Utah Department of Health & Human Services

State of Utah

Section 1115 Demonstration Amendment

Health Related Social Needs

Background

Health Related Social Needs (HRSN) are an individual's unmet, adverse social conditions that contribute to poor health. They are a result of underlying social determinants of health (SDOH) which are conditions in which people are born, grow, work, and age. Research has shown that SDOH and associated HRSN can account for as much as 50% of health outcomes[1] and contribute to health inequities.[2] By addressing HRSN, Medicaid can help enrollees stay connected to coverage and access needed health care services, and supplement existing local, state and federal supports.[3]

Homelessness and housing instability are important social and public health issues worldwide. Homelessness and housing instability affect both physical and mental health and makes accessing health care difficult. As a result, individuals experiencing homelessness or housing instability often face social and economic challenges that may lead to poor health, such as poverty, poor nutrition, and social exclusion. In addition, homeless individuals have a much higher prevalence of behavioral health conditions and mental illness.[4] This has been shown across multiple observational studies.[5] Individuals who lack stable and appropriate housing are less likely to receive proper care for their health conditions.[6] This lack of care results in increased usage of emergency departments

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[1] Hood CM, Gennuso KP, Swain GR, et al. *County Health Rankings: Relationships Between Determinant Factors and Health Outcomes*. American Journal of Preventive Medicine. February 2016; 50(2):129- 135. doi:10.1016/j.amepre.2015.08.024

[2] Centers for Disease Control and Prevention. *NCHHSTP Social Determinants of Health. Frequently Asked Questions*. Published December 19, 2019. Accessed April 15, 2024. https://www.cdc.gov/nchhstp/socialdeterminants/faq.html#:~:text=Social%20determinants%20of%20health%20such,lives%20by%20reducing%20health%20inequities.

[3] Department of Health & Human Services. *CMS Information Bulletin. November 16, 2023*. Accessed April 1, 2024. https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf

[4] Burt MR, Aron L. *America's homeless II: Populations and services*. Published January 1, 2000. Accessed April 1, 2024. http://webarchive.urban.org/publications/900344.html.

[5] Fornaro, M., Dragioti, E., De Prisco, M. *et al. Homelessness and health-related outcomes: an umbrella review of observational studies and randomized controlled trials*. *BMC Med* 20, 224 (2022). https://doi.org/10.1186/s12916-022-02423-z

[6] Liu M, Hwang SW. *Health care for homeless people.* Nat Rev Dis Prim. 2021;7(1):1–2.

and higher rates of hospitalization, often for preventable conditions such as hypertension, diabetes and respiratory conditions.[7,8] Research supports the critical link between stable, decent, and affordable housing and positive health outcomes.[9]

The number of homeless individuals in Utah continues to rise. According to the United States Department of Housing and Urban Development (HUD) Point in Time (PIT) Survey, the number of homeless individuals increased by 14% in 2021 and 10% in 2022. The January, 2023 PIT count numbers increased by 9.6% in Salt Lake County and first-time homelessness increased by 53%.[10]

Formerly incarcerated individuals are almost ten times more likely to be homeless than the general public.[11] Research shows that individuals who are released from prison face considerable challenges in obtaining access to safe, stable, and affordable housing.[12] Additional studies show that housing access is an important foundation for those returning from incarceration with stable housing being a predictor for improved well-being, reduced stigmatization and recidivism.[13]

Providing medical respite care to homeless individuals can help address a significant component of HRSN. Medical respite care is defined as acute and post acute medical care

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[7] Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. *The unmet health care needs of homeless adults: a national study.* Am J Public Health. 2010 Jul;100(7):1326-33. doi: 10.2105/AJPH.2009.180109. Epub 2010 May 13. PMID: 20466953; PMCID: PMC2882397.

[8] Stafford A, Wood L. *Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants.* Int J Environ Res Public Health. 2017 Dec 8;14(12):1535. doi: 10.3390/ijerph14121535. PMID: 29292758; PMCID: PMC5750953.

[9] Moqbool, Viveiros & Ault. *The Impacts of Affordable Housing on Health: A Research Summary.* Center for Housing Policy. Published April, 2015. Accessed April 15, 2024. https://nhc.org/wp-content/uploads/2017/03/The-Impacts-of-Affordable-Housing-on-Health-A-Research-Summary.pdf

[10] Salt Lake County CoC Point-In-Time (PIT) Count Summary, 2023. Accessed April 15, 2024. https://endutahhomelessness.org/wp-content/uploads/2023/06/Salt-Lake-County-CoC-Point-In-Time-PIT-Count-Summary.pdf

[11] National Low Income Housing Coalition. *Formerly Incarcerated People Are Nearly 10 Times More Likely to Be Homeless*. Published August 20, 2018. Accessed April 15, 2024. https://nlihc.org/resource/formerly-incarcerated-people-are-nearly-10-times-more-likely-be-homeless#:~:text=A%20report%20by%20Lucius%20Couloute,homeless%20than%20the%20general%20public.

[12] Keene DE, Smoyer AB, Blankenship KM. *Stigma, housing and identity after prison.* Sociol Rev. 2018 Jul;66(4):799-815. doi: 10.1177/0038026118777447. Epub 2018 Jun 12. PMID: 32855574; PMCID: PMC7449251.

[13] Fontaine J, & Biess J (2012, April). *Housing as a platform for formerly incarcerated persons*. Published April, 2012. Accessed April 15, 2024. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412552-Housing-as-a-Platform-for-Formerly-Incarcerated-Persons.PDF.

for homeless individuals who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital. In most communities, patients who are experiencing homelessness have no other choice but to remain in a hospital for an extended length of time until their illness or injury is resolved. Communities that have medical respite programs offer a cost-efficient transitional care option. Research demonstrates that even brief stays in a medical respite program decreases hospitalization, reduces readmissions, and reduces costs for hospitals and the health care system.[14] Combined with housing placement services and effective case management, medical respite care will allow homeless individuals with complex medical and psycho-social needs to recover from an acute medical condition in a stable environment while reducing future hospital utilization.

Understanding and addressing HRSN is critical to creating equitable health care for all communities. Access to these HRSN services is expected to further help reduce health disparities that are often rooted in social and economic disadvantages.[15] By addressing HRSN, Utah can help its members stay connected to coverage and access needed health care services, thereby providing a regular source of needed care to meet individuals' comprehensive health needs.

Section 1. Program Description and Objectives

With this amendment, the State is requesting authority to provide a defined set of HRSN services to individuals who meet qualifying criteria. These services include the following:

- Provide medical respite care to qualified Adult Expansion Medicaid (AEM) and Targeted Adult Medicaid (TAM) members.
- Expand HRSS benefits to qualified Medicaid members who, within the previous 12 months, were inmates of a correctional facility and received Justice Involved reentry services through Utah's demonstration waiver.

Additional change requests:

- The State is requesting that HRSS benefits for TAM members be provided under the current section 1115 Demonstration be covered under this HRSN framework.

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[14] National Health Care for the Homeless Council. *Medical Respite Care and Homelessness.* Published 2012. Accessed April 14, 2024. https://nhchc.org/wp-content/uploads/2019/08/2012-Medical-Respite-Policy-Statement-doc.pdf

[15] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort.* Published April 1, 2022. Accessed April 14, 2024. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

- In addition, the State is requesting a change to the "Fertility Preservation for Individuals Diagnosed with Cancer" eligibility requirements outlined in the approved Special Terms and Conditions (STC) received from CMS on February 29, 2024. STC 5.12(a)(ii) states that to be eligible for this benefit, a beneficiary must be post-pubertal and younger than 40 years of age. The State is requesting authority to change the limit to younger than 50 years of age.

1.1 Medical Respite Care

On December 30, 2021 the State submitted a section 1115 Demonstration amendment application to CMS, requesting approval to provide temporary medical respite care to homeless individuals covered under the TAM and AEM programs. These services would include time-limited medical care in a stable environment where hospitals will be offered an alternative to discharging patients to the streets while ensuring that the medical care received is not compromised due to unstable living conditions. The objectives are to promote coverage and access to care, improve health outcomes, reduce disparities and create long-term, cost-effective alternatives to traditional medical services. Under this proposed delivery system, the State sought to contract with a single entity selected through the State's procurement process that:

- Has demonstrated experience working with individuals who are homeless; and
- Is capable of providing medical respite in a residential facility.

This new amendment request modifies the previously submitted medical respite amendment application to provide medical respite under the HRSN framework. In addition, the State is requesting authority to contract with no more than two entities to provide these same services, rather than one entity as the State initially requested Additional information regarding hypotheses, eligibility, demonstration benefits and cost sharing requirements is contained in the Medical Respite Amendment application submitted to CMS on December 30, 2021.

1.2 Expand Housing Related Services and Supports Benefits to Recently Incarcerated Individuals

With this amendment, the State is requesting authority to expand the eligibility requirements for HRSS benefits to include qualified Medicaid members who, within the previous 12 months, were inmates of a correctional facility and received Justice Involved reentry services through Utah's demonstration waiver. This request is a result of House Bill 501, "Health Amendments" which was passed and signed into law during the 2024 General Session of the Utah State Legislature. The objectives are to achieve housing stability,

improve mental health or substance use disorder recovery, improve health outcomes, reduce inmate recidivism, and reduce health care costs for this vulnerable population.

The objectives are to achieve housing stability, improve mental health or substance use disorder recovery, improve physical health outcomes, reduce inmate recidivism, and reduce health care costs for this vulnerable population.

HRSN Goals and Objectives

Coverage of targeted HRSN services is likely to assist in promoting the objectives of Medicaid because it is expected to help individuals stay connected to coverage and access needed health care. Increasing certain HRSN services is expected to promote coverage and access to care, improve health outcomes, and create long-term, cost-effective alternatives or supplements to traditional medical services. These services are expected to further help reduce health disparities often rooted in social and economic disadvantages.[16] In addition, predicting the downstream effects on overall Medicaid program costs of covering certain evidence-based HRSN services is extremely difficult, making it hard for CMS to pinpoint the estimated fiscal impact of these expenditures on demonstration budget neutrality or on the State's overall Medicaid program. Treating demonstration HRSN expenditures as hypothetical will give the State the flexibility to test these worthy innovations, especially as CMS anticipates that they might result in overall reductions in future Medicaid program costs.

Providing opportunities for success and access to resources will assist members in actively engaging in promoting and improving their own health and financial well-being. In turn, this will help members meet their HRSN, a critical component to improving the health status of Utahns. Specific goals include, but are not limited to:

- Increase positive health and wellbeing outcomes for target populations including the stabilization of mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction.
- Reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization.

[16] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

- Support state efforts to reduce homelessness and improve ongoing housing stability.
- Improve the quality and effectiveness of care;
- Establishing/improving primary care relationships;
- Reduce costs and burdens on Utah Medicaid and the healthcare system by decreasing hospital admissions, readmissions, length of stay, ambulance transport/emergency services, and emergency department dependence.

Operation and Proposed Timeline

The demonstration will operate statewide. The State intends to implement the proposed benefit as soon as possible after approval. The State requests to operate the demonstration through June 30, 2027.

Demonstration Hypotheses and Evaluation

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

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

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
HRSS Expansion to Recently Incarcerated and TAM			
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.

The demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
This demonstration will increase engage-ment and assessment of unenrolled but eligible chronically homeless members in the homeless population.	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

Section II. Demonstration Eligibility

HRSS for Recently Incarcerated Individuals
Individuals eligible under this HRSS benefit must meet the following requirements: 1. The individual must be Medicaid eligible. 2. Within the previous 12 months, the individual must have been an inmate of a correctional facility and must have received pre-release services through Utah's demonstration waiver. A correctional facility includes a state prison or county jail. It does not include federal prisons. 3. The individual must be experiencing homelessness, housing insecurity, or interpersonal violence and trauma. 4. The individual must meet one needs-based criteria and one risk factor, as described in Table 1.

<table>
<tr><th>Table 1. Needs Based Criteria and Risk Factors</th></tr>
<tr><td>Needs Based Criteria</td></tr>
<tr><td>
1. Requires improvement stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment or behavioral impairment resulting from dementia, brain injury or other medically-based behavior condition/disorder;
2. Requires assistance with one or more Activities of Daily Living (ADLs) one of which may be body care, verbal queuing or hands on assistance.
</td></tr>
<tr><td>Risk Factors</td></tr>
<tr><td>
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;
2. Living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder.
3. Is a victim of domestic violence and living in or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter;
4. Currently living in supportive housing, but who has previously met the definition of chronically homeless defined below:
a. An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
b. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
c. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or
d. An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (a)(i), (a)(ii), or (a)(iii), above.
</td></tr>
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5. Successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including a tribal jail; 6. Court ordered to receive substance use or mental health treatment through a district or tribal court; 7. Currently on probation or parole with a serious mental illness or substance use disorder; 8. Was admitted to (and discharged from) the Utah State Hospital due to an alleged criminal offense; 9. Has been involved in a Drug Court or Mental Health Court, including tribal courts; 10. Receives General Assistance from the Utah Department of Workforce Services; or 11. Was civilly committed to (and discharged from) the Utah State Hospital.

Note: HRSN services will be the choice of the beneficiary; beneficiaries may opt out of HRSN services at any time and will not lose existing Medicaid coverage.

Projected Enrollment

The State estimates the following annual enrollment:

Demonstration	Projected Annual Enrollment
Medical Respite	468
HRSS for Recently Incarcerated	269
HRSS for TAM:	1,940

Section III. Demonstration Benefits and Cost Sharing Requirements

HRSS for Recently Incarcerated Members and TAM
There are no changes to the HRSS benefits provided under this amendment. This amendment expands eligibility for such benefits. Cost sharing will not be required for this benefit. Benefits include: 1. **Tenancy Support Service.** The following services must be provided by Medicaid enrolled providers certified by the State per Administrative rule R523-7-4: a. Tenant screening and housing assessment to identity housing preferences (e.g., housing type, location, living alone or with someone else, roommate

identification, type of accommodations needed, etc.) barriers to successful tenancy, identification of housing transition and retention barriers.

b. Development of an individualized housing support plan to address identified barriers and establish goals to address each issue, identification of providers/services required to meet the established goal.
c. Development of a housing support crisis plan to identify prevention and early intervention services when housing is jeopardized.
d. Participation in planning meetings to assist beneficiaries with the development of a housing support and crisis plan to address existing or recurring housing retention barriers.
e. Assistance with the housing application process, including application/documentation completion and submission.
f. Assistance with completing reasonable accommodation requests.
g. Assistance with the housing search process.
h. Identification of resources to cover housing expenses (e.g., rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses,
i. Ensuring the living environment is safe and move-in ready.
j. Connecting beneficiaries to education and training on tenant and landlord rights, and responsibilities.
k. Providing eviction risk reduction services (e.g., conflict resolution skills, coaching, role playing and communication strategies targeted towards resolving disputes with landlords and neighbors).
    i. Communicating with landlords and neighbors to reduce the risk of eviction.
    ii. Addressing biopsychosocial behaviors that put housing at risk.
    iii. Providing ongoing support with activities related to household management.
    iv. Assistance with the housing voucher/subsidy application and recertification processes.

Beneficiaries with Serious Mental Illness (SMI) have access to Targeted Case Management (TCM) services under Utah's Medicaid state plan. Targeted Adults with a serious mental illness who receive benefits on a fee for service basis and are not enrolled in a Prepaid Mental Health Plan (PMHP) will have access to Tenancy Support Services if they cannot otherwise access Targeted Case Management services. To ensure there is no duplication of services, the state will review and authorize requests for tenancy support services

through the demonstration only after verifying that Targeted Case Management services are not being provided.

2. **Community Transition Services.** Services provided to assist eligible beneficiaries to secure, establish, and maintain a safe and healthy living environment. This service is available to individuals moving from an institution, a congregate living arrangement, beneficiaries moving from a more restrictive to a less restrictive community setting, or beneficiaries who are homeless, or those who are unsafely housed or lack secure housing. Services include:
    a. One-time purchase of essential household items and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; moving expenses; necessary home accessibility adaptations; and activities to assess, arrange and procure necessary resources. Services needed to establish basic living arrangements in a community setting, including kitchen, bathroom and cleaning equipment/goods.
    b. Payment of a security deposit when a member moves into a new residence and it is required for a beneficiary to obtain a lease. To address the complex social determinants of health needs of individuals enrolled in the Targeted Adult Population, the state will impose a maximum of no more than two security deposit payments per beneficiary during the five-year demonstration approval period to help individuals who have transitioned into a community-based living arrangement and subsequently lose the community residence.
    c. One-time non-refundable fees to submit rental applications, establish utility and other services, such as pest eradication, that are essential to the operation of the residence.

Services will be furnished when determined reasonable and necessary, when identified in a member's housing support plan, and when the beneficiary is unable to secure funding/items from other sources. Entities coordinating the purchase of equipment or supplies or paying deposits or other set-up fees for Medicaid members must be enrolled Medicaid providers that are: Housing authorities, public or private not-for-profit service organizations, faith-based organizations, state or local departments and agencies, units of local governments or homeless services providers (who provide housing/homeless services to individuals and/or families who are experiencing homelessness or are at risk of becoming homeless).

3. **Supportive Living Services.** Services designed to link beneficiaries to decent, safe, affordable community-based housing and assist beneficiaries remain in the housing unit. Entities providing Supported Living services for Medicaid members must be Medicaid enrolled providers.
   Coordinated services may include the following, excluding room and board costs:

    1. Routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services.
    2. Mental health screening and assessments, counseling, psychiatric services, clubhouses, peer services and assertive community treatments.
    3. Substance abuse services relapse prevention, counseling, intensive outpatient services, medication assisted treatment, detoxification, residential services and formal/informal (Alcoholic Anonymous/Narcotics Anonymous) recovery support services.
    4. Independent living services, including financial management, entitlement assistance, cooking and meal preparation training and mediation training.
    5. General supportive services such as case management, community support, peer support, crisis intervention and non-medical transportation.

Section IV. Delivery System and Payment Rates for Services

Medical Respite

Services for Demonstration individuals will be provided initially through fee for service (FFS). At a future date, the state may transition delivery of these services through managed care under 1915(b) authority or by amendment to the Demonstration.

The State will contract with no more than two entities selected through the State's procurement process that:

- Have demonstrated experience working with individuals who are homeless; and
- Are capable of providing medical respite in a residential facility.

HRSS for Recently Incarcerated Individuals and TAM

HRSS for Recently Incarcerated and TAM Individuals and will be provided through fee for service (FFS).

Section V. Implementation and Enrollment in Demonstration

Eligible individuals will be enrolled in the demonstrations in accordance with an implementation plan that will be submitted after approval.

Section VI. Demonstration Financing and Budget Neutrality

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

Below are the projected enrollments and expenditures for the remaining demonstration years. These include the projected cost of the existing HRSS demonstration.

Enrollment	DY22 (SFY 24)	DY23 (SFY 25)	DY24 (SFY 26)	DY25(SFY 27)
Medical Respite	0	468	479	490
HRSS for Recently Incarcerated	0	269	275	284
HRSS for TAM	0	1,940	1,985	2,031

Expenditures	DY22 (SFY 24)	DY23 (SFY 25)	DY24 (SFY 26)	DY25(SFY 27)
Medical Respite	$0	$2,301,000	$2,482,000	$2,676,000

HRSS for Recently Incarcerated	$0	$2,352,200	$2,407,500	$2,462,800
HRSS for TAM	$0	$9,583,500	$9,808,800	$10,034,000

Section VII. Proposed Waiver and Expenditure Authority

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

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(10)(B)- Comparability of amount, duration and scope of service	To enable the State to provide additional benefits to Medicaid Expansion beneficiaries compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide medical respite services.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Medicaid Expansion beneficiaries compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.

Expenditure Authority

- **Medical Respite** The State requests expenditure authority to provide medical respite care to homeless individuals enrolled in the Targeted Adult Medicaid program.

- **HRSS for Recently Incarcerated Individuals and TAM** The State requests expenditure authority to provide housing services and supports that would not otherwise be matchable under Section 1903.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing will be advertised in the newspapers of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public will be posted to the State's Medicaid website at https://medicaid.utah.gov/1115-waiver.

Two public hearings to take public comment will be held. The first public hearing will be held on May 16, 2024 from 4:00 pm to 6:00 pm, during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing will be on June 3, 2024 from 4:00 pm to 5:00 pm. Both public hearings will be held via video and teleconferencing.

Public Comment

The public comment period will be held May 16, 2024 through June 15, 2024. .

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal Consultation and Urban Indian Organization Conferment Process Policy , the State ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH has notified the DHHS Tribal Health Liaison of the waiver amendment. As a result of this notification, DIH will begin to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on June 14, 2024 to present this demonstration amendment.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership

at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: medicaiddirector@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

Budget Neutrality

Waiver Year	DY 21	DY 22	DY 23	DY 24	DY 25
With Waiver	$0	$0	$14,236,747	$14,698,288	$15,172,830
Without Waiver	$0	$0	$14,236,747	$14,698,288	$15,172,830

2025 - 2027 Assumptions

1. Population growth 2.4% in 2026 and 2.3% in 2027