request was to renew the waiver for the period of July 1, 2013 through June 30, 2016. CMS never acted on the request for extension. The extension was informally on hold pending Utah's decision to expand Medicaid to the optional adult population between 0-138 percent FPL.

**Section 1115 Extension**- On December 24, 2013, CMS approved a temporary extension of Utah's 1115 PCN Demonstration Waiver until December 31, 2014.

**Section 1115 Extension**- On December 19, 2014, CMS approved a temporary extension of Utah's 1115 PCN Demonstration Waiver to allow the State to consider its approach to Medicaid expansion. This extension also authorized a decrease in the PCN income limit to 95 percent FPL, as well as allowing authority to make individuals age 19-26, whose parents are enrolled in ESI, eligible for premium assistance under the demonstration. This was set to expire December 31, 2015.

**Section 1115(f) Extension-** On June 26, 2015 the state of Utah formally requested an extension of their PCN 1115 Demonstration Waiver under the authority of Section 1115(f) of the Social Security Act. The demonstration which would have expired on December 31, 2015, was approved for a one year extension from January 1, 2016 through December 31, 2016.

### **Section 3: Program Description and Objectives**

Utah's Primary Care Network (PCN) is a statewide Section 1115 Demonstration to expand Medicaid coverage to certain able-bodied adults who were not previously eligible for State Plan services, and to offer these adults and children eligible for CHIP an alternative to traditional direct coverage public programs. For State Plan eligibles who are categorically or medically needy parents or other caretaker relatives, the Demonstration provides a reduced benefit package. Savings from this State Plan population fund a Medicaid expansion for up to 25,000 uninsured adults age 19 to 64, with family incomes up to 95 percent FPL. This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services.

The PCN Demonstration was amended in October 2006 to also use Demonstration savings to offer assistance with payment of ESI premiums through Utah's Premium Partnership for Health Insurance (UPP). The UPP program uses Title XIX funds to provide up to \$150 per month in ESI premium assistance to each uninsured adult in families with income up to 200 percent FPL (a September 2012 amendment increased the FPL from the original level of 150 percent FPL). UPP also uses Title XXI funds to provide premium assistance up to \$120 per month, per child for CHIP eligible children with a family income up 200 percent FPL. UPP children receive dental coverage through direct CHIP coverage or they receive an additional \$20 per month if they receive dental coverage through the ESI.

Effective December 18, 2009, the PCN Demonstration was further amended to enable the State to provide premium assistance to children and adults for coverage obtained under the provisions of COBRA.

Effective January 1, 2014, the PCN Demonstration was amended to reduce the eligibility income level for Demonstration Population I to 100 percent FPL, consistent with the changes in eligibility with the implementation of ACA. In addition, this extension required Utah to use MAGI based methodologies for determining income. Further, the extension approved a transition plan to move Demonstration I individuals with income at 100 percent FPL or greater, off the PCN program and to the federal marketplace. Finally, this extension also amended the waiver to require cost sharing for all demonstration populations, where applicable, consistent with the Utah Medicaid State Plan.

Effective December 19, 2014, the PCN Demonstration was further amended to reduce the eligibility income level for Demonstration Population I from 100 percent FPL to 95 percent FPL. This amendment was made because the combination of the implementation of the Federal Facilitated Marketplace (FFM), the MAGI income methodology and the provisions of the Primary Care Network Program created a unique “donut hole” for some of Utah’s most needy citizens.

## Section 4: Compliance with Special Terms and Conditions

Utah has successfully completed all deliverables required by the Primary Care Network Special Terms and Conditions and continues to work diligently to assure compliance with all waiver requirements. The State maintains comprehensive administrative rules, eligibility policies, and provider manuals that are regularly updated to reflect the most current operational policies and procedures of the Primary Care Network Demonstration Waiver.

Utah has complied with all applicable federal statutes relating to nondiscrimination.

Utah has complied with all applicable requirements of the Medicaid and CHIP expressed in laws, regulations, and policy statements, not expressly waived or identified as non-applicable in the Special Terms and Conditions (STCs), apply to Utah's 1115 Demonstration Waiver, Primary Care Network.

Utah has complied with and has come into compliance with all changes in Federal law affecting the Medicaid or CHIP program that have occurred after the approval of the demonstration award date.

Utah's 1115 Demonstration Waiver adheres to all requirements of the approved 1115 waiver.

Utah has remained within the budget neutrality expenditure cap for all populations.

## Section 5: Compliance with Budget Neutrality Requirements

See Attachment 1

## Section 6: Program Evaluation

See Attachment 2

## Section 7: Public Notice and Tribal Consultation

Public Notice of the State's request for renewal and amendment and notice of Public Hearing was published in the Utah State Bulletin on May 1, 2016 (**Attachment 3**). The public has until June 8, 2016 to provide comment.

On May 13, 2016, a presentation regarding the request for renewal of Utah's 1115 Waiver and amendments was provided to the Utah Indian Health Advisory Board (**Attachment 4-To be added when submitted to CMS**). This is the first step in our approved consultation process.

On May 19, 2016, the State held a meeting of the Medical Care Advisory Committee from 1:30 PM to 3:30 PM to take public comment on the PCN Demonstration Waiver extension request. (**Attachment 5-To be added when submitted to CMS**)

On May 25, 2016 the State held a public hearing from 1:00 PM to 3:00 PM to take public comment on the extension request. (**Attachment 6-To be added when submitted to CMS**)

On May 31, 2016 the State held a public hearing from 11:30PM to 1:00PM to take public comment on the extension request. (**Attachment 6-To be added when submitted to CMS**)

## Section 8: Quality Initiatives

Current Eligibles in thirteen counties receive physical health services through full risk capitated Medicaid Accountable Care Organization (ACO) managed care plans. Mental health and substance use disorder services for populations covered under this waiver are also provided through pre-paid mental health plans.

A copy of the State's latest External Quality Review report is included with this request for renewal. **(Attachment 7)**

A copy of Utah's 2014 (Children) and 2015 (Adults) Consumer Assessment of Health Plans Survey (CAHPS) are included with this request for renewal. **(Attachment 8)**

## Section 9: Future Possible Amendments

After approval of the demonstration application, the State of Utah intends to pursue an amendment seeking flexibility to direct a portion of the demonstration savings into a pool to fund delivery system reforms. These reforms will be aligned and designed to:

- Facilitate the construction of a system of integrated care;
- Help expedite the transformation of Utah Medicaid fee-for-service and managed care reimbursement methodologies to alternative and value based payment arrangements; and
- Improve care quality and the efficiency of care provided to Medicaid and other patients.

Before submitting such an amendment, the State will seek guidance from CMS on the design of the program and conduct a robust public education and input process. At this time, the State envisions that a significant portion of this initiative will be funded through IGTs from the University of Utah Health Care (UUHC) system, the State's academic medical center, and other governmental entities.

## ATTACHMENT 1

### **Compliance with Budget Neutrality Requirements 1115 PCN Waiver Demonstration**



**I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)**

Medicaid Eligibility Group	SFY 2001 Per Member Per Month (PMPM) (Base Year)	Trend Rate	Demonstration Year (DY)					Member Months Total	Budget Neutrality		Budget Neutrality	
			SFY03-DY1 PM/PM	QE 9/02	QE 12/02	QE 3/03	QE 6/03		Limit DY 1 (TF)	Effective FMAP	Limit DY 1 (FF)	Limit DY 1 (FF)
Current eligibles 1902(r)(2) - PCN	\$333.55	1.08	\$389.05				223,729	\$87,042,376	70.93%	\$61,739,157.29		
	n/a	1.08	\$54.00				62,978	\$3,400,812	70.93%	\$2,412,195.95		
							<b>Total BN Limit</b>	<b>\$90,443,188</b>	<b>70.93%</b>	<b>\$64,151,353.24</b>		
Current eligibles 1902(r)(2) - PCN		1.08	\$420.18				251,558	\$105,698,870	71.60%	\$75,680,390.97		
		1.08	\$58.32				115,212	\$6,719,164	71.60%	\$4,810,921.31		
							<b>Total BN Limit</b>	<b>\$112,418,034</b>	<b>71.60%</b>	<b>\$80,491,312.28</b>		
Current eligibles 1902(r)(2) - PCN		1.08	\$453.79				269,541	\$122,315,305	72.04%	\$88,115,945.64		
		1.08	\$62.99				138,562	\$8,727,411	72.04%	\$6,287,226.67		
							<b>Total BN Limit</b>	<b>\$131,042,716</b>	<b>72.04%</b>	<b>\$94,403,172.32</b>		
Current eligibles 1902(r)(2) - PCN		1.08	\$490.09				264,052	\$129,410,401	71.10%	\$92,010,795.28		
		1.08	\$68.02				116,364	\$7,915,597	71.10%	\$5,627,989.37		
							<b>Total BN Limit</b>	<b>\$137,325,998</b>	<b>71.10%</b>	<b>\$97,638,784.65</b>		
Current eligibles 1902(r)(2) - PCN 1902(r)(2) - HIFA*		1.08	\$529.30				214,792	\$113,689,820	70.30%	\$79,923,943.63		
		1.08	\$73.47				133,813	\$9,830,760	70.30%	\$6,911,024.21		
		6.02%	\$150.00				1,169	\$175,350	70.30%	\$123,271.05		
						<b>Total BN Limit</b>	<b>\$123,695,930</b>	<b>70.30%</b>	<b>\$86,958,238.89</b>			
Current eligibles 1902(r)(2) - PCN 1902(r)(2) - HIFA		1.066	\$564.24				194,914	\$109,977,468	71.26%	\$78,369,943.69		
		1.066	\$78.32				148,028	\$11,592,840	71.26%	\$8,261,058.09		
	Inflation	1.066	\$159.90				2,498	\$399,430	71.26%	\$284,633.96		
						<b>Total BN Limit</b>	<b>\$121,969,739</b>	<b>71.26%</b>	<b>\$86,915,635.74</b>			
Current eligibles 1902(r)(2) - PCN 1902(r)(2) - HIFA		1.066	\$601.48				231,636	\$139,323,361	70.94%	\$98,835,992.59		
		1.066	\$83.48				143,979	\$12,019,941	70.94%	\$8,526,946.30		
		1.066	\$170.45				2,875	\$490,054	70.94%	\$347,643.97		
						<b>Total BN Limit</b>	<b>\$151,833,356</b>	<b>70.94%</b>	<b>\$107,710,582.86</b>			
Current eligibles 1902(r)(2) - PCN 1902(r)(2) - HIFA		1.066	\$641.17				278,979	\$178,873,747	71.44%	\$127,787,405.04		
		1.066	\$88.99				124,731	\$11,100,302	71.44%	\$7,930,055.85		
		1.066	\$181.70				3,290	\$597,804	71.44%	\$427,071.13		
						<b>Total BN Limit</b>	<b>\$190,571,853</b>	<b>71.44%</b>	<b>\$136,144,532.02</b>			

**I. CALCULATION OF BUDGET NEUTRALITY LIMIT (Without Waiver Ceiling)**

	SFY11-DY9	Member Months					Total	Budget Neutrality Limit DY 9 (TF)	Effective FMAP	Budget Neutrality Limit DY 9 (FF)
		PM/PM	QE 9/10	QE 12/10	QE 3/11	QE 6/11				
Current eligibles	1.063	\$681.57					321,691	\$219,253,870	71.27%	\$156,262,232.97
1902(r)(2) - PCN	1.063	\$94.60					128,540	\$12,159,955	71.27%	\$8,666,399.69
1902(r)(2) - HIFA	1.063	\$193.15					3,079	\$594,711	71.27%	\$423,850.39
							<b>Total BN Limit</b>	<b>\$232,008,535</b>	<b>71.27%</b>	<b>\$165,352,483.05</b>

	SFY12-DY10	Member Months					Total	Budget Neutrality Limit DY 10 (TF)	Effective FMAP	Budget Neutrality Limit DY 10 (FF)
		PM/PM	QE 9/11	QE 12/11	QE 3/12	QE 6/12				
Current eligibles	1.063	\$724.51					382,634	\$277,220,396	71.02%	\$196,881,924.92
1902(r)(2) - PCN	1.063	\$100.56					101,403	\$10,197,125	71.02%	\$7,241,997.93
1902(r)(2) - HIFA	1.063	\$205.32					2,450	\$503,032	71.02%	\$357,253.22
							<b>Total BN Limit</b>	<b>\$287,920,552</b>	<b>71.02%</b>	<b>\$204,481,176.08</b>

	SFY13-DY11	Member Months					Total	Budget Neutrality Limit DY 11 (TF)	Effective FMAP	Budget Neutrality Limit DY 11 (FF)
		PM/PM	QE 9/12	QE 12/12	QE 3/13	QE 6/13				
Current eligibles	1.063	\$770.15					394,625	\$303,920,140	69.96%	\$212,622,529.87
1902(r)(2) - PCN	1.063	\$106.90					83,304	\$8,904,838	69.96%	\$6,229,824.98
1902(r)(2) - HIFA	1.063	\$218.25					1,834	\$400,278	69.96%	\$280,034.67
							<b>Total BN Limit</b>	<b>\$313,225,257</b>	<b>69.96%</b>	<b>\$219,132,389.51</b>

	SFY14-DY12	Member Months					Total	Budget Neutrality Limit DY 12 (TF)	Effective FMAP	Budget Neutrality Limit DY 12 (FF)
		PM/PM	QE 9/13	QE 12/13	QE 3/14	QE 6/14				
Current eligibles	1.0554	\$812.82	97,748	96,616	101,397	99,491	395,252	\$321,266,951	70.16%	\$225,400,892.79
1902(r)(2) - PCN	1.0554	\$112.82	22,892	20,571	17,852	14,201	75,516	\$8,519,542	70.16%	\$5,977,310.79
1902(r)(2) - HIFA	1.0554	\$230.35	540	527	504	528	2,099	\$483,495	70.16%	\$339,220.25
							<b>Total BN Limit</b>	<b>\$330,269,988</b>	<b>70.16%</b>	<b>\$231,717,423.84</b>

	SFY15-DY13	Member Months					Total	Budget Neutrality Limit DY 13 (TF)	Effective FMAP	Budget Neutrality Limit DY 13 (FF)
		PM/PM	QE 9/14	QE 12/14	QE 3/15	QE 6/15				
Current eligibles	1.05	\$853.46	95,284	91,358	93,841	97,315	377,798	\$322,434,073	70.50%	\$227,316,021.28
1902(r)(2) - PCN	1.05	\$118.46	20,080	26,504	24,108	17,915	88,607	\$10,496,261	70.50%	\$7,399,863.83
1902(r)(2) - HIFA	1.05	\$241.86	670	851	1,176	1,252	3,949	\$955,116	70.50%	\$673,356.89
							<b>Total BN Limit</b>	<b>\$333,885,450</b>	<b>70.50%</b>	<b>\$235,389,241.99</b>

	SFY16-DY14	Member Months					Total	Budget Neutrality Limit DY 14 (TF)	Effective FMAP	Budget Neutrality Limit DY 14 (FF)
		PM/PM	QE 9/15	QE 12/15	QE 3/16	QE 6/16				
Current eligibles	1.05	\$896.13	98,561	97,701	98,131	98,131	392,524	\$351,752,173	70.32%	\$247,352,128.26
1902(r)(2) - PCN	1.05	\$124.38	17,145	21,301	19,223	19,223	76,892	\$9,563,944	70.32%	\$6,725,365.58
1902(r)(2) - HIFA	1.05	\$253.96	1,358	1,469	1,414	1,414	5,654	\$1,435,867	70.32%	\$1,009,701.55
							<b>Total BN Limit</b>	<b>\$362,751,984</b>	<b>70.32%</b>	<b>\$255,087,195.38</b>

	SFY17-DY15	Member Months					Total	Budget Neutrality Limit DY 15 (TF)	Effective FMAP	Budget Neutrality Limit DY 15 (FF)
		PM/PM	QE 9/16	QE 12/16	QE 3/17	QE 6/17				
Current eligibles	1.05	\$940.94					392,524	\$369,339,782	69.98%	\$258,463,979.41
1902(r)(2) - PCN	1.05	\$130.60					76,892	\$10,042,141	69.98%	\$7,027,490.58
1902(r)(2) - HIFA	1.05	\$266.65					5,654	\$1,507,660	69.98%	\$1,055,060.58
							<b>Total BN Limit</b>	<b>\$380,889,584</b>	<b>69.98%</b>	<b>\$266,546,530.56</b>

\* Enrollment in HIFA amendment began in December 2006  
 = Neutrality Limit without waiver ceiling  
 = Actual Member Months  
 = Estimated Member Months  
 = Inflation percentage submitted in HIFA Amendment

**II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)**

A	B	C	D	E	F	G	H	I	J	K
EXPENDITURES (Federal Funds)										
State Fiscal Year (SFY)- Demonstration Year (DY)	BUDGET NEUTRALITY LIMIT (FF)	Current Eligibles	Demo Population I - PCN		Demo Population II	Demo Population III - HIFA		TOTAL	VARIANCE	
	(Sections 1925 and 1931 Adults and Medically Needy Adults)	Adults w/ Children  (Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles)	Childless Adults  (PCN Adults in Demo Population I = 1115)	(High-Risk Pregnant Women = 1115)	Adults w/ Children  (Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles)	Childless Adults  (HIFA Adults in Demo Population III = 1115 Expansion Group)				
SFY03-DY1	\$64,151,353	\$61,595,233	\$2,809,194	\$4,115,233				\$68,519,660	-\$4,368,307	
SFY04-DY2	\$80,491,312	\$64,047,444	\$5,102,354	\$7,856,860				\$77,006,658	\$3,484,654	
SFY05-DY3	\$94,403,172	\$75,766,088	\$5,025,695	\$8,945,075	\$604,159			\$90,341,017	\$4,062,155	
SFY06-DY4	\$97,638,785	\$73,867,437	\$5,003,894	\$7,830,419	\$679,517			\$87,381,267	\$10,257,518	
SFY07-DY5	\$86,958,239	\$69,226,866	\$6,689,112	\$8,423,719	\$640,957	\$58,159	\$4,406	\$85,043,219	\$1,915,020	
SFY08-DY6	\$86,915,636	\$64,034,372	\$7,816,087	\$10,288,425	\$695,696	\$185,045	\$22,970	\$83,042,595	\$3,873,041	
SFY09-DY7	\$107,710,583	\$80,054,703	\$7,678,231	\$9,135,522	\$908,465	\$231,658	\$10,444	\$98,019,023	\$9,691,560	
SFY10-DY8	\$136,144,532	\$98,953,790	\$7,113,145	\$10,884,573	\$1,216,540	\$303,669	\$19,733	\$118,491,450	\$17,653,082	
QE 9/09		\$25,404,224	\$2,089,905	\$3,213,039	\$232,319	\$77,799	\$3,732	\$31,021,018		
QE 12/09		\$24,615,745	\$1,874,409	\$3,044,399	\$347,954	\$76,718	\$4,565	\$29,963,790		
QE 3/10		\$24,962,162	\$1,689,864	\$2,599,851	\$267,213	\$85,476	\$6,696	\$29,611,262		
QE 6/10		\$24,021,210	\$1,461,277	\$2,038,639	\$392,409	\$70,297	\$4,829	\$27,988,661		
								\$118,584,731		
SFY11-DY9	\$165,352,483	\$97,502,287	\$6,667,856	\$7,558,063	\$2,065,462	\$172,847	\$4,491	\$113,971,006	\$51,381,477	
QE 9/10		\$23,642,606	\$1,593,935	\$1,378,275	\$470,913	\$60,549	\$3,671	\$27,149,949		
QE 12/10		\$21,985,218	\$1,448,113	\$1,409,797	\$568,743	\$56,096	\$2,444	\$25,470,411		
QE 3/11		\$26,748,422	\$2,022,504	\$2,547,211	\$519,788	\$57,413	\$1,247	\$31,896,585		
QE 6/11		\$25,483,124	\$1,609,947	\$2,252,914	\$508,848	\$56,720	\$1,193	\$29,912,746		
								\$114,429,691		
SFY12-DY10	\$204,481,176	\$92,034,193	\$4,062,042	\$5,224,680	\$2,178,441	\$180,163	\$4,404	\$103,683,923	\$100,797,253	
QE 9/11		\$21,287,271	\$907,793	\$1,421,012	\$489,245	\$52,067	\$896	\$24,158,284		
QE 12/11		\$24,518,095	\$871,277	\$1,252,389	\$562,682	\$49,336	\$1,270	\$27,255,049		
QE 3/12		\$24,001,563	\$1,065,431	\$1,072,774	\$478,982	\$41,935	\$1,255	\$26,661,940		
QE 6/12		\$25,124,250	\$1,271,595	\$1,751,893	\$660,865	\$36,825	\$983	\$28,846,411		
								\$106,921,684		
SFY13-DY11	\$219,132,390	\$113,308,841	\$2,995,262	\$3,582,783	\$2,310,456	\$143,316	\$3,335	\$122,343,993	\$96,788,397	
QE 9/12		\$24,949,124	\$1,018,742	\$1,563,872	\$519,334	\$30,973	\$1,116	\$28,083,161		
QE 12/12		\$27,674,525	\$864,079	\$1,479,990	\$867,999	\$34,199	\$940	\$30,921,732		
QE 3/13		\$32,399,012	\$493,117	\$824,297	\$515,655	\$39,144	\$731	\$34,271,956		
QE 6/13		\$28,929,148	\$626,379	\$1,170,194	\$419,020	\$43,026	\$835	\$31,188,602		
								\$124,465,451		
SFY14-DY12	\$231,717,424	\$117,389,496	\$2,805,587	\$5,711,682	\$846,407	\$196,273	\$11,671	\$126,961,116	\$104,756,308	
QE 9/13		\$30,520,807	\$808,907	\$1,413,888	\$370,570	\$50,241	\$2,088	\$33,166,501		
QE 12/13		\$28,785,389	\$719,994	\$1,529,438	\$336,585	\$47,608	\$3,843	\$31,422,857		
QE 3/14		\$27,956,030	\$750,936	\$1,513,147	\$152,256	\$49,361	\$3,504	\$30,425,234		
QE 6/14		\$32,146,166	\$620,106	\$1,496,500	\$24,242	\$50,315	\$2,447	\$34,339,776		

II. WAIVER COSTS AND VARIANCE FROM BUDGET NEUTRALITY LIMIT BY QUARTER (Federal Funds)

A	B	C	D	E	F	G	H	I	J	K
EXPENDITURES (Federal Funds)										
BUDGET NEUTRALITY LIMIT (FF)	Current Eligibles	Demo Population I - PCN		Demo Population II	Demo Population III - HIFA		TOTAL	VARIANCE		
	(Sections 1925 and 1931 Adults and Medically Needy Adults)	Adults w/ Children  (Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles	Childless Adults  (PCN Adults in Demo Population I = 1115)	(High-Risk Pregnant Women = 1115)	Adults w/ Children  (Section 1902(r)(2) Adults; also Known as Hypothetical State Plan Eligibles	Childless Adults  (HIFA Adults in Demo Population III = 1115 Expansion Group)				
State Fiscal Year (SFY)- Demonstration Year (DY)										
							\$129,354,368			
SFY15-DY13	\$235,389,242	\$121,818,957	\$3,680,770	\$9,038,162	\$17,994	\$340,914	\$10,048	\$134,906,845	\$100,482,397	
QE 9/14		\$28,420,265	\$757,709	\$2,117,542	\$13,523	\$58,794	\$2,315	\$31,370,148		
QE 12/14		\$32,199,953	\$1,035,542	\$2,615,201	\$4,226	\$73,983	\$2,295	\$35,931,200		
QE 3/15		\$28,594,171	\$1,153,257	\$2,481,997	\$185	\$100,649	\$2,499	\$32,332,758		
QE 6/15		\$32,089,293	\$750,034	\$1,866,826	\$60	\$110,888	\$2,939	\$34,820,040		
TOTAL:								\$134,454,146		
TOTAL: BUDGET NEUTRALITY LIMIT SFY03-15	\$1,810,486,326							\$1,309,711,772	\$500,774,554	Cumulative savings in Federal Funds at the end of SFY15
SFY16-DY14	\$255,087,195	\$119,564,968	\$2,219,610	\$4,296,252	\$42	\$481,130	\$9,536	\$126,571,538	\$128,515,657	
QE 9/15		\$30,564,749	\$637,704	\$1,630,248	\$21	\$115,928	\$2,811	\$32,951,461		
QE 12/15		\$29,217,735	\$472,101	\$517,878	\$0	\$124,637	\$1,957	\$30,334,308		
QE 3/16		\$29,891,242	\$554,903	\$1,074,063	\$11	\$120,283	\$2,384	\$31,642,885		
QE 6/16		\$29,891,242	\$554,903	\$1,074,063	\$11	\$120,283	\$2,384	\$31,642,885		
TOTAL:										
TOTAL: BUDGET NEUTRALITY LIMIT SFY03-16	\$2,065,573,522							\$1,436,283,310	\$629,290,212	Cumulative savings in Federal Funds at the end of SFY16
QE 9/16		\$31,385,804	\$582,648	\$1,127,766	\$11	\$126,297	\$2,503	\$33,225,029		
QE 12/16		\$31,385,804	\$582,648	\$1,127,766	\$11	\$126,297	\$2,503	\$33,225,029		
End of Waiver Extension										
SFY17-DY15	\$133,273,265	\$62,771,608	\$1,165,295	\$2,255,532	\$22	\$252,593	\$5,006	\$66,450,057	\$66,823,208	
TOTAL:										
TOTAL: BUDGET NEUTRALITY LIMIT SFY03-17	\$2,198,846,787							\$1,502,733,367	\$696,113,420	Cumulative savings in Federal Funds at the end of waiver extension 12/31/2016

Legend

- = Estimated Figures
- = Neutrality Limit without waiver ceiling
- = Actual Expenditures from MBES/CBES reports including prior period adjustments
- = Actual Quarterly Expenditures from MBES/CBES reports with no prior period adjustments

Attachment G  
Utah 1115 Budget Neutrality 9-30-2015 & 12-31-2015\_CMS\_print.xlsx

**III. SUMMARY BY DEMONSTRATION YEAR AND CUMULATIVELY (Federal Funds)**

	Budget Neutrality Limit	Waiver Costs on CMS-64	Annual Variance	Variance As % of Annual BN Limit	Cumulative Budget Neutrality Limit	Cumulative Waiver Costs on CMS-64	Cumulative Variance	Variance As % of Cumulative BN Limit
DY #1 (SFY 2003)	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%	\$64,151,353	\$68,519,660	-\$4,368,307	-6.81%
DY #2 (SFY 2004)	\$80,491,312	\$77,006,658	\$3,484,654	4.33%	\$144,642,666	\$145,526,318	-\$883,652	-0.61%
DY #3 (SFY 2005)	\$94,403,172	\$90,341,017	\$4,062,155	4.30%	\$239,045,838	\$235,867,335	\$3,178,503	1.33%
DY #4 (SFY 2006)	\$97,638,785	\$87,381,267	\$10,257,518	10.51%	\$336,684,622	\$323,248,602	\$13,436,020	3.99%
DY #5 (SFY 2007)	\$86,958,239	\$85,043,219	\$1,915,020	2.20%	\$423,642,861	\$408,291,821	\$15,351,040	3.62%
DY #6 (SFY 2008)	\$86,915,636	\$83,042,595	\$3,873,041	4.46%	\$510,558,497	\$491,334,416	\$19,224,081	3.77%
DY #7 (SFY 2009)	\$107,710,583	\$98,019,023	\$9,691,560	9.00%	\$618,269,080	\$589,353,439	\$28,915,641	4.68%
DY #8 (SFY 2010)	\$136,144,532	\$118,491,450	\$17,653,082	12.97%	\$754,413,612	\$707,844,889	\$46,568,723	6.17%
DY #9 (SFY 2011)	\$165,352,483	\$113,971,006	\$51,381,477	31.07%	\$919,766,095	\$821,815,895	\$97,950,200	10.65%
DY #10 (SFY 2012)	\$204,481,176	\$103,683,923	\$100,797,253	49.29%	\$1,124,247,271	\$925,499,818	\$198,747,453	17.68%
DY #11 (SFY 2013)	\$219,132,390	\$122,343,993	\$96,788,397	44.17%	\$1,343,379,661	\$1,047,843,811	\$295,535,850	22.00%
DY #12 (SFY 2014)	\$231,717,424	\$126,961,116	\$104,756,308	45.21%	\$1,575,097,084	\$1,174,804,927	\$400,292,157	25.41%
DY #13 (SFY 2015)	\$235,389,242	\$134,906,845	\$100,482,397	42.69%	\$1,810,486,326	\$1,309,711,772	\$500,774,554	27.66%
DY #14 (SFY 2016)	\$255,087,195	\$126,571,538	\$128,515,657	50.38%	\$2,065,573,522	\$1,436,283,310	\$629,290,212	30.47%
DY #15 (SFY 2017)								
<b>Only two quarters estimated. Waiver extension ends 12/31/2016.</b>	\$133,273,265	\$66,450,057	\$66,823,208	50.14%	\$2,198,846,787	\$1,502,733,367	\$696,113,420	31.66%

**Legend**

- = Estimated Figures
- = Neutrality Limit without waiver ceiling QTD Amount
- = Actual Expenditures 1115 Waivers QTD Amount

## ATTACHMENT 2

### **Program Evaluation**





## **Evaluation of Utah's 1115 Demonstration Waiver**

### **Primary Care Network, High-Risk Pregnancy, and Utah's Premium Partnership**

*Prepared: December 20, 2012*

*Updated: April 22, 2016*

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## Information about the Demonstration

Title: Primary Care Network  
Awardee: Utah Department of Health

### Timeline:

December 11, 2001	Waiver submitted
February 8, 2002	Approved
July 1, 2002	Implemented
June 30, 2007	Original expiration date
June 30, 2010	Extension expiration date
June 30, 2013	Extension expiration date
December 31, 2014	Extension expiration date
December 31, 2015	Extension expiration date
December 31, 2016	Extension expiration date

## A Brief History of the Demonstration

Utah's 1115 waiver is a statewide demonstration to cover previously uninsured individuals through alternative benefit packages. This demonstration uses increased flexibility with current State plan Eligibles to fund a Medicaid expansion for uninsured adults age 19 to 64 with incomes up to 95 percent of the Federal Poverty Level (FPL) with the 5 % income disregard. It is known as the Primary Care Network (PCN) and also includes coverage for High-Risk pregnant women.

The demonstration also provides an employer-sponsored health insurance option for uninsured adults and children with incomes up to 200 percent of the FPL. This option is known as Utah's Premium Partnership for Health Insurance (UPP). A parent with a child eligible for the Children's Health Insurance Program (CHIP) can elect to enroll that child in UPP if the parent has a qualified plan through work.

In addition, the demonstration includes an insurance subsidy option for uninsured adults and children (up to 200 percent FPL) who are eligible for coverage under COBRA.

The original Utah 1115 waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007. On December 21, 2006, the waiver was extended through June 30, 2010. On June 23, 2010, the waiver was extended through June 30, 2013. One-year extensions were granted for the next three years, with the most current extension set to expire on December 31, 2016.

Prior to the demonstration, Utah was providing a limited-benefit program for otherwise uninsured adults through the Utah Medical Assistance Program (UMAP). Coverage for UMAP adults was generally provided with 100 percent state funds. At the time of the

waiver's implementation, the UMAP adults were enrolled in PCN and UMAP was discontinued.

## **Population Groups Impacted**

**Current Eligibles:** This demonstration includes some modifications to benefits received by currently eligible "Non-Traditional Medicaid" clients

**Demonstration Population #1 – PCN enrollees:** Previously uninsured parents and adults without dependent children who enroll in this limited benefit program.

**Demonstration Population #2 – Pregnant women with High-Risk pregnancies:** Previously uninsured women who face a \$5,000 asset copay to enroll in traditional Medicaid.

**Note:** The \$5,000 asset copay requirement was removed in SFY 2014 effectively discontinuing the High-Risk Pregnancy aid category.

**Demonstration Population #3 – UPP adults:** Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

**Demonstration Population #4 – Current eligible CHIP Children:** UPP children - Previously uninsured children who use the premium subsidy to enroll in private, employer-sponsored health insurance.

**Demonstration Population #5 – UPP adults:** Previously uninsured parents and adults without dependent children who use the premium subsidy to enroll in COBRA continuation coverage.

**Demonstration Population #6 – COBRA eligible children:** previously insured children who use a premium subsidy to enroll in COBRA continuation coverage.

## **Purposes, aims, objectives, and goals of the demonstration**

### **Overarching strategy, principles, goals, and objectives**

The primary strategy for this demonstration is to provide valuable benefits to a greater population by slightly reducing benefits to some currently covered populations. The demonstration is founded on the principle that the highest value health care comes from coverage for primary and preventive care. The goal of the demonstration is to reduce the number of uninsured as well as the rate of uninsurance for Utahns while improving the quality, value and access of care received by beneficiaries.

To show that value can be added to the system without increasing costs by shifting some resources from fully indemnified populations to populations that currently have no health care coverage. In addition, the demonstration seeks to increase health insurance coverage without directly providing the coverage through government-managed programs.

### **State's hypotheses on outcomes of the demonstration**

There are five hypotheses in this demonstration that will be evaluated

**Hypothesis #1:** The demonstration will not negatively impact the overall health well-being of Current Eligibles who experience reduced benefits and increased cost sharing.

**Hypothesis #2:** The demonstration will improve well-being in Utah by:

- a. Reducing the number of Utahns without coverage for primary health care.
- b. Improving PCN enrollees' access to primary care.
- c. Improving the overall well-being in the health status of PCN enrollees.

**Hypothesis #3:** The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.

**Hypothesis #4:** The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.

**Hypothesis #5:** The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.

**Hypothesis #6:** The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.

### **Key interventions planned**

Implementation and administration of the Primary Care Network program PCN Expansion

Implementation and administration of the Utah's Premium Partnership Program (UPP) for both employer-sponsored insurance and COBRA continuation coverage.

Implementation and administration of the High-Risk Pregnancy Program.

# Evaluation Design

## General Approach to Evaluation

### Data Sources

**Claims Data:** The State has access to claims data for PCN and High-Risk pregnancy enrollees through the State's Fee for Service system. We will use that data to monitor utilization patterns and costs. The State also has access to claims data for Current Eligibles who are affected by this demonstration. However, it should be noted that Current Eligibles in Box Elder, Cache, Davis, Iron, Morgan, Rich, Salt Lake, Summit, Tooele, Utah, Wasatch, Washington, and Weber counties are enrolled in managed care. Therefore some data on Current Eligibles may not be immediately comparable to that in the State's system.

**Outcome Tracking Data:** Specialty, charitable care is not an included benefit in the PCN demonstration. Primary care providers may contact PCN administration and request a referral for specialty care. Charitable Care Coordinators endeavor to fill this gap by seeking donated charitable care from providers and institutions. Outcomes of these endeavors are tracked and summarized.

**Behavioral Risk Factor Surveillance System:** The report is a summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS). This survey is conducted on all states and territories in partnership with the Centers for Disease Control (CDC). Data has been collect in Utah since 1984. Estimates are based on a sample of Utah residents by interviews conducted in English and Spanish via both landline and cell phone. The health insurance questions asked of 7,385 adults about their health insurance coverage at the time of the interview.

**Public Health Indicator Based Information System (IBIS):** This website gives an overview of the types of data that the Utah Department of Health's Center for Health Data and Informatics provides. Data includes: publications; indicator reports, including public health outcome measures; dataset queries; links and online help; as well as phone and email support.

### Comparison groups

Where possible, the State will compare PCN enrollee utilization and health status to similar populations within traditional Medicaid and Non-Traditional Medicaid.

## **Timelines for Completing and Delivering Elements of the Evaluation**

**Draft Evaluation Report:** April 30, 2016.

**Final Evaluation Report:** Within 60 days after receipt of CMS feedback on the Draft Report.

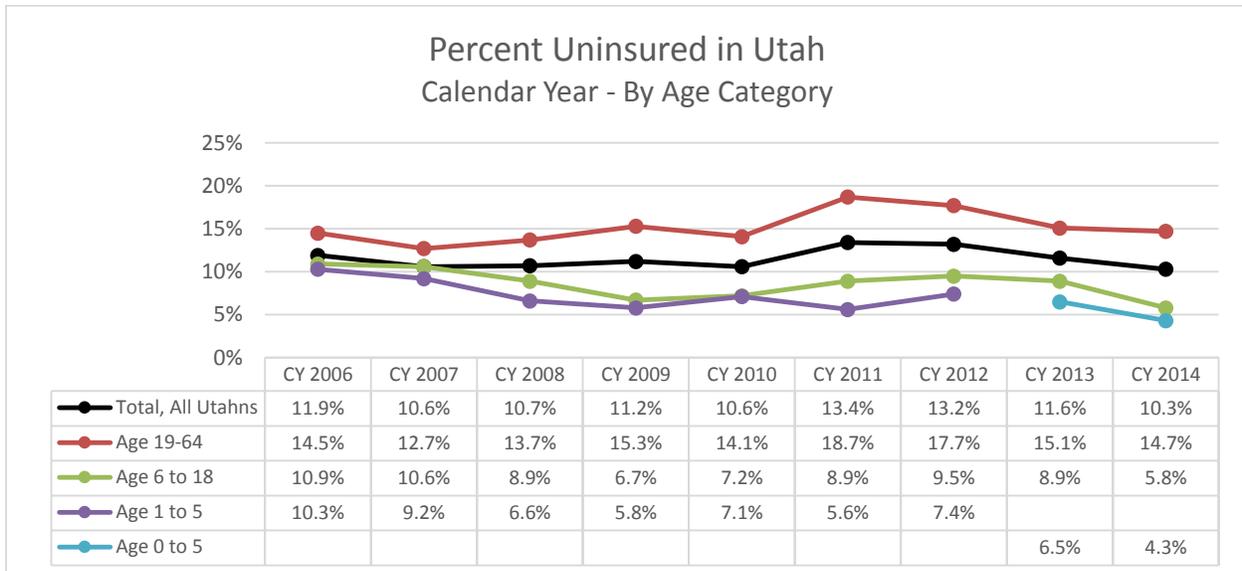
### **Plan for Analysis**

1. Evaluation of performance of the demonstration.
2. Report outcomes.
3. Identify limitations, challenges and opportunities.
4. Identify successes and best practices.
5. Revise strategies or goals.
6. Develop recommendations and implication at the state and federal levels.

# Introduction

Historically, Utahns age 19 to 64 have the highest rate of uninsurance in the state.

In calendar year 2014 (the most recent data available), nearly three times as many Utahns age 19 to 64 (14.7 percent) were uninsured. This is for all adults age 19 to 64 regardless of income level or employment stats. By contrast, just 4.3 percent of children age 0 to 5 and 5.8 percent of adolescents age 6 to 18 were uninsured. See Figure 1.

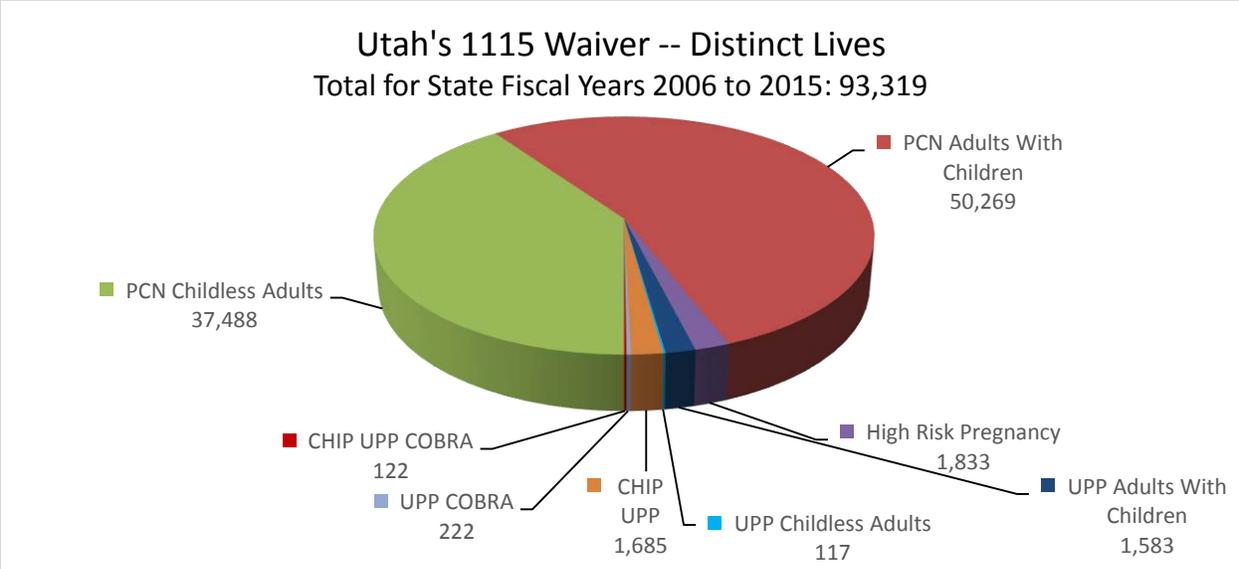


**Figure 1.** Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS), [https://ibis.health.utah.gov/pdf/opha/publication/ins/InsHighlights\\_2014.pdf](https://ibis.health.utah.gov/pdf/opha/publication/ins/InsHighlights_2014.pdf).

According to the 2014 Health Insurance Analysis from the Behavioral Risk Surveillance System, 18.7 percent of all Utahns age 19-64 declared that they were uninsured in 2011. During that same year (CY 2011), 41.3 percent of Utahns with a household income below 150 percent FPL were uninsured (see Figure 5 on page 13). Overall, uninsurance rates have improved in CY 2014, the percent of uninsured among all Utahns age 19-64 dropped 4.0 points to 14.7 percent; the uninsured rate dropped 13.5 points for Utahns age 19-64 with a household income below 150 percent FPL to 27.8 percent.

Utah’s Primary Care Network (PCN) was designed to serve adults in this low-income category, specifically those with an annual household income up to 95 percent of the FPL, by offering limited benefits to cover their day-to-day needs and to encouraging them to use the health care system appropriately. The basic goal of PCN is to serve a larger percentage of this income group with basic benefits than could be served if the coverage were more comprehensive.

During the past ten years (SFY 2006 to SFY 2015), Utah’s PCN has served 93,319 distinct individuals, with an average of 25,785 lives being covered each year. See Figure 2.



**Figure 2** Count of distinct lives enrolled by Utah’s 1115 Demonstration Waiver using SFY 2006 to SFY 2015 enrollment data from the Medicaid Data Warehouse. Each individual is counted only once within the aggregate.

Over half of the people served by Utah’s 1115 Waiver in the past ten years (54 percent) are adults with children. Childless adults account for 40 percent. The remaining six aid categories comprise six percent of the total lives served by Utah’s 1115 Waiver.

Services offered to PCN members include: primary care provider visits; four prescriptions per month; dental exams, dental x-rays, cleanings, and fillings; immunizations; an eye exam (no glasses or contacts); routine lab services and x-rays; limited emergency department visits; emergency medical transportation; and birth control.

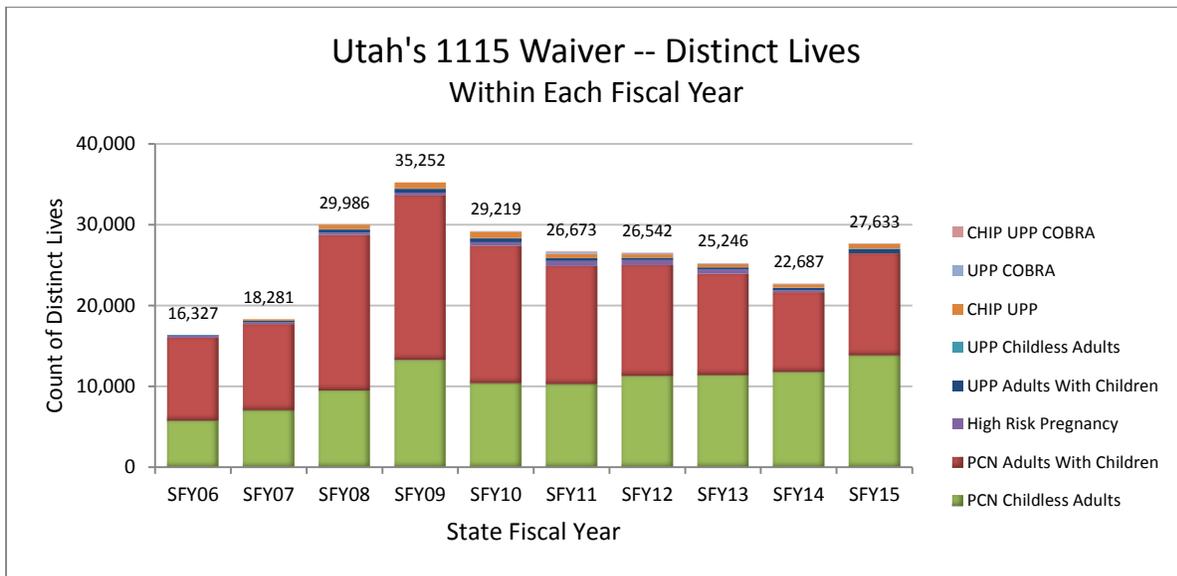
Overnight hospital stays, MRIs, CT scans, and similar services, as well as visits to specialists such as orthopedists or cardiologists are not covered under PCN. To assist PCN clients who may be in need of non-covered services, a written request may be made by a participant’s primary care provider for a PCN Specialty Care Coordinator to assist in finding providers who are willing to donate services or provide treatment for a minimal copay.

Total enrollment fluctuates as applications are only accepted during open enrollment periods, which are held when sufficient resources are available to cover more people. The federal government requires PCN to enroll more adults with children than people without children. Because of this, PCN may schedule separate enrollment times for parents (adults with children) and those without children. To qualify as a parent, the applicant must have children age 18 or younger living at home. Enrollment can be held at any time throughout the year as space becomes available.

The primary source for applicants to learn about Utah’s Primary Care Network is from the Department of Workforce Services (DWS) eligibility workers, as applicants are seeking public assistance.

During SFY 2008 and into SFY 2009, the Utah Department of Health made a concerted effort to increase the awareness of PCN among eligibility workers and ultimately likely PCN candidates resulting in peak enrollment during SFY 2009. During that peak (SFY 2009), a total of over 35,250 distinct individuals were served for at least one month during the year. Moreover, the all-time monthly peak enrollment occurred in June of 2009, with 24,405 individuals participating in the Primary Care Network during the month. See Figure 3.

A renewed education effort with DWS was implemented in SFY 2015 resulting in an increase of 1,946 distinct lives from SFY 2014 (22,687) to SFY 2015 (27,633).



**Figure 3.** Counts of distinct lives enrolled under Utah’s 1115 Demonstration Waiver. Monthly enrollment data is aggregated by state fiscal year from the Medicaid Data Warehouse. “Distinct Lives” counts all individuals enrolled in PCN for at least one month during the fiscal year. An individual is counted only once within each year.

## Evaluation of Hypotheses

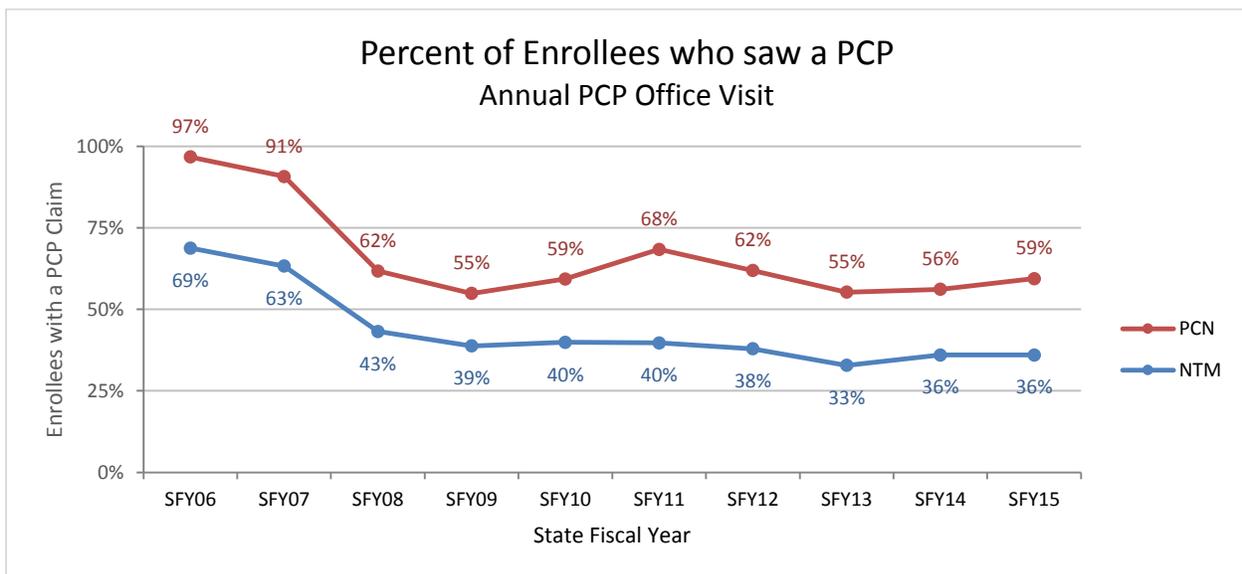
### **Hypothesis 1: The demonstration will not negatively impact the overall well-being, in relation to health status, of Current Eligibles (Non-Traditional Medicaid) who experience reduced benefits and increased cost sharing.**

According to Medicaid claims data, the rate of Primary Care Network (PCN) recipients who had at least one annual visit with a primary care provider (PCP) peaked at 97 percent in SFY 2006. Non-Traditional Medicaid (NTM) participants with an annual visit to a PCP also peaked in SFY 2006 at 69 percent.

Rates of access to a PCP trended downward for both PCN and NTM from SFY 2006 to SFY 2009. However, with similar rates of decrease for both, one did not adversely affect the other.

During SFY 2009 and SFY 2010, Utah converted to a new eligibility enrollment system resulting in an increase in PCN enrollment. The percent of PCN participants who saw a PCP increased through SFY 2010 (59 percent) and SFY 2011 (68 percent), while NTM participants' rate of seeing a PCP remained steady at 40 percent. Thus the increase in access to care among PCN recipients did not affect the rate of access to care among NTM recipients. See Figure 4.

With the implementation of Accountable Care Organizations (ACO) in SFY 2013, part of the NTM population shifted from Medicaid Fee for Service to the ACOs. Even with this shift, the rate of PCN enrollees who saw a PCP did not adversely affect the rate among NTM enrollees.



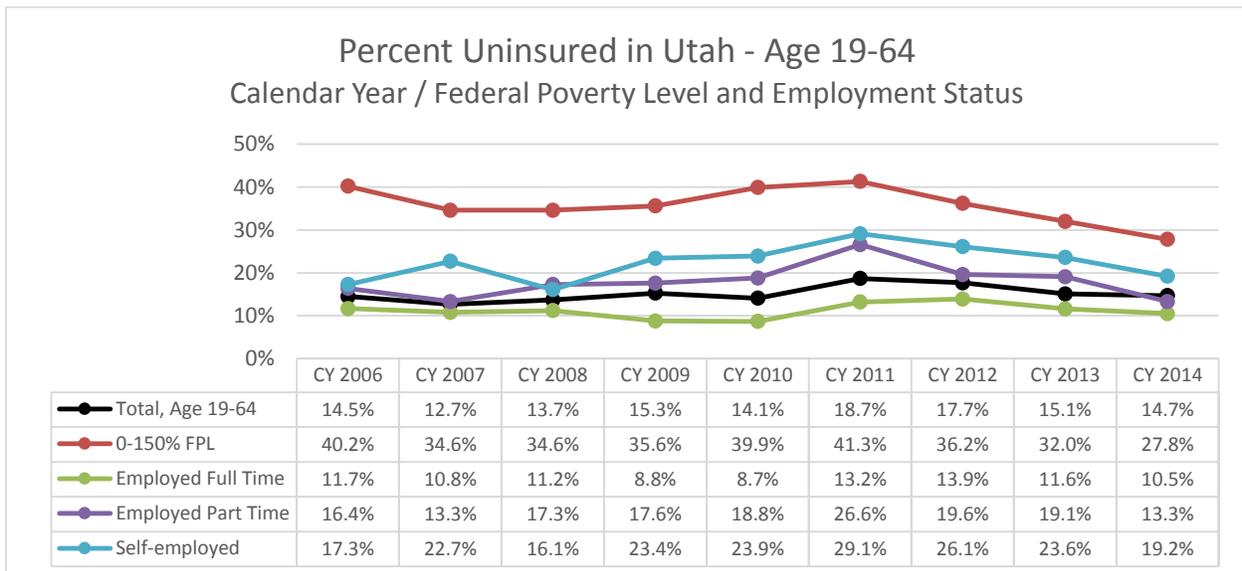
**Figure 4.** Analysis of claims and encounters from the Medicaid Data Warehouse for PCN and Non-Traditional Medicaid. Claims contained the following Current Procedural Terminology (CPT) billing codes: 99201-99205, 99211-99215, 99381-99385, 99391-99395, 99241-99245, 99354, 99355, G0438, G0439, and/or S5190.

**Hypothesis 2a: The demonstration will improve well-being in Utah by reducing the number of Utahns without coverage for primary health care.**

According to the Behavioral Risk Surveillance Risk System (BRFSS), the percent of Utahns without health insurance increased among all adults age 19 to 64 between calendar year (CY) 2008 and CY 2011. This increase in uninsurance affected not only the PCN target group—those at 0-150 percent FPL—but the three major employment groups as well: full-time, part-time, and self-employed.

Since CY 2011, uninsurance among Utahns age 19 to 64 has been steadily declining, most markedly among those at 0-150 percent FPL. In CY 2011, 41.3 percent of those with 0-150 percent FPL were uninsured, the highest percentage in the years covered by this study, 0.9 points higher than the previous high in 2006 (40.2 percent). Three years later in CY 2014, the rate among this low-income group had dropped 13.5 points to 27.8 percent, the lowest rate of uninsurance measured in this category during the nine years of data available for by this study.

During this same time period (CY 2011 to CY 2014), the rate of uninsurance for adults employed part time was cut in half (a decrease of 13.3 points; CY 2011: 26.6 percent to 2014: 13.3 percent). Uninsurance for self-employed adults declined 9.9 points from its high (CY 2011: 29.1 percent to CY 2014: 19.2 percent). The uninsurance rate among Utahns age 19-64 employed full time also improved, down 2.7 points from its high of 13.2 percent in CY 2011 to 10.5 percent in CY 2014. Overall, the rate of uninsurance among all Utahns age 19-64 declined 4.0 points from 18.7 percent in CY 2011 to 14.7 percent in CY 2014. See Figure 5.



**Figure 5.** Summary of 2014 Health Insurance Analysis from the Behavioral Risk Factor Surveillance System (BRFSS), [https://ibis.health.utah.gov/pdf/oph/publication/ins/InsHighlights\\_2014.pdf](https://ibis.health.utah.gov/pdf/oph/publication/ins/InsHighlights_2014.pdf)

In CY 2010, the gap in uninsurance between Utahns employed full time (8.7 percent) and those in the 0-150 percent FPL group (39.9 percent) was at its widest with 31.2 percentage points

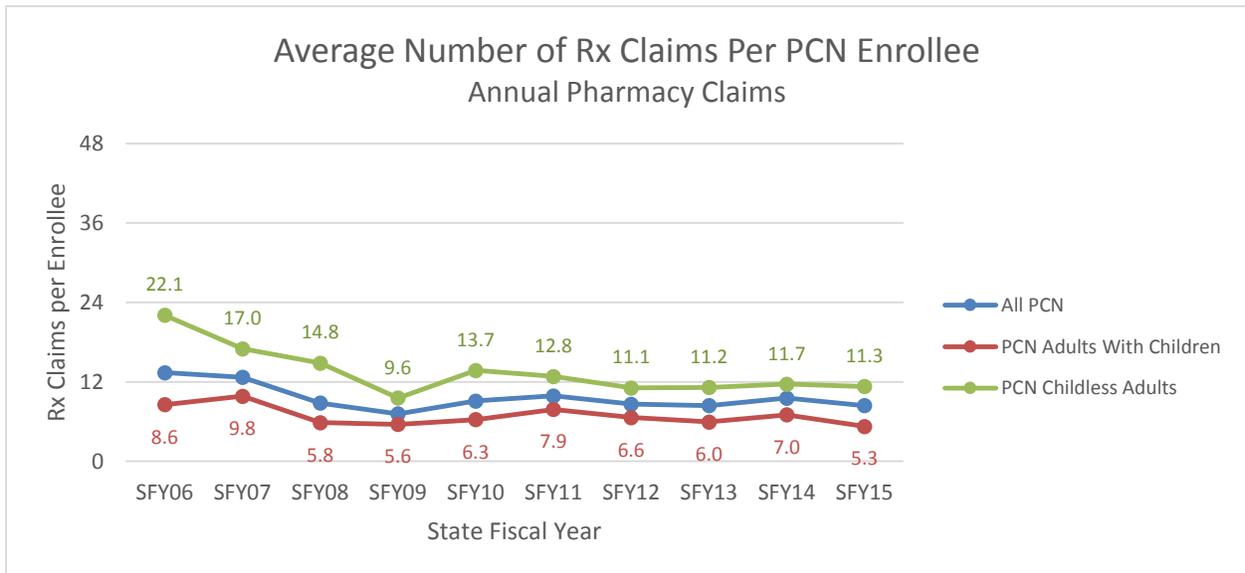
separating the two groups. In CY 2014, with a 17.3 point gap between those employed full time (10.5 percent) and Utahns in the 0-150 percent FPL group (27.8 percent), not only is the gap is now at its narrowest, it also marks the only uninsurance rate for the 0-150 percent FPL group that is under 30 percent in the years covered by this data.

It is postulated that improved (lower) rate of uninsurance in the target group is due, at least in part, to the availability of PCN insurance.

**Hypothesis 2b: The demonstration will improve well-being in Utah by improving PCN enrollees’ access to primary care.**

The PCN benefit covers four prescriptions each month or a maximum of 48 per year. The number of prescriptions is not limited in the Traditional Medicaid and Non-Traditional Medicaid programs.

Within the PCN population, Childless Adults have accessed a greater number of prescription medications annually on average than Adults with Children with the highest average number of prescriptions being 22.1 (Childless Adults) in SFY 2006. The highest average among Adults with Children is 9.8 in SFY 2007. While there are certainly PCN recipients who are using their maximum number of annual prescriptions, the average number of prescriptions claimed for Childless adults is 13.5 (average of SFY 2006 to SFY 2015) and 6.9 for Adults with Children. Both of these rates are well below the maximum of 48 allowed each year indicating that overall PCN recipients do have adequate access to prescription medications. See Figure 6.



**Figure 6.** From the Medicaid Data Warehouse: annually, this measures the total number of pharmacy claims divided by the total number of enrollees for PCN Adults with Children and for PCN Childless Adults.

Through PCN, approximately 25,785 individual lives annually since SFY 2006 have been improved by having access to basic primary medical care and a limited number of prescriptions. This is coverage that is not available through any other source for this group of people.

## **Hypothesis 2c: The demonstration will improve well-being in Utah by improving the overall well-being in the health status of PCN enrollees.**

As a primary care program, PCN does not cover inpatient hospital services such as surgery or overnight hospital stays. If it is determined that a client needs to stay in the hospital for more than 24 hours, the client needs to contact the hospital's billing office to determine eligibility for the hospital's charity care program. Likewise, specialty care services such as cardiology, gastroenterology, etc. are not covered by PCN. However, with a written referral that includes clinical notes from a primary care provider (PCP), PCN Specialty Care Coordinators are committed to assisting with a search for donated services at little or no cost to the client.

From January 2006 to December 2015, PCN Specialty Care Coordinators received a total of 19,190 referrals for specialty care from PCPs. The Care Coordinators voluntarily tracked and categorized the outcomes of these referrals. Outcomes were tracked by quarter for CY 2005 to CY 2010 and then by full year (January to December) for CY 2011 to CY 2015. During a change in the tracking procedure in CY 2011, only successful outcomes were tracked. All outcomes have been summarized into five categories:

### **Services Rendered:** Outcomes include:

- Specialty care was successfully arranged
- Requested service is a covered PCN benefit (specialty care was not required)
- Client arranged their own specialty service
- Client obtained health insurance

### **In Process:** Outcomes include:

- Service is pending
- Client is on a charitable-care waiting list
- Client has been contacted—Care Coordinator is awaiting a response
- Case was transferred
- Duplicate referral

### **Client's action:** Outcomes include:

- Client has not responded to communication
- Service was not required
- Client was not eligible for PCN
- Client refused service

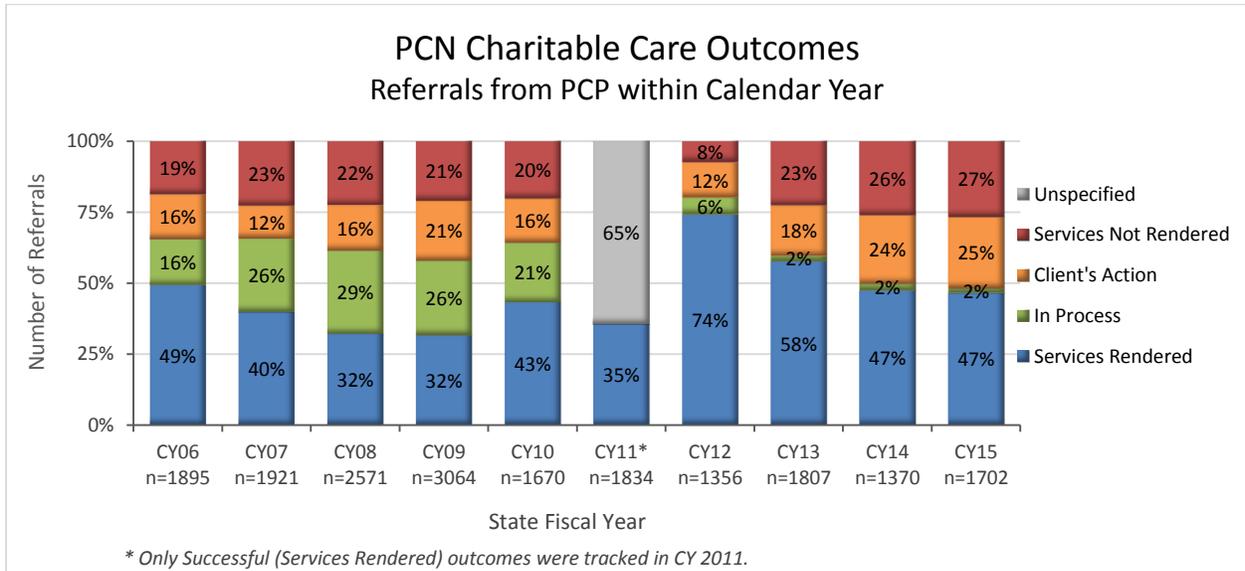
### **Services Not Rendered:** Outcomes include:

- Client cannot pay fee
- Intermountain Healthcare denied charity care
- Service referral was unsuccessful/unavailable

### **Unspecified:** Outcome was not tracked.

The plurality of outcomes (those with the greatest proportion) falls in the “Services Rendered” category, ranging from 32 percent in CY 2008 and CY 2009 to 74 percent in CY 2012. For the three most recent years (CY 2013 to CY 2015), they have been able to petition charitable specialty care for over half of the referrals they received (three-year average is 51 percent).

By comparison, “Services Not Rendered” outcomes range from 8 percent (CY 2012) to 27 percent (CY 2015). The three-year average for these unsuccessful outcomes is 25 percent, half the rate of successful outcomes. See Figure 7.



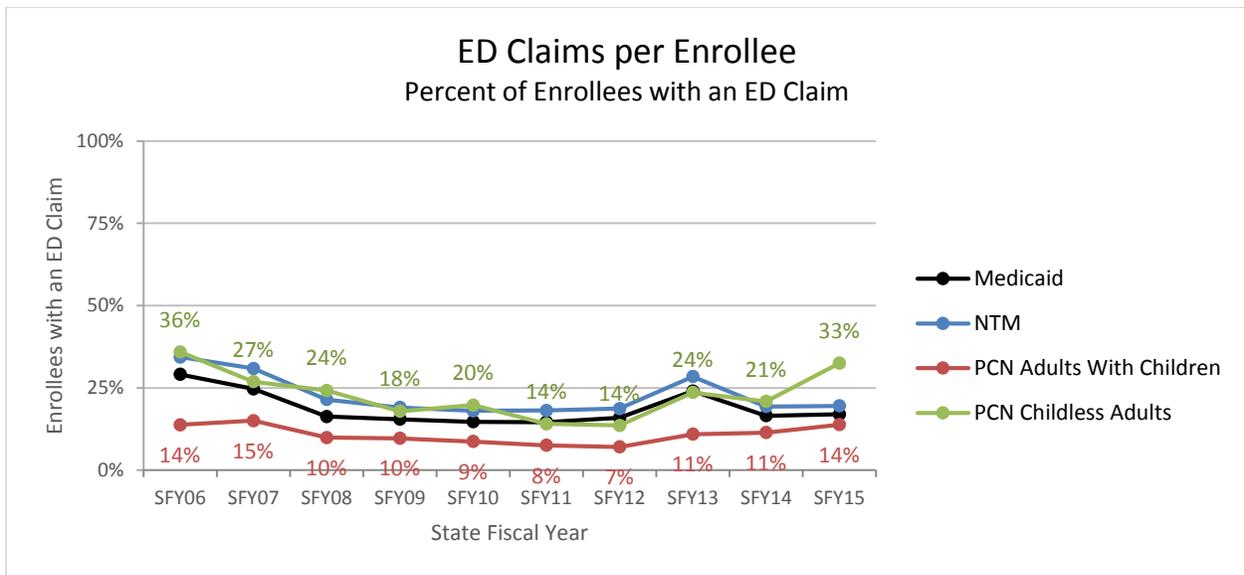
**Figure 7.** Specialty Care Coordinator’s Primary Care Network combined Quarterly Reports from January 2006 to December 2010 and Annual Reports from January 2011 to December 2015. Coordinators tracked requested specialties, outcomes, and geographic area. Outcomes were summarized for this report.

Outcomes identified as “In Process” in most cases were resolved in the following quarter. The group of outcomes categorized as “Client’s Action” were out of the Specialty Care Coordinator’s control, with the majority of them being a non-response from the client, even after the Coordinator attempted to contact him/her at a variety of times of day and days of the week, using all available contact information (landline, cell phone, email, etc.).

**Hypothesis 3: The demonstration will reduce the number of unnecessary visits to emergency departments by PCN enrollees.**

Throughout the ten years reviewed for this report, emergency department (ED) claims among PCN Childless Adults and Non-Traditional Medicaid enrollees have been fairly consistent and consistently about three percentage points higher than traditional Medicaid enrollees. With SFY 2015, as PCN Childless Adult enrollment increased by 28 percentage points (see Figure 3 on page 10) over SFY 2014, the rate of ED claims increased by eight percentage points (SFY 2014: 21 percent to SFY 2015: 33 percent). This would indicate that new enrollees are finally able to access services that have been unavailable before enrolling in the PCN program.

As was also evidenced in recipients’ use of the prescription drug benefit (see Figure 6 on page 14), PCN Adults with Children access ED services at a much lower rate than PCN Childless Adults, NTM, and Medicaid enrollees. In SFY 2015, 14 percent of PCN Adults with Children had an ED claim, compared to 17 percent of Medicaid, 20 percent of NTM, and 33 percent of PCN Childless Adult enrollees. See Figure 8.

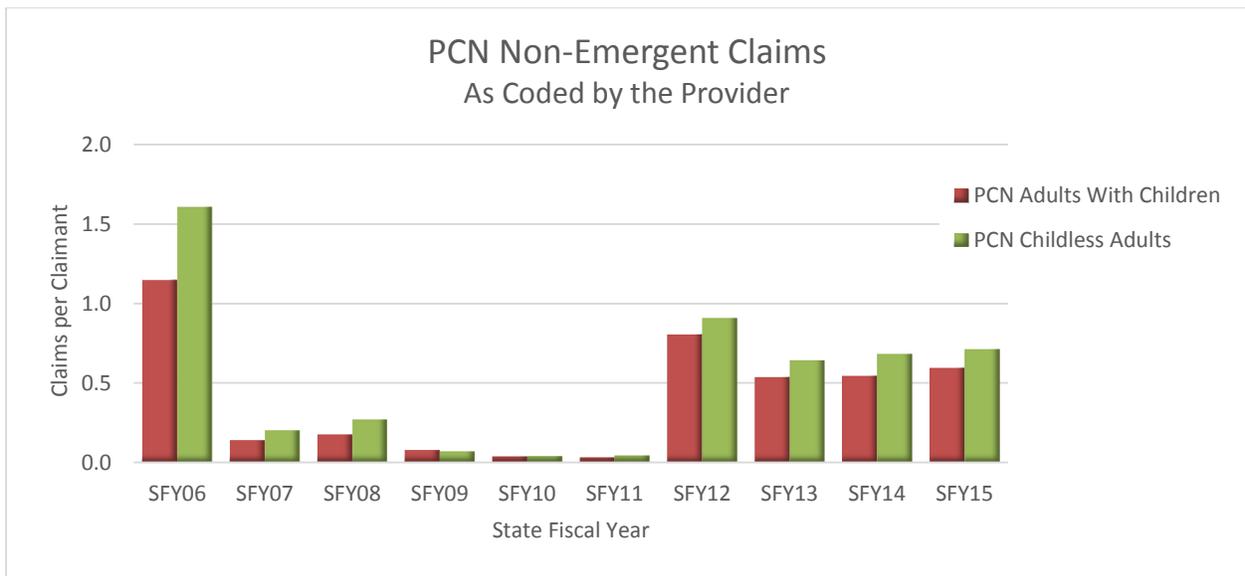


**Figure 8.** Analysis of Utah Medicaid claims data for emergency department (ED) claims, including counts of enrollees, ED recipients, ED claims, and the emergency indicator.

Looking deeper into the status of ED claims—whether they were coded as emergent or non-emergent by the provider—again reveals different behavior between the two PCN categories. Over the ten state fiscal years reviewed for this study, PCN Childless Adults with claims were consistently had more non-emergent claims than PCN Adults with Children. In SFY 2005, the average number of non-emergent claims per PCN Childless Adult was 1.6 compared to 1.2 for PCN Adults with Children.

In SFY 2007, efforts to educate all Medicaid enrollees, not just those covered through the 1115 Waiver, about appropriate emergency department use increased; likewise the overall number of ED claims decreased as did the incidence of non-emergent claims. This trend for the appropriate use of ED services continued through SFY2011 and shows that education campaigns can be effective. See Figure 9.

Unfortunately, the incidence of non-emergent claims increased in SFY 2012 to 0.91 for PCN Childless Adults and 0.8 for PCN Adults with Children. Non-emergent claims have remained above 0.5 per claimant for the last three years. This, once again, calls for a renewed effort to educate public health recipients about appropriate emergency department use.

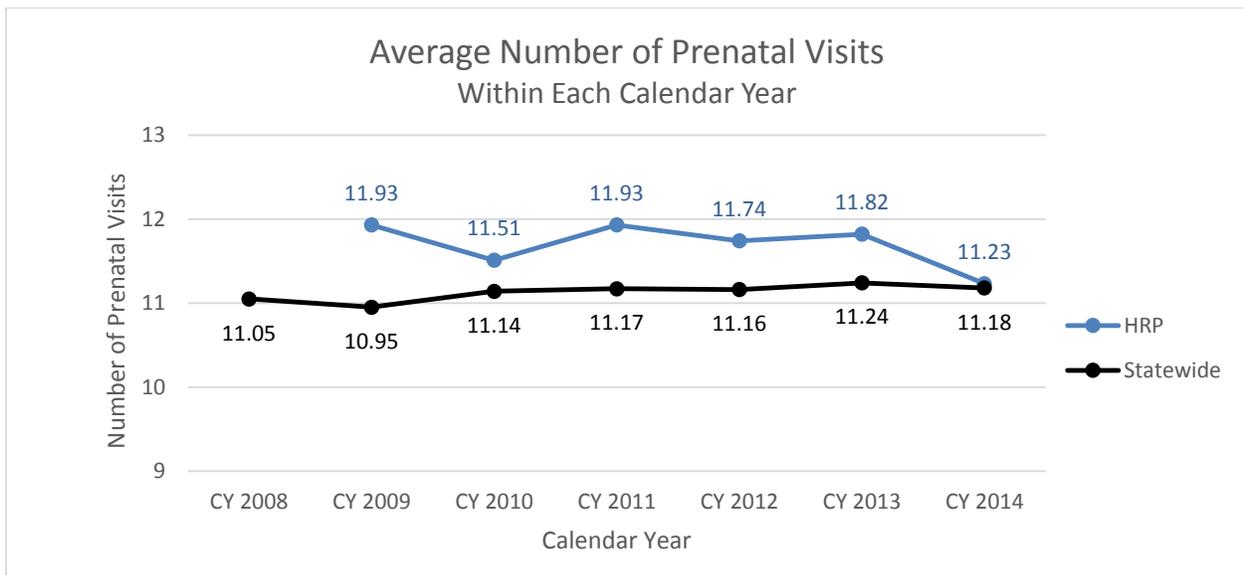


**Figure 9.** Claims include a field to flag emergent services. Available values are Yes, No, or blank. Non-emergent claims are calculated by counting all claims with a value of No or blank and dividing that by the total number of claimants.

#### **Hypothesis 4: The demonstration will increase the number of prenatal visits for High-Risk pregnancies in comparison to the general population.**

According to the Public Health Indicator Based Information System (IBIS), the average number of prenatal visits among all Utah resident mothers with live births in CY 2008 was 11.05, which serves as a baseline for this comparison. This baseline includes all women, regardless of health insurance coverage or risk level. Utah mothers-to-be are encouraged to see their health care provider before the thirteenth week of pregnancy and to go back for at least thirteen visits before birth.

The average number of prenatal visits for the High-Risk Pregnancy (HRP) group within the 1115 Waiver has been consistently higher than the statewide average for all live births. In CY 2009, the first year the HRP data was available, HRP mothers averaged 11.93 prenatal visits, compared to 10.95 for the general population statewide. See Figure 10.



**Figure 10.** Statewide average of prenatal visits data comes from a query of all live births to Utah resident mothers regardless of where they occurred; data source: Public Health Indicator Based Information System (IBIS):

<https://ibis.health.utah.gov/query/result/birth/BirthBirthCnty/AvgPNCVisit.html>.

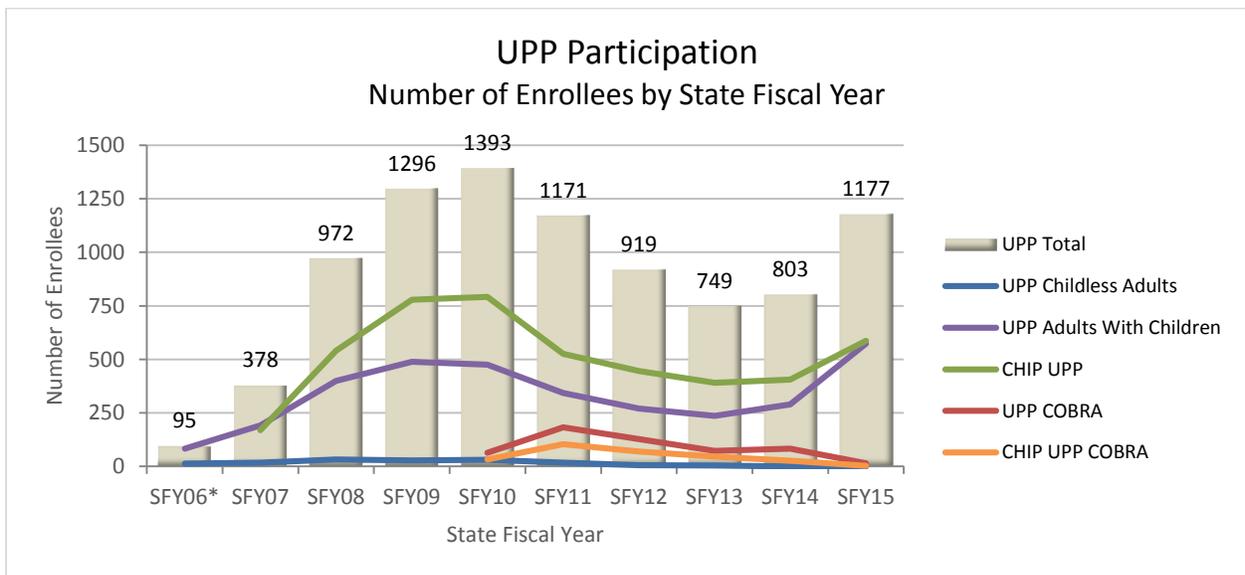
The count and average number of prenatal visits data for High-Risk Pregnancy recipients comes from a query of the Utah Medicaid Data Warehouse.

Early in CY 2014, the Affordable Care Act removed the asset test that made the High-Risk Pregnancy aid category necessary, effectively discontinuing the need for the HRP aid category. Therefore, CY 2013 has the last full year of HRP data. In CY 2013, the HRP group continued to have a higher average number of prenatal visits (11.82) than did the general population (11.24). During CY 2014, the women on HRP were transitioned to traditional Medicaid.

**Hypothesis 5: The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employers' contributions to premiums that is greater than any decrease in contributions in the overall health insurance market.**

In November 2006, Utah’s Premium Partnership for Health Insurance (UPP) was implemented to create opportunities for qualified individuals and their family members under age 18 to purchase employer-sponsored health insurance by reimbursing health insurance premiums up to \$150 per adult and \$120 per child (\$140 per child if dental coverage is also purchased) every month.

The Utah Department of Health with the Department of Workforce Services implemented an awareness push for UPP in SFY 2008 and SFY 2009, when total enrollment in UPP reached its peak of 1,393 total participants during the year. In March 2010, President Obama issued an Executive Order that clarified how rules limiting the use of federal funds for abortion services would be applied to health insurance exchanges. It was determined that the Executive Order in conjunction with the intent of state law created new expectations for the UPP subsidy. In April 2010, an emergency rule was filed to prohibit UPP from reimbursing participants who were enrolled in plans covering abortion services beyond the circumstances allowed for the use of federal funds (i.e., life of the mother, rape, or incest). Subsequently, enrollment in UPP in SFY 2013 dropped to 749 participants. See Figure 11.



**Figure 11.** Counts of distinct lives enrolled Utah’s Premium Partnership for Health Insurance (UPP). Monthly enrollment data is aggregated by state fiscal year from the Medicaid Data Warehouse. “Distinct Lives” counts all individuals enrolled in UPP for at least one month during the fiscal year. An individual is counted only once within each year.

\* SFY 2006 represents a partial year as UPP was introduced in November 2006.

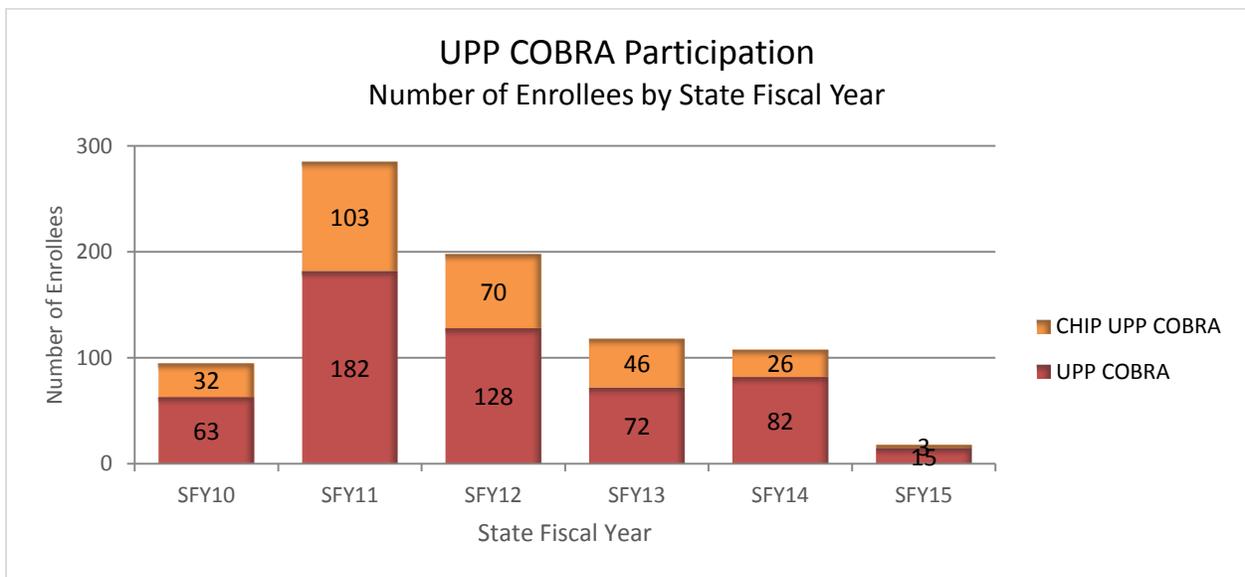
In SFY 2014, the Bureau of Eligibility Policy (BEP) worked with the Department of Workforce Services (DWS) to increase awareness of the UPP benefit. DWS centralized their staff and BEP trained DWS staff on how to identify potential UPP recipients. BEP also educated insurance brokers on the UPP program. This additional training, as well as many employer-based insurance coverages becoming more aligned with the federal definition of abortion coverage, ushered in greater participation in UPP in SFY 2015 when 1,177 distinct lives were covered by the benefit. Awareness efforts to identify appropriate UPP participants continues and enrollment is expected to increase in SFY 2016.

To participate, employers must contribute at least 50 percent of the premium. In SFY 2007, employers were paying 60 percent on average of the employed individual's premium and 86 percent of a dependent's premium. It is expected that employer contributions will settle close to the 50 percent contribution.

**Hypothesis 6: The demonstration will assist individuals currently eligible for or enrolled in COBRA with monthly premium reimbursement to help reduce the number of uninsured while reducing the rate of uninsurance.**

Utah’s 1115 Waiver was amended in SFY 2010 to allow for premium assistance for Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. Based on family size, income, and if the former employer’s health insurance coverage meets basic guidelines, UPP COBRA recipients may be reimbursed for up to \$150 per adult and up to \$120 per child in the family (up to \$140 per child, if the child is enrolled in dental coverage) every month.

In SFY 2011, the American Recovery and Reinvestment Act (ARRA) provided an additional subsidy for employers to pay for COBRA benefits resulting in higher UPP COBRA enrollment until the subsidy ended in February 2011. The end of this subsidy, combined with the 2010 executive order limiting which COBRA plans qualify for UPP assistance, resulted in 30 percent fewer UPP COBRA enrollees in SFY 2012. Continued improvement in the state’s economy as well as a reduced benefit have almost eliminated participation in the UPP COBRA program.



**Figure 12.** Count of distinct Utah Medicaid UPP COBRA enrollees and their dependents with at least one month of eligibility, aggregated by state fiscal years 2010 to 2012.

## **Conclusion and Recommendations**

Utah's 1115 Demonstration Waiver has proven to provide a significant benefit to Utah residents who would otherwise have no health insurance coverage and would likely go without health care.

With the 2016 Utah Legislative Session, limited Medicaid expansion was approved by the legislature. Upon CMS approval, Medicaid coverage will be offered to up to 16,000 Utahns who are currently uninsured, including parents with income up to 55% of the FPL, those who are chronically homeless, those who are involved in the justice system, and some who are mentally ill. House Bill 437 "Health Care Revisions" (HB437) also allows for substance abuse treatment at facilities with no bed-capacity limits and permits specific waiver enrollees to maintain Medicaid coverage for 12 months. HB437 authorizes the Utah Department of Health to apply for the necessary waivers from CMS to implement the provisions described above.

## ATTACHMENT 3

### **Public Notice**



# SPECIAL NOTICES

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## Health Health Care Financing, Coverage and Reimbursement Policy

### Public Hearing to Discuss the 1115 Waiver and H.B. 437 "Health Care Revisions" From the 2016 General Session

The Division of Medicaid and Health Financing (DMHF) will hold public hearings to discuss the renewal of and proposed amendments to the Primary Care Network 1115 Demonstration waiver. Proposed changes to the waiver are required to implement the provisions of H.B. 437 "Health Care Revisions" passed during the 2016 General Session. These amendments include requesting authority to add Medicaid eligibility for additional adults between the ages of 19 and 64 who meet certain criteria. In addition, the State will request a waiver of the Medicaid IMD (institution for mental disease) exclusion. Finally, amendments will be proposed to remove the high risk pregnant woman group, as it is no longer needed due to the Affordable Care Act; making changes to Non-Traditional Medicaid benefits to comply with mental health parity; and removing the EPSDT waiver for 19 and 20 year olds.

These topics will be discussed at public hearings to be held on Thursday, May 19, 2016, from 1:30 p.m. to 3:30 p.m. as part of the monthly Medical Care Advisory Committee (MCAC) meeting, and Wednesday, May 25, 2016, from 1:00 p.m. to 3:00 p.m. Both meetings will be in Room 125 of the Cannon Health Building, 288 North 1460 West, Salt Lake City, Utah.

*A conference line is available for those who would like to attend by phone: 1-877-820-7831, passcode 196690#. Individuals requiring an accommodation to fully participate in this meeting should contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on May 11, 2016.*

**End of the Special Notices Section**

## ATTACHMENT 4

### **Tribal Consultation**

**May 13, 2016**

(To Be Added When Submitted to CMS)



## ATTACHMENT 5

**Public Hearing-MCAC**

**May 19, 2016**

**Agenda and Comments**

(To Be Added When Submitted to CMS)



## ATTACHMENT 6

### **Public Notice**

**May 25th and May 31st, 2016**

(To Be Added When Submitted To CMS)



## ATTACHMENT 7

### **External Quality Review Report**

The most recent External Quality Review Report can be found at:

<https://sites.google.com/a/utah.gov/cqm/home/external-quality-review-2015-2016>



## ATTACHMENT 8

### **CAHPS Report**

The most recent Utah 2014 and 2015 Customer Satisfaction Survey (CAHPS) Report can be found at:

Children- <https://health.utah.gov/myhealthcare/reports/cahps/2014/index.php>

Adults- <https://health.utah.gov/myhealthcare/reports/cahps/2015/>



## ATTACHMENT 9

### **Amendment #16**

### **Adults without Dependent Children-Medicaid**



## Attachment 9

### Section 1115 Demonstration Application

#### Amendment #16

#### Adults without Dependent Children

### Section I- Program Description and Objectives

**1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).**

Under this Demonstration, the State seeks to implement a health coverage improvement program that will cover targeted populations of adults without dependent children. Some of these individuals may currently be covered under the existing Primary Care Network (PCN) program, Section 1115 Demonstration. This Demonstration will cover adults without dependent children age 19-64 years of age, with income at zero percent of the Federal Poverty Level (FPL) using the Modified Adjusted Gross Income (MAGI) methodology. The MAGI methodology includes a five percent FPL income disregard. In addition to the current eligibility criteria, these adults must meet one of the following additional criteria;

1) Be chronically homeless, defined as:

- An individual who has been continuously homeless for at least 12 months or on at least 4 separate occasions in the last 3 years; and has a disabling condition.
- An individual currently living in supportive housing who has previously met the definition of chronically homeless above.

2) Involved in the justice system AND are in need of substance use or mental health treatment, defined as:

- An individual who has successfully completed a behavioral health treatment program while incarcerated in jail or prison;
- An individual involved in a Drug Court or Mental Health Court; or
- An individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense.

3) Needing substance use or mental health treatment, defined as:

- An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder;
- An individual discharged from the State Hospital who was civilly committed.

Individuals eligible under the Demonstration will receive the traditional benefit package available under the State plan. If approved, this group will also receive 12 months of continuous eligibility. With few exceptions, changes that occur during the 12 month certification period will not impact eligibility. In addition, if future waiver amendments would cause a recipient to be ineligible, members currently enrolled through this amendment will be able to complete their original 12-month eligibility period under this waiver.

Utah is also seeking authority to modify the definition of these populations through Utah Administrative Code. For example, if there is a need to change the chronically homeless criteria from 12 months of continuous homelessness to 6 or 18 months, this would be done through a revision to the Utah Administrative Code.

The Demonstration program furthers the objectives of Title XIX of the Social Security Act by promoting continuity of coverage for individuals, improving access to providers, supporting the triple AIM, and providing medical assistance for some of the neediest Utahns.

## **2) Include the rationale for the Demonstration.**

This Demonstration waiver request supports implementation of House Bill 437- "Health Care Revisions", which was signed into law by Governor Gary Herbert on March 25, 2016. After years of deliberation and research, the State has developed a plan for a Utah-specific approach to reduce the number of uninsured adults in the state. This approach targets specific high-need populations.

According to surveys conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), 4.8 percent of Utah adults suffer from serious mental illness, which equates to approximately 97,000 residents. In addition 7.8 percent abuse alcohol or illicit drugs. Without medical coverage, these populations will not be able to access the treatment they need to find and sustain employment, secure housing and avoid re-hospitalization or incarceration. Higher rates of mental and physical illness among individuals who abuse drugs or alcohol are important contributors to health expenditures. In addition, individuals who abuse drugs or alcohol use expensive forms of acute care more often than others. Many times individuals who are released from incarceration are not able to get the care and treatment they need to curtail certain behaviors that are driven by substance abuse and mental illness.

In crafting this Demonstration the Utah Department of Health (UDOH) worked with many stakeholders to determine how to best meet the intent of House Bill 437. Stakeholders involved in discussions included other state agencies such as Department of Corrections,

Department of Workforce Services, Administrative Office of the Courts, Division of Substance Abuse and Mental Health within the Department of Human Services, and the Commission on Criminal and Juvenile Justice. In addition, the UDOH met with county and city government representatives, local mental health agencies, treatment providers, homeless shelter providers and the Association for Utah Community Health. The UDOH also held four informal public discussions to gather public feedback prior to drafting this request. Feedback provided by stakeholders was carefully considered in defining the groups to include in the Demonstration.

**3) Describe the hypotheses that will be tested/evaluated during the Demonstration’s approval period and the plan by which the State will use to test them.**

The Demonstration will authorize the delivery of medical benefits to a targeted group of low-income adults. By providing access to needed medical care, mental health treatment and substance use treatment, the Demonstration will improve health outcomes for participants. The following hypotheses will be tested during the approval period:

Hypothesis	Evaluation Approach	Data Sources
The Demonstration will reduce the number of uninsured Utahns.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Uninsured rates from the Utah Behavioral Risk Factor Surveillance System (BRFSS)
The Demonstration will improve access to primary care, while also improving the overall health status of the target population.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration. Specifically, the number of primary care physician office visits and emergency room visits will be used.	Claims/encounter data from the state’s system.
The Demonstration will reduce the number of psychiatric or substance use disorder admissions to a hospital.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Claims and encounter data

The Demonstration will reduce the length of time individuals are homeless.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Utah HMIS data
The Demonstration will reduce uncompensated care provided by Utah hospitals.	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.	Hospital Costs Report

**4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate.**

The Demonstration will operate statewide.

**5) Include the proposed timeframe for the Demonstration.**

January 1, 2017 - December 31, 2019

**6) Describe whether the Demonstration will affect and/or modify other components of the State’s current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems.**

The Demonstration will not affect and/or modify other components of the State’s current Medicaid and CHIP programs. Individuals eligible under this amendment will receive traditional State plan benefits. In addition, services will be provided through Utah’s current delivery system.

**Section II- Demonstration Eligibility**

**1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).**

The Demonstration will target individuals who meet the following eligibility criteria, listed by priority:

1. Chronically homeless- this is defined as: (1) living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12 months or on at least 4 separate occasions in the last 3 years; and has a diagnosable

substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic illness or disability; or (2) currently living in supportive housing, but who has previously met the definition of chronically homeless defined in (1).

- Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
2. Involved in the justice system AND are in need of substance use or mental health treatment- this is defined as: (1) an individual who has successfully completed a behavioral health treatment program while incarcerated in jail or prison (requirements regarding the type and length of qualifying programs will be established in Utah Administrative Code); (2) an individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or (3) an individual involved in a Drug Court or Mental Health Court. Drug courts require frequent testing and court supervision, and focus upon eliminating drug addiction as a long-term solution to crime. Many drug court participants have co-occurring mental and physical health problems. Mental health courts combine judicial supervision with community health treatment and other support services in order to reduce criminal activity. They seek to address the underlying problems that contribute to criminal behavior.
  3. Needing substance abuse or mental health treatment- this is defined as: (1) an individual receiving General Assistance from DWS, who has been diagnosed with a substance use or mental health disorder. The General Assistance Program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; (2) an individual discharged from the State Hospital who was civilly committed.

In addition to the criteria above, the individual must also meet ALL of the requirements below to be eligible for the Demonstration. Individuals must be:

- Adults, age 19-64 years old, without dependent children;
- A U.S. Citizen or qualified alien;
- A resident of Utah and not in a public institution;
- Have household income of 0% of the Federal Poverty Level (FPL) using the MAGI methodology which includes a five percent FPL income disregard;
- Ineligible for other Medicaid programs that do not require a spenddown to qualify.

Retroactive coverage will be allowed, but may not begin prior to the effective date of the Demonstration program.

Pursuant to 42 CFR 435.1110(c)(1), the Demonstration group will not be eligible for presumptive eligibility.

**Expansion Populations**

Eligibility Group Name	N/A	Income Level
Adult Expansion	N/A	0% FPL after 5% income disregard

**2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.**

When determining eligibility under the Demonstration, Utah will apply the same eligibility standards and methodologies described in the State plan. MAGI methodology will be used and there will be no asset limit.

The state will work with various state agencies and community partners to verify factors of eligibility, whenever possible. For example, the primary verification source for the chronically homeless criteria will be the HMIS system maintained by the Housing and Community Development division of DWS.

**3) Specify any enrollment limits that apply for expansion populations under the Demonstration.**

There are no caps on enrollment in the Demonstration.

Description	Income	Age	Exceptions
Adult Expansion	0% after 5% disregard	19-64	Ineligible if disabled per SSA.

**4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.**

We are anticipating approximately 6,000-7,000 individuals will be eligible under this amendment. This is based on an analysis of the eligibility criteria defined under #1 above using data provided by stakeholders.

**5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of**

**income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State).**

For individuals with a community spouse, we will apply the Spousal Impoverishment rules under Sec. 1924 of the Social Security Act to determine eligibility. We will also apply the Sec. 1924 post-eligibility treatment of income rules. For individuals who do not have a community spouse, we will apply the regular post-eligibility treatment of income rules defined in 42 CFR 435.725.

**6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).**

Upon approval, individuals eligible under the Demonstration will have 12-months of continuous eligibility. Changes during the certification period will not affect eligibility with the exception of the following:

- Moved out of state
- Death
- Determined eligible for another State plan program
- Fraud
- Client request

If the State changes eligibility rules for this targeted population, the changes will not apply to an individual during the 12-month certification period.

**7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.**

Not applicable. MAGI methodology will be used.

### Section III- Demonstration Benefits and Cost Sharing Requirements

**1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

Yes  No (if no, please skip questions 3 – 7)

**2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:**

Yes  No (if no, please skip questions 8 - 10)

**3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration:**

Not applicable

**4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:**

- Federal Employees Health Benefit Package
- State Employee Coverage
- Commercial Health Maintenance Organization
- Secretary Approved

Not applicable.

**5) In addition to the Benefit Specifications and Qualifications form:**

**<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf>, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan.**

Not applicable. The benefits under the Demonstration are the same as the State plan.

**6) Indicate whether Long Term Services and Supports will be provided.**

Yes (if yes, please check the services that are being offered)  No

Benefits under the Demonstration will not differ from those provided under the State plan.

**In addition, please complete the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf>, and the: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf>.)**

- Homemaker**
- Case Management**
- Adult Day Health Services**
- Habilitation – Supported Employment**
- Habilitation – Day Habilitation**
- Habilitation – Other Habilitative**

**Respite**  
**Psychosocial Rehabilitation**  
**Environmental Modifications (Home Accessibility Adaptations)**  
**Non-Medical Transportation**  
**Home Delivered Meals Personal**  
**Emergency Response**  
**Community Transition Services**  
**Day Supports (non-habilitative)**  
**Supported Living Arrangements**  
**Assisted Living**  
**Home Health Aide**  
**Personal Care Services**  
**Habilitation – Residential Habilitation**  
**Habilitation – Pre-Vocational**  
**Habilitation – Education (non-IDEA Services)**  
**Day Treatment (mental health service)**  
**Clinic Services**  
**Vehicle Modifications**  
**Special Medical Equipment (minor assistive devices)**  
**Assistive Technology**  
**Nursing Services**  
**Adult Foster Care**  
**Supported Employment**  
**Private Duty Nursing**  
**Adult Companion Services**  
**Supports for Consumer Direction/Participant Directed Goods and Services**  
**Other (please describe)**

**7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.**

**Yes (if yes, please address the questions below)**

**No (if no, please skip this question)**

**8) If different from the State plan, provide the premium amounts by eligibility group and income level.**

There are no premiums under the Demonstration.

**9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan:**

Not applicable. This will not differ from the State plan.

**10) Indicate if there are any exemptions from the proposed cost sharing.**

Not applicable. This will not differ from the State plan.

## Section IV- Delivery System and Payment Rates for Services

**1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:**

Yes

No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

**2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration’s expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.**

**3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:**

Managed care

Managed Care Organization (MCO)

Prepaid Inpatient Health Plans (PIHP)

Prepaid Ambulatory Health Plans (PAHP)

Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)

Health Homes

Other (please describe)

**4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration. Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:**

**5) If the Demonstration will utilize a managed care delivery system:**

**a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?**

**b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.**

**c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).**

**d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.**

**e) Describe how the managed care providers will be selected/procured.**

**6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.**

**7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration.**

**8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.**

Not applicable. There is no deviation from the State plan.

**9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

Capitation payments for the populations covered under this amendment will be actuarially certified in accordance with 42 CFR Part 438. The contract provisions for these population will comply with the requirements of 42 CFR 438.

**10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

Not applicable.

## **Section V- Implementation of Demonstration**

**1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

The anticipated implementation date of the Demonstration is January 1, 2017. Current PCN eligibles who qualify for the Demonstration, and who can be identified in the eligibility system without further verification, will be moved to the program effective January 1, 2017. All newly eligible individuals can begin receiving benefits effective January 1, 2017.

Milestone	Timeframe
Move current PCN individuals who are eligible for Demonstration to new program	January 1, 2017
Approve newly eligible individuals	January 1, 2017

**2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

Adults without Dependent Children- Current PCN Eligibles

Individuals in this group who can be identified as eligible for the Demonstration program, using existing information in their case file, will be moved to the Demonstration program as of January 1, 2017. No further action will be needed by these individuals. They will be notified of their enrollment in the Demonstration program.

Current PCN eligible individuals who cannot be identified as eligible for the Demonstration program, will be sent notification informing them of the new program. They will be directed to contact DWS (the department that makes Medicaid eligibility determinations) to request an eligibility determination for the Demonstration program. Any PCN eligible individuals who do not request an eligibility determination will have their case reviewed at their recertification date. DWS will then determine if the individual is eligible under this amendment.

New applicants

Eligibility for the Demonstration program will begin on January 1, 2017, with an enrollment date of no earlier than January 1, 2017. Eligibility for the Demonstration program will be determined with any application submitted as early as December 2016.

The State will coordinate with community partners and other state agencies to identify and verify eligibility for the following criteria; (1) chronically homeless, (2) justice system involved with a substance abuse disorder or mental health disorder, and (3) individuals with a substance abuse disorder or mental health disorder. These partners and agencies include; homeless shelters, Adult Probation and Parole, county criminal justice partners and the State Hospital.

Managed Care Enrollment

Enrollment in managed care plans for the Demonstration group will occur as it does for those covered under the State plan. Individuals eligible for the Demonstration who reside in one of the thirteen managed care counties will be notified of the requirement to choose a managed care plan. If they do not choose one, one will be assigned. All eligibles will also be enrolled in a prepaid mental health plan.

**3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.**

The State of Utah currently operates two approved 1915 (b) waivers: the Choice of Health Care Delivery Program & Hemophilia Disease Management program and the Utah Prepaid Mental Health Plan.

The Choice of Health Care Delivery Program waiver allows the state to mandate enrollment in a Medicaid Accountable Care Organization (ACO) in thirteen mandatory enrollment counties. ACOs are responsible to provide physical health benefits to their enrollees except for specific carve outs. Utah currently has four ACOs on contract, HealthChoice Utah, Healthy U, Molina Healthcare of Utah and SelectHealth. These plans will also provide services and care management for the populations addressed in this amendment. The State is not required to go through a separate procurement process. The State intends to also amend its 1915 (b) waiver to include these populations.

Utah's Prepaid Mental Health Plan allows the State to automatically enroll Medicaid members in a prepaid mental health/substance use disorder plan. These plans are administered through local county mental health and SUD authorities who have a statutory obligation to provide behavioral health services to the resident in their counties. The State is not required to conduct a procurement action to allow us to contract with these entities. The State will enroll the populations addressed in this waiver in a Medicaid prepaid mental health plan to receive their mental health and SUD services. The State intends to also amend its 1915 (b) waiver to include these populations.

HB 437 envisions that ACOs and counties will work together to integrate behavioral health care into ACOs. Where there is interest in integration and to the extent feasible within established timeframes, the appropriate 1915(b) waivers will be amended to accomplish this integration.

## Section VI- Demonstration Financing and Budget Neutrality

See Attachment 11.

## Section VII- List of Proposed Waivers and Expenditure Authorities

### **1) Provide a list of proposed waivers and expenditure authorities.**

The state does not intend to request any additional waivers for this population that are beyond what are in our current 1115 waiver.

#### Proposed Waivers

- Section 1902(a)(1)- Statewideness/Uniformity
- Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability
- Section 1902(a)(23)(A)- Freedom of Choice

## Expenditures

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

### **2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.**

Waiver Authority	Reason and Use for Waiver
Section 1902(a)(1)	To enable the state to provide differing types of managed care plans in certain geographical areas of the state for the Title XIX populations affected by this Demonstration.
Section 1902(a)(10)(B)	To enable the state to provide benefits to Title XIX state plan populations affected by this Demonstration that are less than those available to other individuals under the state plan. In addition this waiver enables the state to include additional benefits for Demonstration eligibles, who are enrolled in managed care delivery system, such as case management and health education, compared to the benefits available to individuals eligible under the state plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)	To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration. This does not apply to family planning providers.

## Section VIII- Public Notice

### **1) Start and end dates of the state’s public comment period.**

The state’s public comment period was May 9, 2016 through June 8, 2016.

**2) Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.**

Utah certifies that it provided public notice of the application on the state’s Medicaid website at <http://health.utah.gov/MedicaidExpansion>, beginning May 9, 2016. A news release was also issued on May 9, 2016.

**3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.**

Utah certifies that it convened three public hearings at least twenty days prior to submitting the application to CMS. Utah held the following hearings:

- Salt Lake City- May 19, 2016, 1:30-3:30. This was held during the state’s medical care advisory committee meeting. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments were able to do so. Individuals were also able to participate by teleconference.
- Salt Lake City- May 25, 2016, 1:00-3:00. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments are able to do so. Individuals were also able to participate by teleconference.
- Logan- May 31, 2016, 11:30-1:00. Nate Checketts, Deputy Director, provided an overview of the Demonstration. Individuals who requested to provide public comments were able to do so. Individuals were also able to participate by teleconference.

**4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)**

The state certifies that electronic notification was issued on the state’s website for posting public hearings at <http://pmn.utah.gov>. This website automatically notifies statewide newspapers when public hearing notices are posted. The public hearings were also listed in the Utah State Bulletin at [http://www.rules.utah.gov/publicat/bull\\_pdf/2016/b20160501.pdf](http://www.rules.utah.gov/publicat/bull_pdf/2016/b20160501.pdf).

**5) Comments received by the state during the 30-day public notice period.**

See Attachment 12. (To be added prior to submission to CMS)

**6) Summary of the state’s responses to submitted comments, and whether or how the state incorporated them into the final application.**

See Attachment 13. (To be added prior to submission to CMS)

**7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state’s approved Medicaid State plan, or at least 60 days prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.**

Utah certifies that the state conducted tribal consultation in accordance with the consultation process outlined in the state’s approved Medicaid State Plan. A presentation regarding the Demonstration was given at the Utah Indian Health Advisory Board (UIHAB) meeting held on May 13, 2016. See Attachment 4. (Agenda and minutes to be added prior to submission to CMS)

## Section IX Demonstration Administration

**Name and Title:** Nate Checketts, Deputy Director, Utah Dept. of Health

**Telephone Number:** (801) 538-6689

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## ATTACHMENT 10

### **Amendment #17**

### **Residential Treatment Services for Substance Use Disorders**



## Attachment # 10

### Section 1115 Demonstration Application

#### Amendment # 17

### Substance Use Disorder Residential Treatment Services

The State of Utah offers a full continuum of care for the treatment of substance use disorders (SUD) with the exception of two services; residential treatment and targeted case management. SUD services under the Utah State Plan are available to all Medicaid members in all counties of the state.

In Utah's 1115 PCN Demonstration Waiver, Amendment No. 15, Utah is seeking approval to provide Medicaid covered services to adults without dependent children between the ages of 19 and 64, many of whom have an SUD. With the expansion of coverage, a full continuum of SUD treatment becomes even more critical to address the needs of both current Medicaid members, as well as the new adult populations.

Utah will demonstrate how organized substance use disorder care increases the success of Utah Medicaid members while decreasing the cost of health care for these individuals in other health care systems. Critical elements of Utah's continuum of care are modeled after the American Society of Addiction Medicine (ASAM) criteria.

The Division of Substance Abuse and Mental Health (DSAMH), in the Department of Human Services, is the substance abuse and mental health authority for Utah (see Utah Code Annotated (UCA) §62A-15-103). It is charged with ensuring a comprehensive continuum of substance use and mental health disorder services is available throughout the state. The Utah Department of Health (DOH) is the single state agency for Medicaid and is responsible for the administration of Utah's Medicaid program. Pursuant to state statute, local county mental health and substance abuse authorities are responsible to develop SUD and mental health prevention and treatment services plans and provide these services to the residents of their counties. The local authorities are also responsible to work with and are accountable to the DSAMH and the DOH.

DOH administers a 1915(b) waiver called the Prepaid Mental Health Plan. The majority of SUD services are provided through full risk pre-paid inpatient hospital plans that are entities that either operate under the authority of or an extension of the local substance abuse and mental health authorities. Two locations in the state continue to provide services on a fee for service basis.

In an effort to fill a deficit in Utah's continuum of care, the State of Utah is requesting expenditure authority to provide ASAM Level 3 residential treatment in a non-institutional 24 – hour non-medical, short-term residential program for all Medicaid members. These residential treatment programs provide rehabilitation services to Medicaid members with a substance use disorder diagnosis when determined medically necessary by a Medical Doctor or a Licensed Practitioner of the Healing Arts and in accordance with an individualized treatment plan. Residential services will be available to non-perinatal and perinatal members. These services are intended to be individualized to treat the functional deficits identified in the ASAM criteria.

Medicaid members in need of residential treatment will live on the premises and will be supported in their efforts to restore, maintain and apply interpersonal and independent living skills. They will also access community supports.

Residential treatment facilities are licensed by the Department of Human Services, Office of Licensing, and certified by the DSAMH, in accordance with ASAM criteria. Residential treatment servicing providers are licensed by the Department of Commerce, Division of Occupational and Professional Licensing. All residential treatment facilities and providers of services must be enrolled as Medicaid providers and properly screened and credentialed.

Utah proposes to allow residential treatment services in facilities without a bed capacity limit as follows:

### **Adults**

Residential treatment may range from 1-90 days with a maximum of 90 days. Two 90 day stays per year may be approved with the appropriate order for treatment and individualized treatment plan. A review must be completed every two weeks during any stay to assure continued residential treatment is medically necessary.

### **Adolescents**

Residential treatment will be limited to no more than 30 days. Up to an additional 30 day stay may be authorized if determined to be medically necessary on an annual basis. A review must be completed every two weeks during any stay to assure continued residential treatment is medically necessary. Adolescents require shorter lengths of stay and should be stabilized and moved to less intensive level of treatment as medically appropriate.

**Perinatal**

Perinatal members may receive a longer length of stay based on medical necessity.

The components of Residential Treatment Services are:

- A. Evaluation and Treatment Planning
- B. Individual and Group Therapy/Counseling
- C. Family Therapy
- D. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist resident’s self-administration of medication
- E. Collateral Services
- F. Crisis Intervention Services
- G. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment

**Table One ASAM Criteria Continuum of Care Services and the Utah Medicaid System**

ASAM Level of Care	Title	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N	Needed Authority for Service
0.5	Early Intervention	Screening, Brief Intervention and Referral for Treatment (SBIRT)	Managed care or Fee for Services provider		N	State Plan
1	Outpatient Services	Less than 9 hours of services /week (adults); Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y		State Plan
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more	DHS/OL	Y		State Plan

		hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM	Certified Outpatient Facilities			
2.5	Day Treatment/ Psychosocial Rehabilitation Services	20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour care	DHS/OL Certified Outpatient Facilities	Y		State Plan
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	DHS/OL Licensed and DHS/ASAM Designated Residential Providers		N	CNOM authority
3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y		State Plan
3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for	DHS/OL Licensed and DHS/ASAM Designated	Y		State Plan

		outpatient treatment.	Residential Providers			
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	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y		State Plan
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		State Plan
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use	DHCS Licensed OTP Maintenance Providers, Licensed Prescribers	Y		State Plan

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

Level of Withdrawal Management	<u>Level</u>	<u>Description</u>	<u>Provider</u>	Existing Medicaid Service Y/N	New Medicaid Service Y/N	Needed Authority for New Services
Ambulatory Withdrawal Management	1-WM	Mild withdrawal with daily or less than daily	DHS/OL Certified Outpatient		Y	State Plan

Without Extended on-Site Monitoring		outpatient supervision	Facility w/ Detox Certification; Physician, licensed prescriber; or OTP for opioids			
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		State Plan
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		Y	State Plan

The continuum of care for SUD services outlined in the previous tables is modeled after the levels identified in the ASAM criteria. Utah’s Prepaid Mental Health Plans are responsible for the oversight and implementation of all levels of continuum of care with the exception of ASAM Level 4 which is a medical benefit covered under the Utah Medicaid’s Accountable Care Organization contracts.

**References:**

2015 Utah Annual Report of Medicaid & CHIP:

[https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport\\_2015.pdf](https://medicaid.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/MedicaidAnnualReport_2015.pdf)

DSAMH 2015 Annual Report: <http://dsamh.utah.gov/data/annual-reports/>

Local Human Services Act: <http://le.utah.gov/xcode/Title17/Chapter43/17-43.html>

DSAMH Local Authority/County Plans: <http://dsamh.utah.gov/provider-information/local-authoritycounty-area-plans/>

## ATTACHMENT 11

### **Budget Neutrality Requirements Adults without Dependent Children- Medicaid**

(In Process- Will be Released Shortly)



## ATTACHMENT 12

### **Comments Received During 30-Day Public Notice Period**

(To Be Added When Submitted to CMS)



## ATTACHMENT 13

### **State Responses to Comments**

(To Be Added When Submitted to CMS)

