DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

August 1, 2024

Jennifer Strohecker
State Medicaid Director
Division of Integrated Healthcare
Department of Health & Human Services
PO Box 143101
Salt Lake City, UT 84101

Dear Director Strohecker:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the amended Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically, STC #17, of the section 1115 demonstration, "Utah Medicaid Reform 1115 Demonstration" (Project Nos: 11-W-00145/8 and 21-W00054/8), effective through June 30, 2027. CMS has determined that the amended Evaluation Design, which was submitted on June 3, 2024, and incorporates the demonstration amendment approved on February 29, 2024, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's amended Evaluation Design.

CMS has added the approved amended Evaluation Design to the demonstration's STCs as Attachment I. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Utah on the Utah Medicaid Reform 1115 Demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

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Date: 2024.08.01 09:13:22 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

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

TITLE: Utah Medicaid Reform 1115 Demonstration

AWARDEE: Utah Department of Health and Human Services

All Medicaid and Children's Health Insurance Program (CHIP) requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning July 2, 2024, through June 30, 2027, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

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

TITLE: Utah Medicaid Reform 1115 Demonstration

AWARDEE: Utah Department of Health and Human Services

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

1. **Current Eligibles.** Expenditures for optional services not covered under Utah's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR Part 438 *et seq*. This expenditure authority terminates no later than December 31, 2023.

2. **Demonstration Population III.** Expenditures for premium subsidies related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the health insurance premium for employer sponsored insurance (ESI) to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the federal poverty level (FPL), but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid, as described in the Special Terms and Condition (STCs). This population is subject to cost-sharing requirements established by the ESI plan.

3. **Demonstration Population V.** Expenditures for premium subsidies related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the FPL, but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs. This population is subject to cost-sharing requirements established by the ESI plan.

4. **Individuals who are Blind or Disabled.** Expenditures for dental benefits for individuals who are blind or disabled and who are eligible for Medicaid, as described in the STCs.

5. **Individuals who are Aged.** Expenditures for dental benefits for individuals who are age 65 and older, and are eligible for Medicaid, as described in the STCs.

6. **Former Foster Care Youth from Another State.** Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.

7. **Targeted Adults.** Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment. Expenditures for state plan coverage for individuals who have been determined eligible as a Targeted Adult for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination (continuous eligibility).

8. **Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

9. **Adult Expansion Population.** Expenditures to provide coverage to adults, age 19 through 64, who are not Current Eligibles, and have household income at or below 133 percent of the FPL, as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents receive state plan Alternative Benefit Package (ABP) coverage as specified in the STCs and Attachment L, while members of the Adult Expansion Population who are custodial parents/caretaker relatives receive the ABP benefit package specified in the STCs and Attachment K to the STCs. No later than January 1, 2024, all beneficiaries in the Adult Expansion Population will receive the same full state plan ABP coverage, as outlined in Attachment L in the STCs.

10. **Mandatory Employer Sponsored Insurance.** Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.

11. **Intensive Stabilization Services Program.** Expenditures to provide an assessment and service package including state plan behavioral services and home and community-based respite and non-medical transportation services reimbursed using a daily bundled rate during the first eight weeks of the 16-week intensive stabilization program for Medicaid eligible children/youth in state custody or at risk of being placed in state custody experiencing significant emotional and/or behavioral challenges.

12. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness.**

Expenditures for services furnished to eligible individuals age 21 through 64 who receive treatment for a serious mental illness (SMI) and who are short-term residents in facilities that meet the definition of an IMD.

13. **Expenditures Related to Fertility Preservation for Beneficiaries Diagnosed with Cancer.** Expenditures for fertility preservation provided to eligible individuals with an active diagnosis of cancer which puts them at risk for sterility or iatrogenic infertility as described in STC 5.12.

14. **Expenditures Related to In Vitro Fertilization and Genetic Testing Services.** Expenditures for in vitro fertilization and genetic testing services for qualifying individuals as described in STC 5.13.

15. **Expenditures for Pre-Release Services**. Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

16. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 14, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

Title XIX Requirements Not Applicable to the Demonstration Eligible Populations

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

1. Amount, Duration, and Scope of Services and Comparability **Section 1902(a)(10)(B)**

a. To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group, with the exception of Former Foster Care Youth from another state to whom state plan services will be provided.
b. To enable the state to vary the amount, duration, and scope of services to individuals in the Targeted Adults, blind, aged, and disabled expenditure populations.
c. To enable the state to provide housing related services and supports (HRSS) to eligible members of the Targeted Adult population.
d. To enable the state to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system.

e. To enable the state, through December 31, 2023, to vary the amount, duration, and scope of services offered to individuals in the Adult Expansion Population demonstration, based on whether the individual is a custodial parent/caretaker or not a custodial parent/caretaker.
f. To enable the state to provide intensive stabilization services (ISS) to Medicaid eligible children/youth under age 21 in state custody or at risk of state custody experiencing significant emotional and behavioral challenges.
g. To enable the state to provide a benefit package consisting only of ESI and COBRA premium subsidies to Populations III and V.
h. To enable the state to provide fertility treatment as described in STC 5.12 for beneficiaries diagnosed with cancer.
i. To enable the state to provide in vitro fertilization and genetic testing services as described in STC 5.13.
j. To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

2. Retroactive Eligibility **Section 1902(a)(34)**

To permit the state not to provide retroactive eligibility for individuals in Demonstration Populations III and V.

3. Statewideness/Uniformity **Section 1902(a)(1)**

a. To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX populations affected by this demonstration.
b. To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

4. Freedom of Choice **Section 1902(a)(23)(A)**

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

5. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) **Section 1902(a)(43)**

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

6. Methods of Administration **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

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

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

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

Title XXI Expenditure Authorities

Under the authority of section 1115(a)(2) of the Act as incorporated into Title XXI by section 2107(e)(2)(A), state expenditures described below, shall, for the period of this demonstration, July 1, 2022 through June 30, 2027, and to the extent of the state's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the state's Title XXI plan. All requirements of Title XXI will be applicable to such expenditures for Demonstration Population VI, described below, except those specified below as not applicable to these expenditure authorities.

1. **COBRA Children (Demonstration Population VI).** Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.

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

Title XXI Requirements Not Applicable to Children's Health Insurance Program (CHIP)

Expenditure Authorities for Demonstration Population VI and Current Eligible CHIP Children

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

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

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

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

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

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

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

To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.

5. Benefit Package Requirements **Section 2103**

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

6. Cost Sharing **Section 2103(e)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

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

TITLE: **Utah Medicaid Reform 1115 Demonstration**

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

1. PREFACE

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

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

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

Attachment A.	Developing the Evaluation Design
Attachment B.	Preparing the Interim and Summative Evaluation Reports
Attachment C.	Implementation Plan *[reserved]*
Attachment D.	SUD Implementation Plan
Attachment E.	SMI/SED Implementation Plan
Attachment F.	Monitoring Protocol *[reserved]*
Attachment G.	SUD Monitoring Protocol
Attachment H.	SMI/SED Monitoring Protocol
Attachment I.	Evaluation Design
Attachment J.	Intensive Stabilization Services Claiming Methodology Protocol
Attachment K.	Non-Traditional Benefit Package
Attachment L.	Traditional Benefit Package
Attachment M.	Modified Adjusted Gross Income (MAGI) Conversion Table
Attachment N.	Claiming Methodologies
Attachment O.	Reentry Demonstration Initiative Implementation Plan *[reserved]*
Attachment P.	Reentry Demonstration Initiative Reinvestment Plan *[reserved]*

2. PROGRAM DESCRIPTION AND OBJECTIVES

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

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

The demonstration offers ESI (Demonstration Population III), or Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) (Demonstration Population V) premium subsidies for state qualified insurance plan. Individuals, their spouses, and their children, ages 19 through 26, who have household incomes above 133 percent of the FPL up to and including 200 percent of the FPL are eligible to enroll in the ESI or COBRA programs. In addition, Children's Health Insurance Program (CHIP) eligible children with household income up to 200 percent of the FPL can elect ESI or COBRA premium subsidies as an alternative to direct coverage, provided the ESI or COBRA coverage meets the minimum benefit requirements. The state provides dental

wrap around benefits through direct CHIP coverage if dental is not offered in the child's ESI or COBRA plan.

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

The demonstration also authorizes dental benefits for beneficiaries who are over age 65, have disabilities, or are blind Medicaid beneficiaries, as well as state plan dental benefits to Targeted Adults who receive substance use disorder (SUD) treatment. In addition, all Medicaid beneficiaries, age 21 through 64, have access to Medicaid services while residing in an institution for mental diseases (IMD) for SUD or serious mental illness (SMI) short-term residential stays. The demonstration also provides full state plan coverage for former foster care youth who were enrolled in Medicaid upon "aging out" of foster care in another state or tribe and are now applying for Medicaid as a resident in Utah. The demonstration also provides intensive stabilization services (ISS) to Medicaid eligible children and youth under age 22 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges.

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

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

- Provide health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage;
- Improve beneficiary health outcomes and quality of life;
- Lower the uninsured rate of low income Utahns;
- Provide continuity of coverage for individuals eligible under the demonstration;
- Increase access to primary care;
- Reduce uncompensated care provided by Utah hospitals;
- Reduce barriers to health care and housing, an important social determinant of health;
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
- Improve access to services across the continuum of care;
- Provide for better care coordination for individuals transitioning to community-based care;

- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
- Reduce the overdose death rate; and
- Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act (ADA) of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), and the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, modified budget neutrality agreement for the demonstration as necessary to comply with such change as well as an allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation

becomes effective, or on the last date such legislation was required to be in effect under the law, whichever is sooner.

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

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

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

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

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

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

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid or CHIP. eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice and fair hearing requirements found in 42 CFR 435.917 and 42 CFR part 431 subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition,

the state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, 42 CFR 435.916. For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR section 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not to extend this demonstration, during the last 6 months of the demonstration, enrollment of the new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation. If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals and administrative costs of disenrolling beneficiaries.

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

3.11. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

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

setting payment rates. For substantial modifications to the ABP in this demonstration, the state must follow the public notice requirement set forth in 42 CFR 440.386.

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

3.13. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure the only involvement of human subjects in research activities authorized and/or required by this demonstration is for projects conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program—including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration, as represented in these approved STCs, meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY

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

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

non-MAGI based methodologies, as appropriate) in the same manner as for populations eligible under the Medicaid state plan.

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

4.3. **Eligibility Groups.** The demonstration is comprised of the following Eligibility Groups.

a. Current Eligibles are the following individuals, whose eligibility is derived from the state plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the state plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum. Expenditures on current eligibles are considered demonstration expenditures for purposes of calculation of demonstration budget neutrality. There is no enrollment limit for this group. This demonstration eligibility group will be terminated no later than December 31, 2023 and this state plan population will receive benefits via the state plan after that date.

b. Demonstration Population III is comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.

c. Demonstration Population V consists of adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee’s health coverage).

d. Current Eligible CHIP Children is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.

e. Demonstration Population VI is comprised of children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:

    i. COBRA-Eligible Children: A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.

    ii. COBRA Continuation Children: A child that meets the definition of a targeted low-income child except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium subsidies.

f. The Targeted Adults are comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:

    i. Be chronically homeless, defined as:

        1. An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;

        2. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;

        3. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or

        4. An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (i)(1), (i)(2), or (i)(3), above.

ii. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:

1. An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);
2. An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;
3. An individual on probation or parole with serious mental illness and/or serious substance use disorder;
4. An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
5. Individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.

iii. Needing substance use or mental health treatment, defined as:

1. An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or
2. An individual recently discharged from the Utah State Hospital who was civilly committed, to be further specified in the Utah Administrative Code.

g. Former Foster Care Youth from Another State are defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.

Beginning January 1, 2023, the Former Foster Care Youth from Another State population will include individuals who otherwise meet the definition and turned age 18 on December 31, 2022, or earlier. Individuals who turn age 18 on January 1, 2023, or later, and who qualify as a Former Foster Care Youth, will be eligible under the state plan.

h. Adult Expansion Population is comprised of adults, ages 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible

for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state.

i. Intensive Stabilization Services Population is comprised of children/youth under age 21, whose eligibility is derived from the state plan, and are experiencing significant emotional and/or behavioral challenges while in state custody or are at risk of being placed in state custody.

5. BENEFITS

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

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

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

Organ Transplants	The following transplants are covered: kidney, liver, cornea, bone marrow, stem cell, heart and lung (includes organ donor)
Long Term Care	Not covered
Transportation Services	Ambulance (ground and air) for medical emergencies only (non-emergency transportation, including bus passes, is not covered)
Dental	Dental services are not covered, with exceptions.

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

5.2. **Benefit Definition for Premium Subsidies.**

a. For Adults and Adult Children in Demonstration Populations III and V – Premium Subsidy. The sole benefit provided to persons eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.

b. For Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI) – Premium Subsidy. The primary benefit provided to children eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the child's share of the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.

    i. Dental benefits for children will be offered through two paths. If the health benefit package that is available to a child through qualified premium subsidies coverage includes dental benefits, the child's premium subsidies will be approximately equivalent to the per-child-per-month cost under the Title XXI state plan including dental costs. However, if a child does not receive dental benefits through the qualified premium subsidy plan, the state's minimum dental coverage for children is set by legislation, and is benchmarked to the coverage of the largest private carrier. In this case, the coverage is the same as direct coverage.

c. Minimum Coverage. Utah will ensure that all participating premium subsidy insurance plans cover well- baby/well-child care services, age-appropriate immunizations, and emergency care. The state will also ensure children receive physician visits, hospital inpatient, and pharmacy benefits, at a minimum. To be a "qualified plan" the plans must meet the criteria established in Utah Administrative Code R414-320-2 (12).

d. Additional Benefits. Benefits furnished by qualified premium subsidy insurance plans are not benefits under this demonstration; the only benefit under this demonstration is premium subsidies. Qualified plans are not restricted from offering additional benefits, at the option of the plan, which may vary by the plan to which the individual or family has access.

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

5.4. **Premium Subsidy Determination.** Demonstration Population III, V, and VI beneficiaries, as well as Current Eligible CHIP children, will receive premium subsidies, under the following conditions:

a. In accordance with the enrollment and implementation procedures as defined in Section 6, the state will provide an eligible and enrolled individual or family with a premium subsidy.

b. For children, the premium subsidy amount for participating plans must not exceed the maximum amount of the participant's share of the premium:

i. For ESI plans –

1. Children = $180 per enrollee per month with state wrap around dental benefits,

2. Children = $200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage,

ii. For COBRA plans –

1. Children = $180 per enrollee per month with state wrap around dental benefits,

2. Children = $200 per enrollee per month if the plan provides dental benefits comparable to those offered through direct state coverage.

c. Adjustments for Health Care Inflation. For adults and children enrolled in the premium subsidy programs, the state may increase the maximum amount per month through the state's rulemaking process as long as it does not exceed the without waiver ceiling amount established in the budget neutrality calculation of estimated service expenditures and the subsidy amount found in Utah Administrative Code R414-320-16.

d. For demonstration populations III and V, the maximum premium subsidy will be determined by the amounts found in Utah Administrative Code R414-320-16. Any future changes to decrease the maximum premium subsidy amount must be approved by CMS through an amendment to the demonstration in accordance with the process outlined in STC 3.7.

e. The premium subsidy will be paid directly to the individual/family up to the maximum amount specified in STC 5.4(b) (d).

5.5. **Dental Benefit for Enrollees who are Blind or Disabled.** All individuals who are blind or disabled, 18 and older, who are enrolled in the state plan under Section 1902(a)(10)(C) of the

Act and 42 CFR 435.322, 435.324 and 435.330, will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services.

5.6. **Dental Benefit for Enrollees who are Aged.** All individuals who are age 65 and older, and are eligible for Medicaid, who are eligible to enroll in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.320 and 435.330, will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services.

5.7. **Targeted Adults.** Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits. Beneficiaries that are enrolled in this eligibility category and receiving SUD treatment will receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.

5.8. **Former Foster Care Youth from Another State.** Beneficiaries enrolled in this eligibility category will receive full Medicaid state plan benefits.

5.9. **Adult Expansion Population.** By January 1, 2024, all beneficiaries in the Adult Expansion Population will receive the same benefits, regardless of parental status. Any changes to this coverage must be approved through a future amendment to the demonstration or as a technical change to the demonstration when the change would conform Attachments L or N to the state plan. The benefits the beneficiaries receive after this date are described in Attachment L, which are aligned with the state plan. CMS will update Attachment L at a future date, and any subsequent time, to reflect the changes made to the state plan. Before January 1, 2024, beneficiaries in this category will receive benefits as follows:

a. Custodial Parents/Caretaker Relatives enrolled in this eligibility category will receive the same benefits as Current Eligibles, the non-traditional benefits, which are outlined in Table 1 and Attachment K. These beneficiaries will receive benefits as described in Attachment K. Utah has fully aligned the non-traditional benefit package with the Medicaid state plan except for those benefits limitations listed under table 1. The state has ensured all requirements of section 1937 of the Act are met including the inclusion of coverage for the ten categories of essential health benefits (EHBs). The non-traditional benefit package does not differ in amount, duration or scope from Medicaid state plan benefits, except to the extent that it includes coverage required under section 1937 of the Act that is not included under the state plant and the benefit limitations listed under Table 1. Any changes to this coverage must be approved through a future amendment to the demonstration.

b. Childless Adults/Non-custodial Parents enrolled in this eligibility category will receive full Medicaid state plan benefits, the traditional benefits, as outlined in Attachment L. These beneficiaries will receive benefits as described in Attachment L. Utah has fully aligned its traditional benefit package with the Utah Medicaid state plan while ensuring all requirements of section 1937 of the Act are met, including the inclusion of coverage for the ten categories of EHBs. The traditional benefit package does not differ in amount, duration or scope from Medicaid State plan benefits, except to the extent that it includes coverage required under section 1937 of the Act

that is not included under the state plan. Any changes to this coverage must be approved through a future amendment to the demonstration.

c. With respect to the coverage described in STC 5.9 (a) and (b), the non-traditional benefits and traditional benefits provided to specified categories of beneficiaries within the Adult Expansion Population, Utah assures that these benefit packages comport with the requirements of section 1937 of the Act, except as limitations discussed in this STC, and specifically makes the following assurances:

    i. Utah assures that all services in the EHB benchmark plan used to define the benefit package have been accounted for throughout the Alternative Benefits Plan (ABP) 5 charts found in Attachments I and J and Utah assures the accuracy of all information in ABP 5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid State Plan.

    ii. Utah assures Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services will be provided to individuals under 21 years of age who are covered under the traditional and non-traditional benefit packages.

    iii. Utah assures that it does not apply any financial requirement or treatment limitation to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

    iv. Utah assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (42 CFR 440.347(d) and 45 CFR 156.115(a)(5)(iii). Further, Utah assures that it will not impose combined limits on habilitative and rehabilitative services and devices.

    v. Utah assures that substituted benefits are actuarially equivalent to the benefits they replaced from the EHB benchmark plan used to define EHB benefits, and that the state has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

    vi. Utah assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act. Utah assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

    vii. Utah assures that it will comply with the requirement of section 1937(b)(5) of the Act by ensuring that the benefit package includes at least the EHBs as described in section 1302(b) of the Patient Protection and Affordable Care Act.

viii. Utah assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

ix. Utah assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to beneficiaries include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

x. Utah assures necessary medical transportation (emergency and non-emergency) for the Adult Expansion Population beneficiaries who receive the traditional benefits in accordance with 42 CFR 431.53 and necessary emergency transportation for the Adult Expansion Population beneficiaries who receive the non-traditional benefits, except that Utah assures necessary medical transportation (emergency and non-emergency) for Adult Expansion Population beneficiaries who are eligible for EPSDT services.

xi. Utah assures, in accordance with 42 CFR 440.347(a) and 45 CFR 156.115(a)(4), that it will provide benefits that include preventive services identified at 45 CFR 147.130.

xii. Utah assures that, for each benefit provided under the benefit packages that is not provided through managed care, it will use the payment methodology in its approved state plan for the benefit.

xiii. Utah assures that prescription drug coverage is the same as under the approved Medicaid State Plan for prescribed drugs.

xiv. Utah assures that when it pays for outpatient prescription drugs covered under the benefit packages, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345.

xv. Utah assures that when conducting prior authorization of prescription drugs for Adult Expansion Population beneficiaries receiving the traditional and non-traditional benefit packages, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

xvi. The state assures it will comply with section 1115 Public Notice and Tribal Consultation requirements in STC 3.12 before amending benefits, include in public notice, the method for assuring compliance with 42 CFR 440.345 related to full access to EPSDT services and a description of the method for complying with the provisions of the amendments made by section 5006(e) of the American Recovery and Reinvestment Act of 2009.

d. Mandatory ESI Enrollees. Beneficiaries in this eligibility group that are eligible to enroll in a qualified ESI plan (as described in STC 4.3(h)), are required to enroll in

that plan and will be reimbursed for the full amount of the beneficiary's share of the monthly premium cost of the qualified ESI plan. In order to ensure the beneficiary receives Medicaid benefits, wrap-around benefits will be provided through a fee-for-service (FFS) delivery system.

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

a. Psychoeducational services (mental health rehabilitation);

b. Personal services;

c. Respite care; and

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

5.11. **Intensive Stabilization Services Program.** Beneficiaries enrolled in this eligibility category will receive state plan and home and community-based crisis stabilization services during the first eight -weeks of the intensive program on a FFS basis using a daily bundled rate. The benefits included in the daily bundled rate are detailed in Table 2.

Table 2. Benefits for Intensive Stabilization Services Program

Bundled Crisis Stabilization Service	State Plan or Non-State Plan Services
Psychiatric Diagnostic Evaluation	State Plan Service
Mental Health Assessment by a Non-Mental Health Therapist	State Plan Service
Psychotherapy with Patient and/or Family Member	State Plan Service
Family Psychotherapy with Patient Present and Family Member Psychotherapy without Patient Present	State Plan Service
Group Psychotherapy and Multiple Family Group Psychotherapy	State Plan Service
Psychotherapy for Crisis	State Plan Service
Psychotherapy with Evaluation and Management (E/M) Services	State Plan Service
Therapeutic Behavioral Services	State Plan Service
Psychosocial Rehabilitative Services	State Plan Service
Peer Support Services	State Plan Service
Case/Care Management	State Plan Service
Non-emergency medical transportation	State Plan Service
Non-medical transportation	Currently Not Covered in State Plan
Respite	Currently Not Covered in State Plan

5.12. **Fertility Preservation for Individuals Diagnosed with Cancer.** Fertility preservation services are available for beneficiaries undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile. Cost

sharing requirements for this benefit will not differ from those under the state plan. Reimbursement for cryopreservation storage is covered as a single payment for five years. Additional 5-year storage increments may only be requested for members that retain eligibility.

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

    i. A beneficiary must have been diagnosed by a physician or other qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility;

    ii. The beneficiary is post-pubertal and younger than 40 years of age;

    iii. The beneficiary's state of health is sufficient to undergo fertility preservation procedures; and

    iv. The member has received fertility counseling as well as psychotherapy, when medically indicated.

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

    i. Collection and storage of eggs and sperm consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine or the American Society of Clinical Oncology.

    ii. Preimplantation genetic testing prior to cryopreservation storage, with coverage as described in Utah's coverage and reimbursement materials and policy manuals.

    iii. Cryopreservation storage, which is covered as a single payment for a five-year period. If the individual remains eligible for Medicaid or demonstration coverage, the state will continue to provide cryopreservation storage in five-year increments.

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

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

    i. Services provided under this benefit require prior authorization.

ii. Investigational or experimental procedures will not be covered.

iii. Post-cryopreservation procedures are not covered under this benefit.

iv. Cryopreservation of eggs or sperm for fertility preservation purposes other than iatrogenic infertility are not covered.

d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 15 (General Reporting Requirements) and 18 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

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

a. **Eligibility.**

i. To be eligible for genetic testing services, an individual must have a familial medical history or be in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.

ii. To be eligible for IVF services, a beneficiary must meet the below requirements.

1. Be between the ages of 18 and 35; and,

2. Has been diagnosed by a physician or other qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition.

3. Has been diagnosed by a physician or other qualified health professional as having a genetic trait associated with myotonic dystrophy.

b. **Scope of Benefit.** For eligible beneficiaries, this benefit includes the following services.

i. Genetic testing services for individuals that satisfy the requirements in STC

5.13(a);

ii. Preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus; and

iii. In vitro fertilization services for individuals that satisfy the requirements in STC 5.13(a).

c. **Limitations.** Access to this benefit is subject to the following limitations.

i. Qualifying beneficiaries may receive up to three cycles of IVF per lifetime.

ii. The eligible individual has had a prior authorization for this service approved by DIH.

d. **Monitoring, Reporting, and Evaluation.** The monitoring, reporting, and evaluation of this benefit will be subject to the same requirements as the overall demonstration, as described in Sections 15 (General Reporting Requirements) and 18 (Evaluation of the Demonstration) of these STCs. The state will follow CMS guidance to ensure the Evaluation Design is amended to provide a rigorous evaluation of this component of the demonstration.

6. ENROLLMENT AND IMPLEMENTATION

6.1. General Requirements

a. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.

b. Any individual who is denied eligibility in any health coverage program authorized under this demonstration must receive a notice from the state that gives the reason for denial, and includes information about the individual's right to appeal.

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

a. Adults with incomes above 133 percent, up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population III will be given the option to receive premium subsidies for ESI.

b. Families with dependent children that are eligible for CHIP may elect to have their children receive premium subsidies for ESI, instead of receiving CHIP coverage. However, children may opt back into direct coverage at any time.

c. The state must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is employed, that the employer offers health insurance as a benefit, that the benefit qualifies for the premium subsidy, and that the employee elects to participate and maintains participation in the ESI plan for all individuals receiving subsidies from the state;

ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between CHIP coverage and ESI coverage, so that they can make an informed choice (if the individual is eligible for CHIP);

iii. Ensure the consent of the responsible adult family member to receiving ESI premium subsidies instead of coverage through CHIP (if the individual is eligible for CHIP);

iv. Allow children to opt out of ESI and begin receiving CHIP coverage at any time, with an immediate effective date upon request;

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in ESI coverage and the individual's/family's share of the premium;

vi. Require clients to notify the Utah Department of Health and Human Services within ten days if they change their ESI plan, there is a change in the amount of their premium, or their ESI coverage is terminated;

vii. Ensure that the total amount of subsidies provided to an individual or family does not exceed the amount of the employee's financial obligation toward their ESI coverage;

viii. Provide for recovery of payments made for months in which the individual or family did not receive ESI coverage. The federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a redetermination of eligibility at least once every 12 months.

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

a. Adults with incomes above 133 percent up to and including 200 percent of the FPL who meet all other requirements for Demonstration Population V will be given the option to receive premium subsidies for COBRA.

b. Families with dependent children that are eligible for CHIP, and whose children have lost COBRA-eligible ESI coverage, may elect to have their children receive premium subsidies for COBRA coverage, instead of receiving CHIP coverage.

c. The state may offer premium subsidies for COBRA coverage to all adults and children who are receiving COBRA coverage. COBRA premium subsidies may be offered to adults and children who would be eligible for CHIP, if uninsured. The state must establish and maintain procedures (which may be done through rulemaking) that will:

i. Ensure that at least one adult family member is eligible for COBRA continuation coverage, that the COBRA benefit qualifies for the COBRA premium subsidy, and that the eligible individual elects to participate and maintains participation in the COBRA plan for all individuals receiving COBRA subsidies from the state;

ii. Provide written information prior to enrollment explaining the differences in benefits and cost sharing between CHIP coverage and COBRA coverage, so that they can make an informed choice (if the individual is eligible for CHIP);

iii. Ensure the consent of the responsible adult family member to receiving COBRA premium subsidies instead of coverage through CHIP (if the individual is eligible for CHIP);

iv. Allow children to opt out of the Utah COBRA Premium Subsidy Program and begin receiving CHIP coverage at any time; with an immediate effective date upon request.

v. Obtain regular documentation, and verify at least quarterly, that the individual or family continues to be enrolled in COBRA coverage and the individual's/family's share of the premium. Verification may include the use of the Coverage Election Notice, forms developed by the state, and use of inter-agency administrative databases such as eFILE;

vi. Require clients to notify the Utah Department of Health within 10 days if there is a change in the amount of their premium or their COBRA coverage is terminated;

vii. Ensure that the total amount of the Utah COBRA Premium Subsidy Program subsidy(ies) provided to an individual or family does not exceed the amount of the former employee's financial obligation toward their COBRA coverage

viii. Provide for recovery of payments made for months in which the individual or family did not receive COBRA coverage. The federal share must be returned within the timeframes established in statute and regulations; and

ix. Provide for a review of benefits on a timeframe consistent with anticipated changes in COBRA coverage or premiums and a redetermination of eligibility at least once every 12 months.

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

a. There is no sanction period before a child, who has been involuntarily disenrolled from a premium subsidy program, could be enrolled in CHIP.

b. Children involuntarily disenrolled from premium subsidies will be seamlessly enrolled in the CHIP program. Utah CHIP will ensure that there is no break in coverage.

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

a. Individuals may at any time apply for Medicaid and, if determined eligible, be enrolled in direct coverage.

b. At least every 12 months, the state must remind each individual by mail, an eligibility redetermination, or other comparable means, that he or she is entitled to apply for Medicaid and provide directions on how to initiate an application. In particular, the reminder must point out that the participant is likely to qualify for Medicaid if pregnant.

6.6. **Enrollment in Dental Benefits.** There is no separate enrollment process required for individuals who are aged, blind or, disabled and otherwise enrolled in the state plan, or Targeted Adults who are receiving SUD treatment, to receive dental services through this demonstration.

6.7. **Targeted Adults Enrollment.**

a. Individuals applying for Medicaid will be screened for eligibility in other Medicaid programs before being enrolled in the Targeted Adults eligibility group.

b. This state has 12 -month continuous eligibility and the state will provide for a redetermination of eligibility at least once every 12 months. Within a beneficiary's 12-month eligibility period, the state's eligibility system automatically identifies Targeted Adults with household incomes above 133 percent of the FPL. The beneficiary will remain a Targeted Adult for the remaining 12-month eligibility period, but expenditures made during the time the beneficiary is over income will have the claims submitted to receive the state's regular FMAP, instead of newly eligible enhanced FMAP. The state will report on the percentage for which they submit regular claims under this group on the quarterly and annual monitoring reports.

c. The Targeted Adults group or any subset of this group may be closed to new enrollment at the state's election. If this eligibility group is closed to new enrollment, the state will stop taking applications. Applications will not be held over for a new enrollment period. However, closing enrollment does not preclude individuals from being enrolled in the Adult Expansion Population, which is always open for enrollment.

d. The state will provide continuous benefits for a period of 12 months to the Targeted Adults. Changes during this period will not affect a beneficiary's benefits with the exception of the following reasons:

   i. Moving out of state;

   ii. Death;

   iii. Determined eligible for another Medicaid eligibility category;

   iv. Fraud; or

   v. Client request.

e. All eligibility criteria, including income, will be considered at the time of the individual's annual eligibility redetermination to determine if the individual continues to meet eligibility for Medicaid.

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

a. **Beneficiary Enrollment Requirements.** The state may mandatorily enroll members of the Adult Expansion Population into UMIC managed care organizations (MCO) for delivery of their physical and behavioral health services in the five urban counties in the state (Davis, Salt Lake, Utah, Washington, and Weber), except as provided in paragraph (e) of this STC. Further, the state may mandatorily enroll members of the Adult Expansion Population in an ACO and a PMHP, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC.

b. **Auto-Assignment.** If a beneficiary does not choose a managed care plan (UMIC MCO or ACO/PHMP) within the time frames defined in (b)(iii), he or she may be auto-assigned to a managed care plan. When possible, the auto assignment algorithm shall take into consideration the beneficiary's history with a primary care provider, and when applicable, the beneficiary's history with a managed care plan. If this is not possible, the state will equitably distribute beneficiaries among managed care plan as specified in this STC.

   i. Beneficiaries who are newly enrolling in the Adult Expansion Population and residing in a mandatory managed care county (either a UMIC MCO or ACO/PMHP model) will receive a pending managed care plan selection that will be placed on the beneficiary's case using a "round robin" method, consistent with the auto-assignment standards described in the previous paragraph, so that each managed care plan receives approximately the same number of new cases.

   ii. Returning Medicaid beneficiaries will have their previous managed care plan reinstated if it has been less than two years since they were enrolled in

managed care. If it has been more than two years or if their previous managed care plan is no longer available for enrollment, their pending assignment will be based on the "round robin" method, after taking into consideration the beneficiary's history with a primary care provider.

iii. All beneficiaries subject to mandatory enrollment into managed care will receive a letter that informs them of the need to select a plan(s) and that if they do not respond within 10 days, the state will assign a plan(s). If a beneficiary (including beneficiaries with special health care needs) contacts the state and indicates that he or she has a current primary or specialty provider, the state will assist the member in selecting a plan(s) that includes that provider in its network. After 10 days, if a member has not responded, the system-assigned (i.e., pending) plan(s) will be the member's plan(s).

c. **Open Enrollment Period.** An open enrollment period will be held for beneficiaries from mid-May to mid-June each year, during which such beneficiaries may select a different available managed care plan for enrollment.

d. **Enrollment Exemptions.** The following populations are exempt from mandatorily enrolling in UMIC MCO or ACO and PMHP:

i. Utah Medicaid beneficiaries residing in the Utah State Hospital or the Utah State Developmental Center;

ii. Beneficiaries with presumptive eligibility;

iii. Individuals enrolled in the Healthy Outcomes Medical Excellence (HOME) program;

iv. Medicaid members enrolled in Utah's Buyout Program; and

v. Adult Expansion Population beneficiaries mandatorily enrolled in ESI.

e. **Enrollment Exemption Process.** The state will allow a beneficiary not to enroll in or to disenroll from a managed care plan and to enroll in a FFS delivery system, or to switch from a managed care plan to another available managed care plan, in the event that enrollment in the current managed care plan or in any available managed care plan, as applicable, would not meet the beneficiary's health care needs and there is a reasonable expectation that the beneficiary's health would suffer if he or she were not permitted to switch to a different available managed care plan or enroll in FFS delivery. Exemption requests must be submitted for approval to the state Medicaid agency.

f. **Disenrollment.** The state allows enrollees to make a request to disenroll from/transfer between managed care plan plans or enroll in FFS as described in STC 6.8(e). The determination must be made no later than the first day of the second month following the month in which the enrollee or a plan files the request with the state. If determination is not made within this time frame, the request is deemed approved.

6.9. **Mandatory ESI Enrollment.** For beneficiaries in the Adult Expansion Population who are required to enroll in a qualified ESI plan as specified in STC 4.3(h), access to and enrollment in a qualified ESI plan and the beneficiary's premium amount will be verified at initial application, every three months, and at annual recertification.

6.10. **Intensive Stabilization Services Enrollment.** The intensive stabilization services teams (clinician and ISS staff will screen and request authorization/approval for ISS for Medicaid eligible children/youth who are experiencing significant emotional and/or behavioral challenges based on medical necessity, acuity, and need.

7. COST SHARING

7.1. **Cost Sharing.** Cost sharing must comply with Medicaid requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR §447.56(a), and be reflected in the state plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447.52(b) applies to the demonstration.

7.2. **Demonstration Populations III and Current Eligible CHIP Children in ESI and Demonstration Populations V and VI in COBRA.** Adults and children of families that choose premium subsidies will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified plan. Children who choose to receive coverage through premium subsidies will be charged cost sharing amounts set by their ESI or COBRA coverage and will not be limited to the Title XXI five percent out-of-pocket family income maximum. All other cost sharing, including co-payments, and co-insurance, are set by the qualified plan and the responsibility of the participant.

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

7.4. **Enrollment Fee.** The state must not impose an enrollment fee on any demonstration populations.

8. DELIVERY SYSTEMS

8.1. **Comprehensive Service Delivery System.** Utah's MCOs, ACOs, and PMHPs must provide a comprehensive service delivery system that provides the full array of benefits and services offered under the program for which the relevant organization or plan has contracted to provide coverage. This includes the integration of a participant's physical health and behavioral health needs as further articulated by the delivery system requirements set forth below.

8.2. **Compliance with Managed Care Regulations.** The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority.

8.3. **Description of Managed Care Program.** Under terms of this demonstration, the state is authorized to provide managed medical assistance benefits through managed care delivery systems, consistent with regulations in 42 CFR part 438. The state may mandatorily enroll Current Eligibles, Targeted Adults, Adult Expansion Population to receive the health care benefits pursuant to Section 6 of the STCs.

8.4. **Managed Care Contracts.** In accordance with managed care regulations published at 42 CFR part 438, CMS requires that the state must submit MCO contracts to CMS for review and approval to ensure compliance with beneficiary informational requirements, quality outcome provisions, and other applicable federal requirements. The state must provide CMS with a minimum of 90 days to review and approve contracts and/or any changes to contracts. The state must submit any supporting documentation deemed necessary by CMS. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the requirements of this STC are met or any identified deficiency in a contract is corrected.

8.5. **ESI and COBRA Delivery Systems.** Demonstration Populations III through VI will receive services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium subsidies.

8.6. **Dental Services.**

a. The state will deliver services through a fee-for-service (FFS) payment model and contract with entities to provide dental services to the blind and disabled population.

i. The state will enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described in STC 5.5 & 5.6 above through an intergovernmental transfer (IGT) consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

ii. The contracted entities must guarantee access statewide.

b. The state will deliver services through an FFS payment model and contract with entities to provide dental services to the Targeted Adults who are receiving SUD treatment. The state must ensure that contracted entities:

i. Have demonstrated experience working with beneficiaries who are being treated for both a SUD and a major oral health disease;

ii. Operate a program, targeted at the individuals described in STC 8.6(b) above, that has demonstrated effectiveness in providing dental services to such individuals who are receiving SUD treatment, as reflected in a peer-reviewed evaluation or study; and

iii. Enter into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described above through an IGT consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity; and

iv. Can guarantee access to care statewide.

c. The state will deliver dental services to the aged population through an FFS payment model and by contracting with an entity that:

i. Operates a program for aged individuals that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals;

ii. Enters into agreements with the single state agency to transfer an amount equal to the program's non-federal share of the cost of providing dental services to the population described in STC 5.6 above through an IGT consistent with section 1903(w)(6)(A) of the Act. Only units of government are eligible to contribute the nonfederal share through an IGT and the IGT funds will be derived from state or local tax revenue. No payment under this demonstration may be dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity; and

iii. Can guarantee access to care statewide.

8.7. **Intensive Stabilization Services Delivery System.** Intensive Stabilization Services will be delivered during the first eight weeks of the intensive program on a FFS basis using a daily bundled rate. Please refer to Attachment J: Intensive Stabilization Services Program Claiming Methodology Protocol.

9. FEDERAL MEDICAL ASSISTANCE PERCENTAGE

9.1. The state will receive the enhanced Federal Medical Assistance Percentage (FMAP) for the Adult Expansion Population, as well as the Targeted Adults, who are newly eligible within the meaning of section 1905(y)(2)(A) of the Act. As part of the standard 1115 demonstration process, Utah may request to amend the demonstration, including coverage for the Adult

Expansion Population, if the enhanced FMAP for the newly eligible beneficiaries in this population changes.

9.2. For beneficiaries who are members of the Adult Expansion Population and Targeted Adults, the state will make an individual income-based determination for purposes of the enhanced FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan approved by CMS on December 20, 2019. In general, and subject to any adjustments described in this STC under the enhanced FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the enhanced FMAP is not available. The relevant MAGI-converted standards for each population group in the Adult Expansion Population and Targeted Adults are described in Attachment M.

9.3. **Claiming Methodology.** For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to the Adult Expansion Population, the determination of which beneficiaries qualify for enhanced FMAP methodology as a newly eligible adult shall be determined pursuant to a claiming methodology deliverable found in Attachment N.

9.4. **Resource Proxy Adjustment.** The state has elected not to apply a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

9.5. **Enrollment Cap Adjustment.** The state has elected to not apply an enrollment cap adjustment.

9.6. **Special Circumstances and Other Adjustments to the Adult Group FMAP Methodology.** The state has elected to not apply a special circumstances adjustment.

9.7. **Expansion State Designation.** The state does not meet the definition of expansion state in 42 CFR 433.204(b) and therefore does not qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

9.8. **Assurances.** The state assures the following:

a. The application of the enhanced FMAP claiming methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

b. The application of the enhanced FMAP claiming methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

10. SUBSTANCE USE DISORDER

10.1. **Opioid Use Disorder/Substance Use Disorder Program.** The demonstration benefit package for Medicaid members includes opioid use disorder (OUD)/SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an

IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Medicaid members residing in IMDs under the terms of this demonstration for coverage of medical assistance and OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD as CMS approved the state's Implementation Plan on November 9, 2017. Under this demonstration, beneficiaries have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

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

Table 3. Utah OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Therapy (Individual; Group; Family; Collateral)	State plan (Individual services covered)	
Intensive Outpatient Program	State plan (Individual services covered)	
Partial Hospitalization Treatment (including Day Treatment for children/youth under the age of 21)	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	Services provided to individuals in IMDs
Crisis Intervention (including Mobile Crisis)	State plan (Individual services covered)	
Residential Crisis Stabilization	State plan (Individual services covered)	Services provided to individuals in IMDs

10.2. **SUD Implementation Plan.** The state's SUD Implementation Plan, initially approved for the period from November 1, 2017 through June 30, 2022, remains in effect for the approval

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

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

a. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

b. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of demonstration approval;

c. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in Utah Administrative Code R501 Residential Treatment Programs. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

d. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval;

e. **MAT Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval;

f. **Sufficient Provider Capacity at Critical Levels of Care including MAT:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

g. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone;

h. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 10.2; and

i. **Improved Care Coordination and Transitions:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

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

a. The SUD Health IT section of the Implementation Plan includes implementation milestones and dates for achieving them (see Attachment D).

b. The SUD Health IT Plan must align with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan describes the state's goals, each DY, to enhance the state's prescription drug monitoring program (PDMP).[1]

d. The SUD Health IT Plan addresses how the state's PDMP enhances ease of use for prescribers and other state and federal stakeholders.[2] This also includes plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan describes ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[2] *Ibid.*

substance—and reviewing the patients' history of controlled substance prescriptions— prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan describes the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery, as applicable. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan describes how the activities described in (a) through (e) above will: (a) support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns[3] and (b) ensure that Medicaid does not inappropriately pay for opioids–and that states implement effective controls to minimize the risk.

g. In developing the Health IT Plan, states shall use the following resources.

    i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

    ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

    iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state includes in its SUD Monitoring Protocol (see STC 16.6) an approach to monitoring its SUD Health IT Plan which includes performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Monitoring Reports (see STC 16.8).

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

j. The state shall advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Wherever it is appropriate, the state must require that contractors providing services paid for by funds authorized under this demonstration shall adopt the standards, referenced in 45 CFR Part 170.

ii. Wherever services paid for by funds authorized by this demonstration are not addressed by 45 CFR Part 170 but are addressed by the ISA, the state should require that contractors providing such services adopt the appropriate ISA standards.

11. INTENSIVE STABILIZATION SERVICES PROGRAM

11.1. **Overview.** This program provides ISS to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. It is intended to support Utah's System of Care, which is a customized service approach to keep families safely together while effectively helping children with emotional and/or behavioral health needs thrive in their homes, schools, and communities.

11.2. **Operations**. The program is administered through the Utah Department of Health and Human Services (DHHS). The state is contracting with Regional Administrators throughout the state to serve 29 counties. The Regional Administrators are responsible to subcontract with ISS teams who will screen the Medicaid children/youth based on medical necessity, acuity, and need to authorize ISS using this daily bundled rate. The ISS providers are all Medicaid enrolled providers.

11.3. **Eligibility.** Medicaid eligible children/youth under age 21, whose eligibility is derived from the state plan, and are experiencing significant emotional and/or behavioral challenges while in state custody or are at risk of being placed in state custody.

a. **Target Group.** The ISS program is available to Medicaid enrolled child/youth under age 21, who meet the following needs-based criteria that would otherwise be allowable under a 1915(i) state plan amendment (SPA).

b. **Needs-Based Criteria.** The Medicaid enrolled child/youth is assessed using the ISS Utah Family and Children Engagement Tool (UFACET) evaluation. The Medicaid enrolled child/youth must have a rating of at least "2" or higher indicating the need for assistance with at least one of the following significant emotional and/or behavioral challenges that impair the child's ability to focus and control impulsive behaviors that affect their ability to control or regulate emotions to the point where it interferes with their daily lives and relationships and negatively affects performance at school, work and/or home: short attention span, impulsiveness, aggression, self-

injurious behaviors, risk of harm to others, fighting withdrawal, excessive fear or anxiety, hostility, irritability uncooperative, oppositional, and non-compliant with rules or authority figures.

And the child/youth must also meet at least one of the following risk factors:

i. A history of receiving services, or at risk of receiving services, from one or more DHS agencies (child welfare, juvenile justice, service for people with disabilities, mental health or substance abuse, and/or the courts). At risk of receiving services may include one or more of the following:

    1. The child has juvenile court charges;
    2. The child has been on probation previously;
    3. The child/family has an open child protection investigation;
    4. The child is in the process of eligibility determination for disability services;
    5. The child has received inpatient psychiatric services and/or has been referred to the Pediatric program at the Utah State Hospital; or
    6. The child has a mental health condition or substance abuse history.

ii. At risk of being placed into the custody of a state agency, which includes one of the following:

    1. The child is on probation or has sufficient juvenile court charges that the judge is considering placement with the Department for community placement or secure care;
    2. The child/family has an open in-home services case with the Division of Child and Family Services based on a finding of dependency, or a child protection investigation, and placement of the child(ren) in protective custody is being recommended;
    3. The child has been in custody previously under similar circumstances;
    4. The child is in the process of eligibility determination for disability services and the family is struggling to provide care for them;
    5. The child has a serious mental health condition or substance use history and the family is struggling to continue care for them;
    6. The child has experienced significant disorders post adoption; or
    7. The child has experienced multiple failed private placements.

iii. At risk of reverting back to a higher level of care due to behavioral or emotional concerns;

iv. Has been involved in the Juvenile Competency process;

v. Has been frequently utilizing hospital emergency services to manage behavioral, developmental, and/or mental health challenges; or

vi. Has been referred to the DHS High Level Staffing Committee.

11.4. **Benefits.** This program provides both state plan behavioral health services and home and community-based services (HCBS) that are not currently authorized through the state plan. The state plan services included in the daily bundled rate are outlined in Table 2 and the service benefits, limitations, and provider qualifications are specified in the state plan. The HCBS provided include:

a. **Service name:** Respite

i. **Service Description:** Services provided to Medicaid children/youth on a short-term basis due to the absence of, or need for relief for the persons who normally provide care for the Medicaid child/youth. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the Demonstration participant's home, a DHHS licensed group home, or another community-based setting approved by DHHS.

ii. **Service Limits:** Room and board costs will not be paid when services are provided in the Demonstration participant's home or place of residence. The service will be approved if it complies with DHHS respite policies.

iii. **Provider Specifications:** Providers must meet qualifications as specified by DHHS and must be a Medicaid enrolled provider.

b. **Service name:** Non-Medical Transportation

i. **Service Description:** This transportation service will be provided to Medicaid children/youth that are determined by the Care Manager to be in need of short-term transportation to and/or from a non-medical activity that is an integral part of the youth's individualized service plan where there are no other feasible transportation options. Coverage of transportation for the primary caregiver is provided when the primary caregiver is accompanying the child. These nonmedical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after-school programs not associated with a youth's Individual Education Plan (IEP), and parent support services that include the child.

ii. **Service Limits:** This service must be a part of a comprehensive individualized service plan developed by a Care Manager and requires prior authorization. The youth must be currently authorized and receiving care management services. Frequency and duration of service must be supported by a needs assessment and included in the participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting.

iii. **Provider Specifications:** Providers and their staff must meet minimum levels of education, experience, and training as delineated by DHHS and the provider and staff must be enrolled as a Utah Medicaid provider.

11.5. **Delivery System.** As of November 25, 2019, ISS will be delivered during the first eight weeks of the intensive program on a FFS basis using a daily bundled rate. Please refer to Attachment H: Intensive Stabilization Services Program Claiming Methodology Protocol.

11.6. **Additional Delivery System Requirements: HCBS Not Authorized through the State Plan.** The following additional delivery system requirements apply to all the HCBS services in this demonstration.

a. **Demonstration Participant Protections.** The state will assure that children and youth are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities. The state will also develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

b. **Fair Hearings.** All enrollees must have access to the state fair hearing process as required by 42 CFR 431 Subpart E.

c. **Conflict of Interest.** The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

d. **Approved Quality Improvement Strategy.** The state is required to work with CMS to develop approvable performance measures within 90 days following approval of the 1115 for the following waiver assurances (i through vi below):

i. **Administrative Authority:** A performance measure should be developed and tracked for any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

ii. **Eligibility based on 1115 Requirements:** A performance measure should be developed that tracks eligibility for the ISS Program that meets the section 1115 requirements.

iii. **Qualified Providers:** The state must have performance measures that track that providers meet licensure/certification standards and that non-certified providers are monitored to meet state requirements.

iv. **Service Plan:** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for the Medicaid children/youth receiving ISS. Performance measures are required to demonstrate service plans address all assessed needs and personal goals, that services are delivered in accordance with the service plan including type,

scope, amount, duration, and frequency specified in the service plan, and for choice of non-state plan HCBS services.

v. **Health and Welfare:** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider.

vi. **Financial Accountability:** The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of HCBS. The state must have performance measures that track that it provides evidence that claims are coded and paid for in accordance for services rendered. The state will audit rates used by each provider to ensure they are consistent with the approved rate methodology.

e. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Outreach (DHCBSO) no later than 21 months prior to the end of the approved demonstration extension period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a DRAFT report to the state and the state will have 90 days to respond. Upon receipt of the state's response, DHCBSO will review the evidentiary report to determine whether the assurances have been met and will issue a FINAL report to the state within 60 days.

f. The state must annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

12. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

12.1. **SMI/SED Program Benefits.** Since CMS's approval of the SMI/SED Implementation Plan, beneficiaries have had access to the full range of otherwise covered Medicaid services, including SMI treatment services. SMI services range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state worked to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings for beneficiaries receiving coverage through this demonstration's SMI Program, to be monitored pursuant to the SMI/SED Monitoring Protocols outlined in STC 15.6 below.

12.2. **SMI/SED Implementation Plan.** The state's SMI/SED Implementation Plan, initially approved for the period from December 16, 2020 through June 30, 2022, remains in effect for the approval period from July 1, 2022 through June 30, 2027, and is affixed to the STCs as Attachment E. Any future modifications to the approved SMI/SED Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

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

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

i. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

ii. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

iii. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

iv. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

v. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);

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

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

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

ii. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who may experience homelessness upon discharge or who would be discharged to unsuitable or unstable housing with community providers that coordinate housing services, where available;

iii. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider they were referred to;

iv. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through

the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);

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

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

i. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;

ii. Commitment to implementation of the SMI/SED Financing Plan described in STC 12.4;

iii. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;

iv. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

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

i. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;

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

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

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

Plan, and was included as a section of the SMI/SED Implementation Plan (see STC 12.2) to develop the infrastructure/capabilities of the state's health IT infrastructure.

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

The state includes in its SMI/SED Monitoring Protocol (see STC 15.6) an approach to monitoring its SMI Health IT Plan which will include performance metrics to be approved in advance by CMS.

The state monitors progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Report (see STC 15.8).

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

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

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

Components of the Health IT Plan include:

a. The Health IT Plan describes, as applicable, the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SED/SMI care delivery. The state also indicated efforts to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    i. The Health IT Plan describes the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

ii. In developing the Health IT Plan, the state should have used the following resources:

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

12.4. **SMI/SED Financing Plan.** As part of the SMI/SED Implementation Plan referred to in STC 12.2, the state submitted a financing plan for approval by CMS. The SMI Financing Plan is incorporated into the STCs as part of the Implementation Plan in Attachment E and, may only be altered with CMS approval. Components of the SMI/SED Financing Plan include:

a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers;

b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings; and

c. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

12.5. **Availability of FFP for the SMI/SED Services Under Expenditure Authority #11.** FFP is only available for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving

covered services in an IMD. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days—or 45 days, as relevant.

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

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

13. HOUSING RELATED SERVICES AND SUPPORTS PROGRAM

13.1. **Overview.** This program provides housing related services and supports (HRSS) in the form of tenancy support, community transition and supportive living services to beneficiaries experiencing homelessness, food, or transportation insecurity, or interpersonal violence and trauma.

13.2. **Eligibility.** HRSS are available to Medicaid beneficiaries, ages 19 – 64, who are members of the Targeted Adult under the demonstration as defined in STC 4.3(f)4.

a. **Target Group.** The HRSS program is available to Medicaid beneficiaries in the Targeted Adult population.

b. **Needs-Based Criteria and Risk Factors.** Beneficiaries in the Targeted Adult population must meet one needs-based criteria and one risk factor, as described in Table 4. Community transition services are not a state plan benefit and will be provided to all beneficiaries in the Targeted Adult population who meet the following criteria/risk factors.

Table 4. Needs Based Criteria and Risk Factors

Needs Based Criteria
● 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; ● Requires assistance with one or more Activities of Daily Living (ADLs) one of which may be body care, verbal queuing or hands on assistance.
Risk Factors
● 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; ● 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; ● 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; ● Currently living in supportive housing, but who has previously met the definition of chronically homeless defined in STC 4.3(f)(i)4; ● Successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including a tribal jail; ● Court ordered to receive substance use or mental health treatment through a district or tribal court; ● Currently on probation or parole with a serious mental illness or substance use disorder; ● Was admitted to (and discharged from) the Utah State Hospital due to an alleged criminal offense; ● Has been involved in a Drug Court or Mental Health Court, including tribal courts; ● Receives General Assistance from the Utah Department of Workforce Services; or ● Was civilly committed to (and discharged from) the Utah State Hospital.

13.3. **Benefits.** The following HRSS the state will provide include:

a. **Tenancy Support Service.** The following services will be provided by Medicaid enrolled providers certified by the state per Administrative rule R523-7-4).

i. 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.

ii. 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.

iii. Development of a housing support crisis plan to identify prevention and early intervention services when housing is jeopardized.

iv. 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.

v. Assistance with the housing application process, including application/documentation completion and submission.

vi. Assistance with completing reasonable accommodation requests.

vii. Assistance with the housing search process

viii. 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,

ix. Ensuring the living environment is safe and move-in ready.

x. Connecting beneficiaries to education and training on tenant and landlord rights, and responsibilities.

xi. Providing eviction risk reduction services (e.g., conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors)

1. Communicating with landlords and neighbors to reduce the risk of eviction.
2. Addressing biopsychosocial behaviors that put housing at risk;
3. Providing ongoing support with activities related to household management

xii. Assistance with the housing voucher/subsidy application and recertification processes.

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

b. **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:

i. 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.

ii. 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.

iii. 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 are 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).

c. **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:

i. Routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services.

ii. Mental health screening and assessments, counseling, psychiatric services, clubhouses, peer services and assertive community treatments.

iii. 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.

iv. Independent living services, including financial management, entitlement assistance, cooking and meal preparation training and mediation training.

v. General supportive services such as case management, community support, peer support, crisis intervention and non-medical transportation.

Targeted Adults are not enrolled with the Prepaid Mental Health Plans (PMHPs) or one of the Utah Medicaid Integrated Care (UMIC) plans for their behavioral health services, and receive these benefits on a fee for service basis. Because these services are not otherwise available through Medicaid state plan or 1915(b)(3), all otherwise eligible Targeted Adults would receive supportive living services under the demonstration.

13.4. **Quality Improvement Strategy.** The state must have an approved Quality Improvement Strategy and is required to develop performance measures to address the following requirements:

a. Service plans: a) address assessed needs of HRSS participants; b) are updated annually; and c) document choice of services and providers.

b. Eligibility Requirements: a) an assessment for HRSS eligibility is provided to all applicants for whom there is reasonable indication that HRSS services may be needed in the future; b) the processes and instruments described in the approved program for determining HRSS eligibility are applied appropriately; and c) the HRSS benefit eligibility of enrolled individuals is reassessed at least annually or if more frequent, as specified in the approved program.

c. Providers meet required qualifications.

d. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

e. The SMA retains authority and responsibility for program operations and oversight.

f. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to HRSS participants by qualified providers.

g. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

h. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.

i. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Outreach (DHCBSO) no later than 21 months prior to the end of the approved demonstration extension period which includes evidence on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a DRAFT report to the state and the state will have 90 days to respond. Upon receipt of the state's response, DHCBSO will review the evidentiary report to determine whether the assurances have been met and will issue a FINAL report to the state within 60 days.

j. The state must annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year. Additional reporting requirements pertaining to the HRSS component is included in Section 15, and the state must integrate information outlined in STC 13.4 through its demonstration monitoring reports, further discussed below.

14. REENTRY DEMONSTRATION INITIATIVE

14.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid individuals who are residing in a state prison, county jail, or youth correctional facility (hereinafter "correctional facility") as further specified in the STCs below.

14.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

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

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

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care; and

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

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

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 14.1; and

b. Have been found eligible for Medicaid.

14.4. **Scope of Pre-Release Services**. The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 14.10. The state may provide these services in-person or, as-needed, through telehealth.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

iv. Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning;

v. Diagnostic services, including laboratory and radiology services, and treatment services in addition to those identified in STC 14.4(a)(ii);

vi. Prescribed drugs, in addition to those identified in STCs 14.4(a)(ii) and 14.4(a)(iii), and medication administration;

vii. Family planning services and supplies;

viii. Services provided by community health workers;

ix. Peer support services;

x. Treatment for Hepatitis C; and

xi. Medical equipment and supplies and/or medical equipment provided upon release.

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

14.5. **Participating Correctional Facilities**. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to the State Medicaid Agency's approval of a facility's readiness, according to the implementation timeline described in STC 14.9. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

14.6. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Utah's scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

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

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

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

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

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

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 14.3

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable.

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments and managed care plans.

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by the State Medicaid Agency to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

14.10. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be

incorporated into the STCs as Attachment O titled "Reentry Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

14.11. **Reentry Demonstration Initiative Reinvestment Plan**. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment P). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment P the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment P) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment P titled "Reentry Demonstration Initiative Reinvestment Plan."

14.12**. Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among the State Medicaid Agency and Qualified Applicants listed in STC 14.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants which are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 14.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 14.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 14.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Utah's Qualified Applicants in STC 14.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid or CHIP application; (3) submitting the Medicaid or CHIP application to the county social services department or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible

individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 16.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1. Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

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

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

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

15. GENERAL REPORTING REQUIREMENTS

15.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 ($5M) per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A

deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) Thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) thirty days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

a. For each deliverable, the state may submit a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

b. If CMS agrees to an interim corrective plan in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

c. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released

d. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

15.2. **Deferral of Federal Financial Participation from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

15.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

15.4. **Compliance with Federal Systems Updates**. As federal systems continue to evolve and incorporate additional 1115 reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

15.5. **Implementation Plan.** The state is required to submit an Implementation Plan to cover certain key policies being tested under this demonstration, including those approved through future demonstration amendments. The state will be expected to provide additional details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan must include definitions and parameters of key policies, and describe the state's strategic approach to implementing the policies, including timelines for meeting milestones associated with these key policies, as applicable.

Depending on the implementation timeline of specific policies approved within the demonstration and timing of any future amendment approval, the due date for such an Implementation Plan will be determined collaboratively between CMS and the state. In general, the due date for the draft Implementation Plan for a specific policy shall be no later than 90 days of the approval of any such policies. The state must submit a revised Implementation Plan within 60 calendar days after receipt of CMS's comments. Once determined complete by CMS, the Implementation Plan will be incorporated into the STCs, as Attachment C.

15.6. **SUD and SMI/SED Monitoring Protocols.** The state must submit a Monitoring Protocol for each of the SUD and SMI/SED programs authorized by this demonstration within 150 calendar days after approval of this demonstration extension. The SUD and SMI/SED Monitoring Protocols must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the SUD and SMI/SED Monitoring Protocols will be incorporated into the STCs, as Attachment D and E, respectively. Progress on the performance measures identified in the SUD and SMI/SED Monitoring Protocols must be reported via the Quarterly and Annual Monitoring Reports. Components of the SUD and SMI/SED Monitoring Protocols include, as appropriate:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas (listed in STCs 10.2 and 12.2), information relevant to the state's SMI Financing Plan described in Attachment E, and information relevant to the state's Health IT Plans described in STCs 10.3 and 12.3;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the General Reporting Requirements described in Section 15 of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

15.7. **Monitoring Protocol for Other Policies.** The state must submit to CMS a Monitoring Protocol, addressing components of the demonstration not covered by the SUD and SMI/SED Monitoring Protocols, no later than 150 calendar days after approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs. Depending on the implementation timeline of specific policies within the demonstration and any future amendment approval, the due date for such Monitoring Protocol will be determined collaboratively between CMS and the state.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those could be among the performance metrics as described in STC 15.8 below), the state will be required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the Quarterly and Annual Monitoring Reports. For the qualitative elements (e.g., operational updates as described in STC 15.8 below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service

expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

15.8. **Monitoring Reports.** The state must submit three (3) Quarterly Monitoring Reports and one (1) Annual Monitoring Report each DY. The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates. The operational updates will focus on progress towards meeting the milestones. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, and how challenges are being addressed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, monitoring reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate how the state is progressing towards meeting the demonstration's milestones and/or goals and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, and if conducted,

grievances and appeals. For example, the state must continue reporting metrics data that will support tracking the state's trajectory in meeting its SUD and SMI program milestones and goals. Furthermore, in addition to monitoring enrollment and access to care, the state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policy composition and objectives, to be reported for all demonstration populations as well as stratified by key demographic subpopulations of interest and demonstration components.

The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 1.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

The state must track beneficiary participation, screening, receipt of referrals and social services over time under the HRSS program component as well as adoption of information technology infrastructure to support data sharing between the state or partner entities administering the demonstration and social services organizations.

The required monitoring and performance metrics must be included in the Monitoring reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SMI Health IT and SUD Health IT. The state will include a summary of progress made in regards to SMI and SUD Health IT requirements outlined in STCs 10.3 and 12.3.

15.9. **SUD and SMI/SED Mid-Point Assessment(s).** The state must conduct an independent Mid-Point Assessment by June 30, 2025. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning, and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of managed care organizations (MCO), SUD and SMI treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the Mid-Point Assessment Report to CMS no later than 60 calendar days after June 30, 2025 and the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD and SMI/SED Implementation Plans, the SMI Financing Plan, and the SUD and SMI/SED Monitoring Protocols for ameliorating these risks. Modifications to the applicable Implementation Plan, Financing Plan, and Monitoring Protocols are subject to CMS approval. Elements of the Mid-Point Assessment include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD and SMI/SED Implementation Plans, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SUD and SMI/SED Monitoring Protocols;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plan or SMI/SED Financing Plan or to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

15.10. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of the demonstration. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

15.11. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.12. **Close-Out Report**. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in 17.7 and 17.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. The final Close-Out Report is due to CMS no later than thirty (30) days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 15.1.

15.13. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

15.14. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Monitoring Report.

16. GENERAL FINANCIAL REQUIREMENTS

16.1. **Allowable Expenditures**. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

16.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures

reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

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

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

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

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

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

16.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 15.2. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

16.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 17:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

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

16.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart (table 5) provides a master list of MEGs defined for this demonstration.

Table 5: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Current Eligibles	Main Budget Neutrality	X		X	See Expenditure Authority #1
Adult Expansion Population	Hypo	X		X	See Expenditure Authority #9
Mandatory ESI for Adult Expansion	Hypo	X		X	See Expenditure Authority #10
Targeted Adults	Hypo	X		X	See Expenditure Authority #7
Dental – Targeted Adults	Hypo	X		X	See Expenditure Authority #7
Dental – Blind & Disabled Adults	Hypo	X		X	See Expenditure Authority #4
Dental - Aged	Hypo	X		X	See Expenditure Authority #5
Former Foster Care Youth From Another State	Hypo	X		X	See Expenditure Authority #6
SUD	Hypo	X		X	See Expenditure Authority #8
SMI	Hypo	X		X	See Expenditure Authority #12
Intensive Support Services	Hypo	X		X	See Expenditure Authority #11
ESI/COBRA	Hypo	X		X	See Expenditure Authority #2 and #3
HRSS	Hypo	X		X	See STC #13
In Vitro Fertilization and Genetic Testing	Hypo	X		X	See Expenditure Authority #13

Table 5: Master MEG Chart					
Services					
Fertility Treatment for Individuals Diagnosed with Cancer – Male	Hypo	X		X	See Expenditure Authority #14
Fertility Treatment for Individuals Diagnosed with Cancer – Female	Hypo	X		X	See Expenditure Authority #14
Cryopreservation	Hypo	X		X	See Expenditure Authority #14
Reentry Initiative Services	Hypo	X		X	See Expenditure Authority #15
Reentry Initiative Non-Services	Hypo		X	X	See Expenditure Authority #16

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

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the

demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 17, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 15, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 6: MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Current Eligibles	See Expenditure Authority #1	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	12/31/2023
Adult Expansion Population	See Expenditure Authority #9	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of Service	MAP	Y	7/1/2022	6/30/2027
Mandatory ESI for Adult Expansion	See Expenditure Authority #10	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Targeted Adults	See Expenditure Authority #7	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Dental – Targeted Adults	See Expenditure Authority #7	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Dental - Blind & Disabled Adults	See Expenditure Authority #4	N/A	Follow CMS-64.9 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Dental - Aged	See Expenditure Authority #5	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Former Foster Care Youth From Another State	See Expenditure Authority #6	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027

Table 6: MEG Detail for Expenditure and Member Month Reporting								
SUD	See Expenditure Authority #8	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
SMI	See Expenditure Authority #12	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
Intensive Support Services	See Expenditure Authority #11	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
ESI/COBRA	See Expenditure Authority #2 & #3	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of service	MAP	Y	7/1/2022	6/30/2027
HRSS	See STC section 13	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	7/1/2022	6/30/2027
In Vitro Fertilization and Genetic Testing Services	See STC 5.13	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y; Each member month represents one user of the service in a given month	2/29/2024	6/30/2027
Fertility Treatment for Individuals Diagnosed with Cancer – Male	See STC 5.12	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	2/29/2024	6/30/2027
Fertility Treatment for Individuals Diagnosed with Cancer – Female	See STC 5.12	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	2/29/2024	6/30/2027

Table 6: MEG Detail for Expenditure and Member Month Reporting								
Cryopreservation	See STC 5.12	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	2/29/2024	6/30/2027
Reentry Initiative Services	See Expenditure Authority #15	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	MAP	Y	7/2/2024	6/30/2027
Reentry Initiative Non-Services	See Expenditure Authority #16	N/A	Follow CMS-64.10 Base Category of Service Definitions	Date of Service	ADM	Y	7/2/2024	6/30/2027

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

Table 7: Demonstration Years		
Demonstration Year 21	July 1, 2022 to June 30, 2023	12 months
Demonstration Year 22	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 23	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 24	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 25	July 1, 2026 to June 30, 2027	12 months

16.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined that 97.4 percent of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6) and 2.6 percent will be matched at the state's regular Title XIX FMAP rate. Should state data indicate that there is an estimate more accurate than 2.6 percent by which to adjust claiming for individuals defined in 42 CFR 433.204(a)(1), CMS will work with the state to update this percentage to the more accurate figure, as supported by the state's proposed methodology and data. CMS anticipates no increase in enrollment among individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) that are experiencing homelessness for the continuous eligibility period; therefore, no change in FMAP claiming is required for the homeless population.

16.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** 97.4 percent of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), unless otherwise adjusted as described in STC 16.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining 2.6 percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular Title XIX FMAP rate.

16.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in section 17. CMS will provide technical assistance, upon request.[4]

16.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

16.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget

[4] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

16.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 16.18.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or State technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following:

mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or,

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

17. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

17.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, if applicable, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

17.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 5, Master MEG Chart and Table 6, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk

for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

17.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

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

Table 8: Main Budget Neutrality Test

MEG	PC or Agg *	WOW Only, WW Only, or Both	Trend Rate	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
Current Eligibles	PC	Both	3.3%	$628.81	$649.69	n/a	n/a	n/a
*PC = Per Capita; Agg = Aggregate								

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

17.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to

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

17.6. **Hypothetical Budget Neutrality Tests.**

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

Table 9a. Hypothetical Budget Neutrality Test 1

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

b. **Hypothetical Budget Neutrality Test 2: Dental Services.** The table below identifies

the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9b. Hypothetical Budget Neutrality Test 2								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Dental – Targeted Adults	PC	Both	5.3%	$40.57	$42.72	$44.98	$47.36	$49.87
Dental – Blind & Disabled Adults	PC	Both	4.8%	$21.08	$22.09	$23.15	$24.26	$25.42
Dental – Aged	PC	Both	3.4%	$34.00	$35.16	$36.36	$37.60	$38.88

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

Table 9c. Hypothetical Budget Neutrality Test 3								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Former Foster Care Youth from Another State	PC	Both	5.2%	$1,679.32	$1,766,64	$1,858,51	$1,955.15	$2,056.82

d. **Hypothetical Budget Neutrality Test 4: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated

"WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 4 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9d. Hypothetical Budget Neutrality Test 4								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
SUD	PC	Both	5.2%	$4,468.94	$4,701.32	$4,945.79	$5,202.97	$5,473.52

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

Table 9e. Hypothetical Budget Neutrality Test 5								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
SMI	PC	Both	5.3%	$14,998.93	$15,793.87	$16,630.95	$17,512.39	$18,400.55

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

Table 9f. Hypothetical Budget Neutrality Test 6								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
ISS	PC	Both	4.2%	$2,501.79	$2,606.87	$2,716.36	$2,830.45	$2,949.33

g. **Hypothetical Budget Neutrality Test 7: ESI/COBRA.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9g. Hypothetical Budget Neutrality Test 7								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
ESI/COBRA	PC	Both	5.2%	$247.15	$260.00	$273.52	$287.74	$302.70

h. **Hypothetical Budget Neutrality Test 8: HRSS.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9h. Hypothetical Budget Neutrality Test 8								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**

HRSS	PC	Both	5.3%	$7,318.35	$7,706.22	$8,114.65	$8,544,73	$8,997.60

i. **Hypothetical Budget Neutrality Test 9: Fertility Preservation Services for Individuals Diagnosed with Cancer.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 9 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9i. Hypothetical Budget Neutrality Test 9								
MEG	**PC or Agg ***	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**	**DY 24 PMPM**	**DY 25 PMPM**
Fertility Treatment for Individuals Diagnosed with Cancer – Male	PC	Both	5.3%	—	$500	$526.50	$554.40	$583.79
Fertility Treatment for Individuals Diagnosed with Cancer – Female	PC	Both	5.3%	—	$9,375.00	$10,042.46	$10,574.71	$11,135.17
Cryopreservation	PC	Both	5.3%	—	$500	$526.50	$554.40	$583.79

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

Table 9j. Hypothetical Budget Neutrality Test 10

MEG	PC or Agg *	WOW Only, WW Only, or Both	Trend Rate	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM	DY 24 PMPM	DY 25 PMPM
In Vitro Fertilization and Genetic Testing Services	PC	Both	5.0%	—	$7,421.38	$7,814.71	$8,228.89	$8,665.02

k. **Hypothetical Budget Neutrality Test 11**: **Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 11. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 9k: Hypothetical Budget Neutrality Test 11

MEG	PC or Agg	WOW Only, WW Only, or Both	Trend Rate	DY 21	DY 22	DY 23	DY 24	DY 25
Reentry	PC	Both	5.7%	—	—	$1,028.19	$1,086.80	$1,148.74
Reentry Non-Services	Agg	Both	N/A	—	—	$2,847,829.00	$4,271,743.50	$4,271,743.50

17.7. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

17.8. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 7/1/2022 to 6/30/2027. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

17.9. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 10: Main Budget Neutrality Test Mid-Course Correction Calculations		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY21	Cumulative budget neutrality limit plus:	2.0 percent
DY21 through DY22	Cumulative budget neutrality limit plus:	1.5 percent
DY21 through DY23	Cumulative budget neutrality limit plus:	1.0 percent
DY21 through DY24	Cumulative budget neutrality limit plus:	0.5 percent
DY21 through DY25	Cumulative budget neutrality limit plus:	0.0 percent

18. EVALUATION OF THE DEMONSTRATION

18.1. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 15.1.

18.2. **Independent Evaluator.** Upon approval of the demonstration, the state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. When

conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

18.3. **Draft Evaluation Design**. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, CMS's evaluation design guidance for SUD and SMI/SED, and any other applicable CMS evaluation guidance and technical assistance for the demonstration's other policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, including establishing valid comparison groups and assuring causal inferences in demonstration evaluations. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 18.7 and 18.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

18.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

18.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and also its effectiveness in achieving the goals.

For example, hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths

due to overdose. Hypotheses for the SMI/SED component of the demonstration must relate to, for example, utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination.

Evaluation hypotheses for the HRSS component of the demonstration must focus on areas such as severity and mitigation of beneficiaries' social needs, utilization of preventive and routine care, utilization of hospital and institutional care, and beneficiary physical and mental health outcomes. The state must analyze coverage, access to primary care, avoidance of inappropriate care utilization, reductions in uncompensated care, and health outcomes to understand the effectiveness of the Adult Expansion and employer-sponsored insurance (ESI) demonstration components. For the other components of the demonstration, the state must—as applicable—develop and test hypotheses in alignment with program goals that support analyzing demonstration effects on enrollment rates, uninsurance rates, access to primary care, access to mental health care, rates of emergency department visits (emergent and non-emergent), and access to dental services. The evaluation must also provide an assessment of the state's process for winding down the Current Eligibles population, and any potential lessons thereof.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

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

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing

estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

In addition, the state must also conduct a demonstration cost assessment to include, but not limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses together to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). CMS underscores the importance of the state undertaking a well-designed beneficiary survey to assess, for instance, beneficiary understanding of the various demonstration policy components, including the housing related support services, and beneficiary experiences with access to and quality of care.

Furthermore, the evaluation must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, and/or geography)—to the extent feasible—to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's various policies might support bridging any such inequities.

18.6. **Evaluation Budget**. A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

18.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the

demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved evaluation design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration / phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

e. The Interim Evaluation Report must comply with Attachment B (Preparing the Evaluation Report) of these STCs.

18.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Evaluation Report) of these STCs, and in alignment with the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. The state must submit a revised Summative Evaluation Report sixty (60) calendar days after receiving CMS's comments on the draft Summative Evaluation Report. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

18.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of

demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

18.10. **State Presentations for CMS**. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

18.11. **Public Access**. The state shall post the final documents (e.g., Implementation Plans, Monitoring Protocols, Monitoring Reports, Mid-Point Assessment Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

18.12. **Additional Publications and Presentations.** For a period of twenty-four (24) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given thirty (30) days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

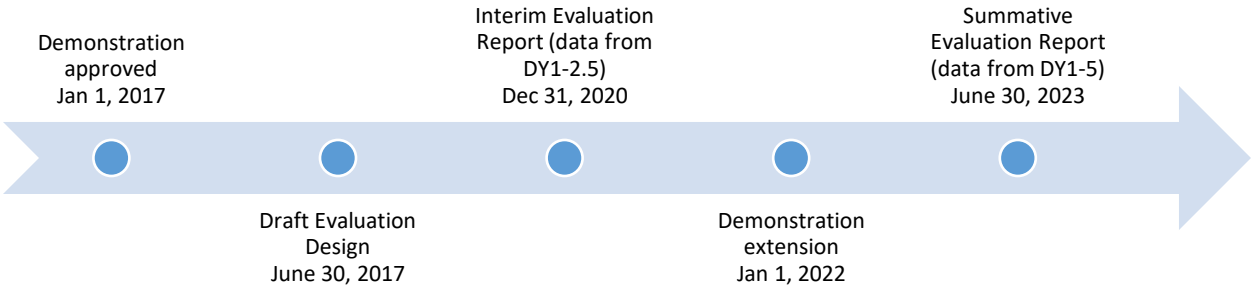
Attachment A:
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If

the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.

Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the

numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

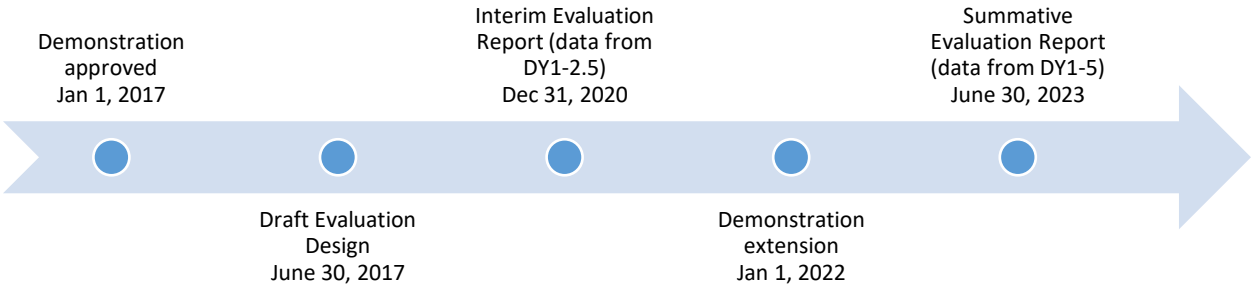
Attachment B:
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow

the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for extension, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.

3) *Evaluation Period* – Describe the time periods for which data will be collected.

4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    a. If the state did not fully achieve its intended goals, why not?
    b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment(s)

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: Implementation Plan

[To be incorporated after CMS approval]

Attachment D: SUD Implementation Plan

State of Utah SUD 1115 Waiver Implementation Plan

Division of Medicaid and Health Financing
Utah Department of Health

Table of Contents

Overview

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

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

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

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

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

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

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

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

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

Comprehensive Benefit Design

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

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

ASAM Level of Care	Title	Description	Provider	Existing Medicaid Service Y/N	New Medicaid Service Y/N
0.5	Early Intervention	Screening, Brief Intervention and Referral for Treatment (SBIRT)	Managed care or Fee for Services provider	Y as of July 1, 2017	

1	Outpatient Services	Less than 9 hours of services /week (adults); Less than 6 hours /week adolescents) for recovery or motivational enhancement therapies/strategies, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours /week (adolescents) to treat multi-dimensional instability, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
2.5	Day Treatment/ Psychosocial Rehabilitation Services	20 or more hours of service/week for multi-dimensional instability, not requiring 24 hour care, MAT, TCM	DHS/OL Certified Outpatient Facilities	Y	
3.1	Clinically Managed Low-Intensity Residential Services	24 hour structure with trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	

3.3	Clinically Managed Population Specific High Intensity Residential Services	24 hour structure with trained counselors to stabilize multi-dimensional imminent danger; Less intense milieu; and group treatment for those with cognitive or other impairments unable to use fill active milieu or therapeutic community and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.5	Clinically Managed High Intensity Residential Services	24 hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment, MAT, TCM	DHS/OL Licensed and DHS/ASAM Designated Residential Providers	Y	
3.7	Medically Monitored Intensive Inpatient Services	24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. 16 hour/day counselor availability, MAT, TCM	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	
4	Medically Managed Intensive Inpatient	24 hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric Hospitals	Y	

OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use. MAT includes methadone, Suboxone, Naltrexone	DHS/OL Licensed OTP Maintenance Providers, Licensed Prescribers	Y	

Table Two- ASAM Criteria for Withdrawal Services

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

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

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

Residential treatment

Services for Adolescents and Youth with an SUD

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

Level of Care: 0.5 (Early Intervention)

Current State:

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

Future State:

No changes are expected.

Summary of Actions Needed:

None

Level of Care: 1.0 (Outpatient Services)

Current State:

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

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

Future State:

No changes are expected

Summary of Actions Needed:

None

Level of Care: 2.1 (Intensive Outpatient Services)

Current State:

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

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

Future State:

No changes are expected

Summary of Actions Needed:

None

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

Current State:

Utah Medicaid covers Day Treatment/Psychosocial Rehabilitation Services for all members as a service available through on a fee for services basis and through Utah's Prepaid Mental Health Plans. Coverage, code and billing details can be found in the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No immediate changes are expected.

Summary of Actions Needed:

None

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

Current State:

Residential treatment for substance abuse disorders can be provided within institutions for mental disease (IMDs). An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64. One of the primary goals of the 1115 SUD waiver is to waive this restriction and allow IMDs to provide treatment to all Utah Medicaid members, including inpatient and residential treatment.
Utah Medicaid currently covers the discrete individuals services provided to Medicaid members who are in a residential treatment facility at ASAM level 3.1 or 3.5 with no more than 16 beds.

Future State:

Utah Medicaid determined a per diem rate to pay for residential treatment for substance use disorder. Therefore upon approval of Utah's amendment to its 1115 waiver and Utah's SUD Implementation Plan, Level 3.1 (clinically managed low-intensity residential) and Level 3.5 (clinically managed high-intensity residential) will be reimbursable in a facility with 17 or more beds (IMD) for all Utah Medicaid populations (fee-for-service and managed care).
The State will reimburse residential programs based on a bundled per diem payment. The bundled rate methodology for both Level 3.1 and 3.5 residential services will initially be based around a mix of current discrete services Medicaid eligible individuals receive while in a residential treatment setting. Only facilities that have been designated by the Division of Substance Abuse and Mental Health (DSAMH) as a Level 3.1 or Level 3.5 residential facility will receive reimbursement from Utah Medicaid. The development of improved certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Summary of Action Items:

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

Action Implementation Timeline

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

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

Current State

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

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

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

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

Summary of Action Items:

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

Action Implementation Timeline

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

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

Future State:
No changes are expected

Summary of Actions Needed:

None

Sub Support Service – Addiction Recovery Management Services

Current State:
Utah currently covers addiction recovery management services. Please see the Utah Medicaid Provider Manual for Rehabilitative Mental Health and Substance Use Disorder Services.
https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/Rehabilitative%20Mental%20Health%20And%20Substance%20Use%20Disorder%20Services/RehabMentalHealthSubAbuse7-17.pdf

Future State:

No changes are expected
Summary of Actions Needed:

None

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

Patient Assessments

The Utah State Division of Substance Abuse and Mental Health (DSAMH) requires that the Local Authority Substance Use and Mental Health Providers complete the following (1) Biopsychosocial Assessment (2) ASAM Patient Placement Criteria and (3) Screening for substance use disorder, mental health and suicide risk. However, DSAMH does not require one specific multi-dimensional tool. The assessment should be ongoing, strength based, and comprehensive to identify individual strengths and needs. These requirements are found in the DSAMH Division Directives: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Divison_Directives_FY_17_Final.pdf.

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

(b) Biomedical conditions or complications;

(c) Emotional, behavioral, or cognitive conditions;

(d) Readiness to change;

(e) Relapse, continued use or continued problem potential; and

(f) Recovery environment.

(3) The assessment shall include relevant information on:

(a) The individual's psychosocial function, substance use including tobacco/nicotine, mental and physical health, and other factors, such as educational experiences, trauma history, cultural issues, legal involvement, and family relationships that are relevant to the purpose of the assessment;

(b) Strengths, resiliencies, natural supports, interests of the individual, and an evaluation of the individual's unique abilities;

(c) Developmental and functional levels, social, emotional, communication abilities and strengths, and independent living skills;

(d) Cognitive, social, and affective development; family, peer, and intimate relationships; trauma; current or past emotional, physical or sexual abuse; suicidality; and safety;

(e) Collateral information from other sources that are relevant to the individual's situation and provides insight into the issues in Subsection R523-4-6(2)(a) through (2)(d).

(4) The assessment shall include a diagnosis when clinically indicated.

(5) Based on the screening and the assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs.

(6) The levels of care and array of services shall be based on the ASAM."

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

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

episodes of treatment may be necessary.

Future State:

All providers will be trained on ASAM criteria

Summary of Actions Needed:

Ongoing provider training on ASAM criteria

Action Implementation Timeline

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

Independent Third Party

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

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline:

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

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

Certification of Residential Facilities

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

In addition, counties that contract for residential services have detailed contracts with providers based on ASAM Criteria.
The Office of Licensing audits to these guidelines. DSAMH conducts annual monitoring site visits to Local Authorities reviewing Policy and Procedures, licensures, schedules, clinical documents. Copies of DSAMH monitoring tools and reports can be found at: https://dsamh.utah.gov/provider-information/contracts-monitoring/.

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline

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

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

Network Development Plan

Overall Strategy- Addiction Treatment Services Providers

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

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

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

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

Future State:

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

Summary of Actions Needed:

The DSAMH provider inventory needs to be updated to identify providers by ASAM level of care and whether or not providers are accepting new patients.
DMHF and DSAMH will continue to work together to assure Medicaid members in need of SUD treatment services have access to care.

Action Implementation Timeline:

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

Program Integrity Safeguards

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

Risk-Based Screening

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

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

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

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

Provider Revalidation

The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to revalidate provider enrollments at intervals not to exceed every five years. The CMS revalidation requirement for durable medical equipment (DME) and home medical equipment (HME) providers, including pharmacy providers with DME or HME specialty enrollments, is more frequent, at intervals not to exceed every three years.
Utah Medicaid providers receive notification letters when it is time to recredential their enrollments. Notification with instructions for revalidating are sent 90 and 60 days in advance of the revalidation deadline. Notices are mailed to the Service Location address indicated on the provider's service location profile. Providers with multiple service locations must revalidate the enrollment of each service location. Providers that fail to submit revalidation paperwork in a timely manner will be disenrolled from participation in Utah Medicaid.
After disenrollment, the provider will need to submit a new Utah Medicaid Provider Enrollment Application and all Documents to reenroll with Utah Medicaid.
Disenrollment with subsequent re-enrollment may result in a gap in the provider's eligibility.

Provider Agreements

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

Billing and Compliance Issues

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

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

Benefit Management

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

Future State:

No changes are expected.

Summary of Actions Needed:

None

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

Level of Care: OTS (Opioid Treatment Services)

Current State:

Utah Medicaid currently provides coverage for opioid treatment program (OTP) services, including the daily administration of methadone. Methadone programs are licensed by the Department of Human Services. Methadone is only administered by licensed clinics, which bill Utah Medicaid directly on a fee for service basis for any Medicaid member, even those enrolled in managed care. Methadone is a carved out service for managed care.
Methadone providers are enrolled as Utah Medicaid Providers or as an ordering, prescribing, or referring provider in accordance with Section 6401 of the Patient Protection and Affordable Care Act.
Utah Administrative Rule R523-4 requires that "All individuals with alcohol and/or opioid disorders shall be educated and screened for the potential use of medication-assisted treatment." In addition, the DSAMH Directives require that, "
Local Substance Abuse Authority treatment programs . . .
ii. Evaluate all clients who are opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) within the first 10 days of services and document the results of the assessment. Educate the client about MAT options; when clinically indicated and the client is amenable:

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

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

c. Refer the individual for MAT.

Some Local Authority Residential Providers have a physician in their program that can provide MAT (Buprenorphine) to contracted residential treatment providers. In addition, they coordinately closely with the Utah State Opioid Treatment Providers who provide MAT to residential programs on or off site.
In Utah, the illegal use of prescription drugs has reached epidemic proportions.

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

Over the last decade, prescription pain medications have been responsible for more drug deaths in Utah than all other drugs combined. However, coordinating with multiple partners and focusing prevention and intervention efforts has resulted in Utah seeing a decrease in opioid related deaths by 7.6% in one
year https://www.health.utah.gov/vipp/pdf/RxDrugs/PrescribingPracticeInUtah.pdf. DSAMH collaborates with the Department of Health to increase access to naloxone, a drug that reverses opiate overdose, and to increase efforts to prevention abuse and misuse. Following the Strategic Prevention Framework, prevention efforts include coalition work, changing laws, and strategic use of evidence-based prevention programs. DSAMH has been actively involved in numerous state initiatives designed to reduce the impact of opioid abuse:

- Use Only As Directed (UOAD) began in 2007 in collaboration with the Utah Department of Health, Department of Human Services, Law Enforcement, and private industry. This statewide campaign focuses on safe use, storage, and disposal of prescription medications. Since 2013, Intermountain Healthcare has been an active partner. In August 2016, Intermountain Healthcare and UOAD launched a new campaign at McKay Dee Hospital, showing that every day, 7,000 prescriptions are filled in Utah.

- The Center for Disease Control released a revised set of Prescriber Guidelines in 2016. The guidelines outline appropriate prescribing protocols in an effort to decrease the over prescribing of opioids for non-cancer incidences.
- Take Back Events—semi-annual event collecting thousands of pounds of unused and expired medications.

Successful treatment may include:

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

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

A range of care with a tailored treatment program and follow-up options can be crucial to success. Treatment should include both medical and mental health services as needed.
Follow-up care may include community- or family-based recovery support systems. Medication Assisted Treatment (MAT) is a safe and effective strategy for reducing opioid use and the risk of overdose. Currently, there are three MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. These medications are used in combination with counseling and behavioral therapies, to provide a "whole-patient" approach. People may safely take medications used in MAT for months, years, several years, or even a lifetime. Plans to stop a medication must always be discussed with a doctor. Methadone works by changing how the brain and nervous system respond to pain. It lessens the painful symptoms of opiate withdrawal and blocks the euphoric effects of opioids. By law, methadone used to treat opiate-use disorder can only be dispensed through an Opioid Treatment Programs (OTP) certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), regulated by the Drug Enforcement Agency (DEA), Licensed by Department of Human Services and accredited by one of the major healthcare accreditation entities.

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

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

Strategies to Address Prescription Drug Abuse / Opioid Use Disorder

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

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

Prior Authorization Criteria

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

Prescribing Guidelines

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

ADDITIONAL INFORMATION

Weber Human Services (WHS) and Davis

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

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

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

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

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

Drug Courts

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

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

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

Future State:

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

Summary of Actions Needed:

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

Action Implementation Timeline

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

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

Milestone 6 Improved Care Coordination and Transitions between Levels of Care

Transitions of Care

Current State

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

Future State:

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

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

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

Summary of Actions Needed:

Utah will amend provider manuals and managed care contracts.

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

Action Implementation Timeline

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

ADDITIONAL INFORMATION

Case Management

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

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

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

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

Crisis Intervention Team (CIT)

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

Certified Peer Support Specialists (CPSS)

Peer Support Specialists are adults in recovery from a substance use or mental health disorder that are fully integrated members of a treatment team. They provide highly individualized services in the community and promote client self-determination and decision-making.

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

Trauma-informed Approach

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

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

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

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

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

their practices.
Future State:
No changes are expected.

Summary of Actions Needed:

None

Grievances and Appeals

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

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

https://rules.utah.gov/publicat/code/r410/r410-014.htm.
Future State:
Utah Administrative Code and internal procedures are consistent with recent changes to federal regulations.
Summary of Actions Needed:
Utah Medicaid will review 42 CFR 431 Part E and 42 CFR 438 Part F once again to assure Utah Code reflects the requirements of current federal regulation.
Action Implementation Timeline

- Utah Medicaid will conduct a review of current administrative code and federal regulations to determine any needed updates by November 30, 2017.

- Utah Medicaid will implement any necessary changes to administrative code and internal procedures by March 31, 2018

Attachment E: SMI/SED Implementation Plan

Section 1115 SMI/SED Demonstration Implementation Plan

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

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

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

State may submit additional supporting documents in Section 3.

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

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

2. Describe the timelines and activities the state will undertake to achieve the milestones.

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

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

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

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

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

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

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

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

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

2. Required implementation information, by SMI/SED milestone

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

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current State:** In accordance with Utah Administrative Code R432-101 Specialty Hospital, all psychiatric facilities must be licensed and certified through the Utah Bureau of Health Facility Licensing and Certification. Residential Treatment Programs are required to be licensed through the Utah Office of Licensing. **Hospitals**: Utah's Bureau of Health Facility Licensing and Certification has established licensing and certification requirements for psychiatric hospitals. Participating psychiatric hospitals will be licensed and approved by the Bureau of Health Facility Licensing and Certification.

	Through the state survey process psychiatric hospitals are required to meet 42 CFR part 482. The Division of Licensing and Certification uses the State Operations Manual survey guidelines for psychiatric hospitals. The enrollment process and requirements for psychiatric hospitals are posted on the Division's external website. **Residential Treatment Programs**: The Utah Department of Human Services, Office of Licensing licenses residential treatment programs. R501-19 details the requirements a program must meet to be licensed and includes regulations for specialized treatment services for substance abuse treatment, services for children and youth, and services for people with disabilities.
	Future Status: Utah will continue operation of current requirements for hospitals. The State will develop methodologies for enrollment of residential treatment programs that include verification of accreditation by a national accreditation association.
	Summary of Actions Needed: The Medicaid Provider Enrollment process will be updated to require submission of verification of accreditation by a national accreditation association. In addition, all necessary system program changes needed in order to enroll residential treatment programs with the appropriate identifier. (Timeline: 6-12 months)

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current Status:** Currently the Utah Department of Health Facility Licensing, Certification, and Resident Assessment may conduct administrative inspections on a routine basis for any licensed facility. **Hospitals:** R432-3-4 requires: (1) The Department (Utah Department of Health Facility Licensing, Certification, and Resident Assessment) or its designee may, upon presentation of proper identification, inspect each licensed health care facility or agency as necessary to determine compliance with applicable laws, rules and federal regulations. (2) Each licensed health care facility or agency must: (a) allow authorized representatives of the Department immediate access to the facility or agency, including access to all staff and patients; and (b) make available and permit photocopying of facility records and documents by, or on behalf of, the Department as necessary to ascertain compliance with applicable laws, rules and federal regulations. Copies become the responsibility and property of the Department. In addition, current state law allows for on site, unannounced visits to ascertain compliance with licensure requirements **Residential Treatment Center:** Utah code states: 62A-2-118. Administrative inspections. (1) The office may, for the purpose of ascertaining compliance with this chapter, enter and inspect on a routine basis the facility of a licensee. (2) Before conducting an inspection under Subsection (1), the office shall, after identifying the person in charge: (a) give proper identification; (b) request to see the applicable license; (c) describe the nature and purpose of the inspection; and (d) if necessary, explain the authority of the office to conduct the inspection and the penalty for refusing to permit the inspection as provided in Section 62A-2-116. (3) In conducting an inspection under Subsection (1), the office may, after meeting the requirements of Subsection

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

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

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

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

Prompts	Summary
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current Status:** According to Utah Administrative Code R432-101-11, both hospitals and residential treatment programs are required to "have a well-defined quality assurance plan designed to improve the delivery of patient care through evaluations of the quality of patient care services and resolution of identified problems". This rule further requires all providers maintain a "Plan for Patient Care Services", which is a "written plan that ensures the care, treatment, rehabilitation, and habitation services provided are appropriate to the needs of the patient population service and the severity of the disease, condition, impairment, or disability". The Plan for Patient Care services must be kept up to date and all corrective actions and meeting minutes must be presentable upon request by the State.
	Future Status: Utah will continue operation of current requirements.
	Summary of Actions Needed: None
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals, residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	**Current Status**: Both residential treatment centers and hospitals are required by Utah administrative code to have transfer and discharge policy in place in order for beneficiaries to be provided with the necessary aftercare and follow up services following discharge. **Hospital**: All Medicaid-enrolled psychiatric hospitals, including the participating IMD facilities, are required to comply with all applicable CMS Conditions of Participation (COP), including but not limited to 42 CFR 482.43, which establishes

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

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

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

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

Prompts	Summary
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of	**Current Status:** In partnership with local partners, Utah Medicaid completed the initial assessment on September 30th 2020. Some important results are the lack of IMD facilities available to beneficiaries, the need to increase crisis response in rural areas, and the need to increase crisis receiving centers throughout the state.
	Future Status: Utah Medicaid commits to conducting an availability assessment annually and will discuss any improvements that need to be made in ongoing assessments and reports.

the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	**Summary of Actions Needed:** Utah will complete the next annual assessment of the availability of mental health providers by September 30th, 2021.

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

care and length of stay	current standards of care. They are required to ensure decisions on utilization management are based on the best practice guidelines. Although managed care plans are already using a tool as discussed above, the contracts currently do not have a specific requirement to use an assessment tool.
	Future Status: Add to contracts for managed care plans to use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay".
	Summary of Actions Needed: 1. Modify managed contracts to include a requirement that they must use a "widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay". 2. Follow up with managed care plans to ensure they are requiring the utilization of a patient assessment tool (Timeline: 6-12 months)

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

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

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

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

identification/engagement, integration, and specialized programs for young people	increase early intervention strategies including preschool based programming for youth with co-occurring mental health and autism spectrum disorder needs. There are currently five programs operating throughout Utah. Each of these programs operates under different names. They provide services to youth ages 2-8 who are in need of co-occurring mental health and autism/developmental needs. Utah's Department of Human Services also uses the System of Care's High-Fidelity Wraparound (HFW) model, through this model and working with DSAMH, Utah is able to work with family advocacy and peer led organizations to provide high fidelity wraparound services and family and youth peer support services. These services are meant to provide early intervention for the youth and their families, and to help navigate the complex mental health system. Early childhood programs are also provided through Utah's Department of Child and Family Services with partnerships with local family support centers that provide mental health services and crisis nursery services. School based services are also provided in conjunction with county behavioral health authorities and schools to increase early engagement and access to services.
	Future Status: Early childhood training needs have been identified to help build out more robust mental health services and partnerships between agencies that serve children. These early childhood training needs include a consultation and competency model that will provide training to providers who serve younger children (0-5) throughout their communities. These trainings are meant for both clinical and non-clinical professionals and will increase the overall capacities throughout local communities. Ongoing efforts to increase partnerships and services with schools and Local Authorities. Currently there are partnerships with over 350 local schools throughout Utah. For the future, it is anticipated that these partnerships will continue to grow based on need in local areas with new schools being added yearly. Youth in Transition services and training opportunities are also being developed. DSAMH leads a State Youth In Transition team that meets monthly and are working on a health disparities project and creating a strategic plan.
	Summary of Actions Needed: Within the next 12 months, the Department of Human Services will enter into a contract for an early childhood competencies and consultation program that will include training for Local Authorities and their community partners.

	Within 18 months, DSAMH and the Local Authorities will continue to partner with the Utah State Board of Education and Local Education Agencies to increase the local involvement for services, including increasing access to telehealth services and in person services that will be provided in local schools. A full school based implementation manual will also be completed in that timeframe.

Prompts	Summary
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**Current Status** Utah adopted the Crisis Now model for implementation and expansion of crisis services. In 2019, Utah established a statewide crisis line in which all crisis calls statewide are routed through one line. The Utah crisis line then serves to direct individuals into other appropriate care including warm hand offs for additional assessment to local behavioral health providers, to dispatch Mobile Crisis Outreach Teams based in communities throughout the state, or to higher levels of care when needed. As crisis stabilization services are built the crisis line will be able to provide direct referrals into those facilities as well. Utah Medicaid recently added Assertive Community Treatment and Mobile Crisis Outreach Teams to the State Plan. Utah Medicaid also submitted a SPA to receive approval for bundled daily rates for services provided at a Crisis Receiving Center or a mental health residential treatment program. Utah currently either operates or is in the process of implementing several crisis services related initiatives. 1. Crisis Line: Currently any individual in Utah can access crisis services via the Utah Crisis Line, which is funded by a mix of county and state funds. 2. Mobile Crisis Outreach Team (MCOT): The four urban counties/Local Authorities in Utah have been operating MCOT teams. Seven additional rural/frontier Local Authorities will begin operating MCOT services in FY21. These are funded via a mix of state general funds, local funds, and Medicaid reimbursement. 3. Stabilization and Mobile Response (SMR)- in three regions, currently in the works to expand to one additional region, 4. Crisis Receiving Centers: Four Local Authorities will be standing up crisis receiving centers between FY 21 and

	FY23. These will be funded by state general funds with a plan to add a bundled rate to the Utah State Plan. 5. Sub-Acute.
	Future Status Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan 1. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 2. Expand MCOT statewide: Goal of even additional rural/frontier local Authorities will begin operating MCOT services by January 1, 2021 pending sustainable funding plan approved and adopted. 3. Expand SMR statewide: Goal of SMR to be in four regions by Spring of 2021 dependent on funding. 4. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 5. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. 6. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system 7. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce
	Summary of Actions Needed 1. On January 1, 2021, pending CMS approval, Utah will add Crisis Receiving Centers and mental health residential treatment as a bundled rate to the State Plan. 2. By December 2020, Utah will finalize administrative rule governing Crisis Receiving Centers.

	3. Sustainable funding plan for crisis line: Plan will be submitted to the Utah Crisis Commission by Summer 2021. 4. Expand MCOT statewide: Goal of statewide MCOT by July 1, 2022 pending sustainable funding plan approved and adopted. 5. Expand SMR statewide: Goal of SMR to be in four regions by Spring 2021 dependent on funding. 6. Crisis stabilization centers- modified for rural areas: goal of a stepped rollout of a minimum of one center implementing services annually beginning SFY22. 7. Increased crisis prevention strategies including access to robust outpatient care/services. Ongoing in partnership with behavioral health workforce expansion plans. Ongoing. 8. Engagement and partnership with police dispatch to divert non-public safety calls from law enforcement into the crisis system. Ongoing. 9. Continue to address workforce capacity through the Utah Medical Education Council. This multi stakeholder group is in the process of compiling a Mental Health Workforce Report to identify needs and gaps in the workforce. Ongoing.
5.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified	**Current Status:** Utah currently offers a comprehensive continuum of community-based mental health services. Outpatient, partial hospitalization, and residential mental health treatment services have been part of the Utah State Plan since 1987. The state continuously monitors access to mental health services through its managed care plans, external quality reviews, and through the Utah Department of Substance Abuse and Mental Health (DSAMH). Managed care plans are required to follow 42 CFR 438.68 Network adequacy standards. In accordance with 42CFR 438.358, Utah Medicaid contracts with an external quality organization to validate the managed care plans for network

Community Behavioral Health Clinic model.	adequacy for the preceding 12 months. Utah Code 62A-15-103 assigns responsibility to DSAMH to work with the county behavioral health authorities to conduct annual program audits and reviews to ensure adequate plans and community based services are available throughout Utah. DSAMH is required to review the Local Authority Area Plans annually and audit each county behavioral health authority to these plans. In 2019, Utah Medicaid began reimbursing for the Assertive Community Treatment (ACT) model of care. Utah currently has one ACT team at SAMHSA fidelity with plans to expand to more teams. On January 1 2020, Utah Medicaid implemented four new integrated managed care plans. These plans cover both physical health behavioral health services. Through these new integrated plans, beneficiaries are able to receive care management in a more complete manner.
	Future Status DSAMH will continue to monitor county behavioral health authorities to ensure provision of mandated services including issuing Division Directives and requiring annual Area Plans as well as annual audits. DSAMH will work with key stakeholders to identify gaps in services including workforce shortages and partner on strategies to build out increased access to a continuum of community based services. DSAMH will continue to expand access to ACT services and AOT services. An additional ACT team in SLCO will launch FY21 (current year) and an AOT team will launch in Weber county
	Summary of Actions Needed 2020 Utah will finalize the Utah administrative rule governing ACT Teams. The state will require an annual plan by each Local Mental Health Authority that outlines the local plan for service delivery to high acuity clients and will provide support to build out AOT and/or ACT services when clinical need arises.

Prompts	Summary
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: ● *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* ● *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not yet the case, please describe how this will be achieved and over what time period	The State assures that it has a sufficient health IT infrastructure to achieve the goals of the demonstration. The State has an established health IT infrastructure that is based on the goal to improve interoperability across the continuum of care on behalf of all beneficiaries. The State's health IT infrastructure includes achieving goals that will improve health outcomes, facilitate access, simplify care, and reduce the overall costs of healthcare. In order to achieve these goals, the State utilizes the State Medicaid Health Information Technology Plan (SMHP), an incentive based program that encourages hospitals and providers to utilize Electronic Healthcare Technology in order to improve outcomes for beneficiaries. Currently the state utilizes the Clinical Health Information Exchange (cHIE), which has been accredited through the Electronic Healthcare Network Accreditation Commission. The cHIE is the state-designated Health Information Exchange platform that allows providers and MCOs to collect and connect patient data within one main system throughout the state of Utah. https://uhin.org/solutions/use-cases/clinical-use-cases/

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

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

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

[2] Available at https://www.healthit.gov/isa/.

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

[3] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.
[4] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

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

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

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

	Summary of Actions Needed: None.

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

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

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

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

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

	Summary of Actions Needed: None

Section 3: Relevant documents

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

Attachment F: Monitoring Protocol

[To be incorporated after CMS approval]

Attachment G: SUD Monitoring Protocol

Substance Use Disorder (SUD)

Note: PRA Disclosure Statement to be added here

The SUD monitoring protocol workbook (part A) is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Planned Metrics (Version 7.0)
State Utah
Demonstration Name Utah Medicaid Reform 1115 Demonstration

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, codes, target population, etc.)[b,c]	State plans to phase in reporting (Y/N)	SUD monitoring report in which metric will be phased in (Format DY#Q#; e.g., DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: *1* ***(Do not delete or edit this row)***	*EXAMPLE:* *Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE:* *Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE:* *Assessment of need and qualification for SUD treatment services*	*EXAMPLE:* *CMS-constructed*	*EXAMPLE:* *Other monthly and quarterly metrics*	*EXAMPLE:* *Medical record review or claims*	*EXAMPLE:* *Month*	*EXAMPLE:* *Quarterly*	*EXAMPLE:* *Recommended*	*EXAMPLE:* *Y*	*EXAMPLE:* *07/01/2018-06/30/2019*	*EXAMPLE:* *Increase*	*EXAMPLE:* *Increase*	*EXAMPLE:* *N*	*EXAMPLE:* *The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE:* *Y*	*EXAMPLE:* *DY2Q1*	*EXAMPLE:* *This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	The ratio of metric #6 divided by metric #3 will increase by 5% overall	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y	The state uses HCPCS code H0018 to identify IMD's billing for SUD IMD services. Only licensed SUD residential treatment programs can bill this code. System provider enrollment and reimbursement editing logic controls	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	The ratio of metric #6 divided by metric #3 will increase by 5% overall	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Increase	5% increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	5% increase from baseline	Y	The state uses the following logic to identify SUD providers: a provider who bills a procedure code under AOD Medicaid Treatment in the adult value set; OR category of service 22 (Substance Abuse Treatment) or provider type 50 (Alcohol and Drug Center) and a capitation was not paid.	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metrics	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	5% increase from baseline	Y	Utah will use claims data where MAT is dispensed for a list of Medic	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Increase	5% increase from baseline	Y		N		
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Medical record review or claims	Year	Annually	Recommended	N								
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure]b	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Increase	5% increase from baseline	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #3489; Medicaid Adult Core Set; Adjusted HEDIS measure]c	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Increase	5% increase from baseline	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Decrease	25% reduction from baseline	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Decrease	10% reduction from baseline	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2016-12/31/2017	Increase	5% increase from baseline	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Decrease	5% reduction from baseline	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2017-06/30/2018	Decrease	5% reduction from baseline	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/01/2017-06/30/2018	Decrease	5% reduction from baseline	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	07/01/2017-06/30/2018	Decrease	Decrease	Y		N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Required	Y	07/01/2017-06/30/2018	Decrease	Decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metrics that are established quality measures	Claims	Year	Annually	Required	Y	01/01/2017-12/31/2017	Increase	5% increase from baseline	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								

Table: Substance Use Disorder Demonstration Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
54	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
55	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
56	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metrics	Claims; State-specific IMD database	Year	Annually	Required	Y	07/01/2017-06/30/2018	Stabilize	No more than 30 days	Y	The state uses HCPCS code H0018 to identify IMD+ billing for SUD IMD services. Only licensed SUD residential treatment programs can bill this code. System provider enrollment and reimbursement editing logic controls for allowable provider billing.A list of approved SUD IMD+ can be found at: https://bpsmanuals.health.utah.gov/Medicaidpolicy/Tables/Table_XVIII_-_IMD_s_with_a_Licensed_SUD_Treatment_Program.htm	N			
Q1	*Project ECHO - OPIOID, ADDICTION, & PAIN ECHO*	Utah will work with the University of Utah's Project ECHO program on Opioid, Addiction & Pain	Health IT	State-specific	Other annual metrics	Administrative r	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	Increase			N		
Q2	*Online Provider Directories*	Prepaid Mental Health Plans (PMHP) will be required to implement online provider directories, up	Health IT	State-specific	Other annual metrics	Administrative r	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	Increase			N		
Q3	*MAT Continuity Models*	Utah will track MAT continuity with and without behavioral counseling therapy. Utah will identify	Health IT	State-specific	Other annual metrics	Administrative r	Year	Annually	Required	Y	07/01/2017-06/30/2018	Increase	5% increase from baseline			N		
State-specific metrics																		
[Insert row(s) for any additional state-specific metrics by right-clicking on row 53 and selecting "Insert"]																		

[a] There are no CMS-provided metrics related to milestone 3.

[b] If the state is not reporting a required metric (i.e., column K = "N"), enter explanation in corresponding row in column P.

[c] The state should use column P to outline calculation methods for specific metrics as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations Monitoring Protocol Instructions.

[d] Ratio 1 and 2 reported for Metric #17(1) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[e] Ratio 1 and 2 reported for Metric #17(2) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

[f] While grievances and appeals metrics are recommended for reporting, the state is required, per 42 CFR 431.428(a)(5, to provide updates on the results of beneficiary satisfaction surveys, if conducted during the reporting year, including updates on grievances and appeals from beneficiaries, in in its annual (Q4) monitoring report.

Medicaid Section 1115 SUD Demonstrations Protocol (Part A) - Planned Subpopulations (Version 7.0)

State: Utah
Demonstration Name: Utah Medicaid Reform 1115 Demonstration

Table: Substance Use Disorder Demonstration Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format metric number, comma separated)
EXAMPLE: *Age group* ***(Do not delete or edit this row)***	*EXAMPLE:* *Children <18, adults 18–64, and older adults 65+*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #1-3, 6-12, 23, 24, 26, 27*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults 12-21, Adults 21-65*	*EXAMPLE:* *N*	*EXAMPLE:* *1, 2, 3*
Age group	Children <18, adults 18–64, and older adults 65+	Required	Metrics #1-3, 6-12, 23, 24, 26, 27	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	The state uses category of aid (COA) beginning with a 'Q' from its system, to identify individuals who are dual-eligible and recieving a full or partial Medicaid benefit. This does not include those who are only entitled to restricted benefits based on dual-eligiblity status inlcuding QMB, SLMB, QDWI and QI. Individuals receiving the restricted benefits above are not eligible for SUD-related Medicaid services. This is controlled by their 'Q' COA in the state system. If the individual has a 'Q' COA (not including those with restricted benefits) at anytime during the month and received a SUD-related service identified in Metrics #1-3 and 6-12, the state will include them in the count.	Y	
Pregnancy status	Pregnant, Not pregnant	Required	Metrics #1-3, 6-12	CMS-provided	Y	Y	The state uses the "pregnancy indicator" in its systems to identify pregnant individuals. If an individual is identified as pregnant in the eligblity system the prenancy indicator will be sent over to DOH systems. If an individual is pregnant at any time during the month, they will be indicated using the prenancy indicator, and will be included in the count.	Y	
Criminal justice status	Criminally involved, Not criminally involved	Required	Metrics #1-3, 6-12	CMS-provided	N		The state does not have any methods or data sources available to identify individuals who are criminally involved.		
OUD population	Opioid diagnosis	Recommended	Metrics #2-12, 23, 24, 26, 27, 36	CMS-provided	N				
[Insert row(s) for any state-specific subpopulation(s)]									

[a] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[b] If the state is reporting on the Dual-eligible status, Pregnancy status, Criminal justice status, and OUD population subpopulation categories, the state should use column H to outline its subpopulation identification approach as explained in Version 4.0 of the Medicaid Section 1115 Substance Use Disorder Demonstrations Monitoring Protocol Instructions.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should (1) select N in column G and (2) provide an explanation and the

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Reporting Schedule (Version 7.0)

State: Utah
Demonstration Name: Utah Medicaid Reform 1115 Demonstration

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SUD demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety and in the correct format for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SUD demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviation from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e., column H="Y"), the state should describe these deviations in column I, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviations from standard reporting schedule," to indicate the SUD measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Substance Use Disorder Demonstration Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SUD demonstration year (SUD DY1)	
Start date	07/01/2022
End date	06/30/2023
Dates of first quarter of the baseline period for CMS-constructed metrics	
Reporting period (SUD DY and Q)	DY6Q1
Start date	07/01/2022
End date	09/30/2022
Broader section 1115 demonstration reporting period corresponding with the first SUD reporting quarter, if applicable. If there is no broader demonstration, fill in the first SUD reporting period. (Format DY#Q#; e.g., DY3Q1)	DY21Q1
First SUD monitoring report due date (per STCs) (MM/DD/YYYY)	11/29/2022
First SUD monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs)	
Baseline period for EQMs	CY2022
SUD DY and Q associated with monitoring report	DY7Q1
SUD DY and Q start date (MM/DD/YYYY)	07/01/2023
SUD DY and Q end date (MM/DD/YYYY)	09/30/2023
Dates of last SUD reporting quarter:	
Start date	04/01/2027
End date	06/30/2027

Table 2. Substance Use Disorder Demonstration Reporting Schedule

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2022	09/30/2022	11/29/2022	DY21Q1	DY6Q1	Narrative information	DY6Q1	N		
					Grievances and appeals	DY6Q1	n.a.		
					Other monthly and quarterly metrics		N		
					Annual metrics that are established quality measures		Y	Utah will report EQMs in Quarter 1 Monitoring Reports.	CY2021
					Other annual metrics		Y	Reporting to continue per previous demonstration reporting schedule.	DY5
10/01/2022	12/31/2022	03/01/2023	DY21Q2	DY6Q2	Narrative information	DY6Q2	N		
					Grievances and appeals	DY6Q2	n.a.		
					Other monthly and quarterly metrics	DY6Q1	N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2023	03/31/2023	05/30/2023	DY21Q3	DY6Q3	Narrative information	DY6Q3	N		
					Grievances and appeals	DY6Q3	n.a.		
					Other monthly and quarterly metrics	DY6Q2	Y	State has an approved two-quarter lag to allow for claims run-out. State will pause reporting for this quarter and continue reporting other monthly and quarterly metrics in its DY6Q4 monitoring report.	n.a. - not reporting in this reporting quarter
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2023	06/30/2023	09/28/2023	DY21Q4	DY6Q4	Narrative information	DY6Q4	N		
					Grievances and appeals	DY6Q4	n.a.		
					Other monthly and quarterly metrics	DY6Q3	Y	State has approved two-quarter lag to allow for claims run-out	DY6Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2023	09/30/2023	11/29/2023	DY22Q1	DY7Q1	Narrative information	DY7Q1	N		
					Grievances and appeals	DY7Q1	n.a.		
					Other monthly and quarterly metrics	DY6Q4	Y	State has approved two-quarter lag to allow for claims run-out	DY6Q3
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics	DY6	Y		n.a. - not reporting in this reporting quarter
10/01/2023	12/31/2023	02/29/2024	DY22Q2	DY7Q2	Narrative information	DY7Q2	N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[8] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Grievances and appeals	DY7Q2	n.a.		
					Other monthly and quarterly metrics	DY7Q1	Y	State has approved two-quarter lag to allow for claims run-out	DY6Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY6
01/01/2024	03/31/2024	05/30/2024	DY22Q3	DY7Q3	Narrative information	DY7Q3	N		
					Grievances and appeals	DY7Q3	n.a.		
					Other monthly and quarterly metrics	DY7Q2	Y	State has approved two-quarter lag to allow for claims run-out	DY7Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
04/01/2024	06/30/2024	09/28/2024	DY22Q4	DY7Q4	Narrative information	DY7Q4	N		
					Grievances and appeals	DY7Q4	n.a.		
					Other monthly and quarterly metrics	DY7Q3	Y	State has approved two-quarter lag to allow for claims run-out	DY7Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2024	09/30/2024	11/29/2024	DY23Q1	DY8Q1	Narrative information	DY8Q1	N		
					Grievances and appeals	DY8Q1	n.a.		
					Other monthly and quarterly metrics	DY7Q4	Y	State has approved two-quarter lag to allow for claims run-out	DY7Q3
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics	DY7	Y		n.a. - not reporting in this reporting quarter
10/01/2024	12/31/2024	03/01/2025	DY23Q2	DY8Q2	Narrative information	DY8Q2	N		
					Grievances and appeals	DY8Q2	n.a.		
					Other monthly and quarterly metrics	DY8Q1	Y	State has approved two-quarter lag to allow for claims run-out	DY7Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY7
01/01/2025	03/31/2025	05/30/2025	DY23Q3	DY8Q3	Narrative information	DY8Q3	N		
					Grievances and appeals	DY8Q3	n.a.		
					Other monthly and quarterly metrics	DY8Q2	Y	State has approved two-quarter lag to allow for claims run-out	DY8Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2025	06/30/2025	09/28/2025	DY23Q4	DY8Q4	Narrative information	DY8Q4	N		
					Grievances and appeals	DY8Q4	n.a.		
					Other monthly and quarterly metrics	DY8Q3	Y	State has approved two-quarter lag to allow for claims run-out	DY8Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[8] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2025	09/30/2025	11/29/2025	DY24Q1	DY9Q1	Narrative information	DY9Q1	N		
					Grievances and appeals	DY9Q1	n.a.		
					Other monthly and quarterly metrics	DY8Q4	Y	State has approved two-quarter lag to allow for claims run-out	DY8Q3
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics	DY8	Y		n.a. - not reporting in this reporting quarter
10/01/2025	12/31/2025	03/01/2026	DY24Q2	DY9Q2	Narrative information	DY9Q2	N		
					Grievances and appeals	DY9Q2	n.a.		
					Other monthly and quarterly metrics	DY9Q1	Y	State has approved two-quarter lag to allow for claims run-out	DY8Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY8
01/01/2026	03/31/2026	05/30/2026	DY24Q3	DY9Q3	Narrative information	DY9Q3	N		
					Grievances and appeals	DY9Q3	n.a.		
					Other monthly and quarterly metrics	DY9Q2	Y	State has approved two-quarter lag to allow for claims run-out	DY9Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2026	06/30/2026	09/28/2026	DY24Q4	DY9Q4	Narrative information	DY9Q4	N		
					Grievances and appeals	DY9Q4	n.a.		
					Other monthly and quarterly metrics	DY9Q3	Y	State has approved two-quarter lag to allow for claims run-out	DY9Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

SUD reporting quarter start date (MM/DD/YYYY)	SUD reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SUD reporting period (Format DY#Q#; e.g., DY1Q3)	SUD reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SUD	Deviation from standard reporting schedule (Y/N/n.a.)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2026	09/30/2026	11/29/2026	DY25Q1	DY10Q1	Narrative information	DY10Q1	N		
					Grievances and appeals	DY10Q1	n.a.		
					Other monthly and quarterly metrics	DY9Q4	Y	State has approved two-quarter lag to allow for claims run-out	DY9Q3
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics	DY9	Y		n.a. - not reporting in this reporting quarter
10/01/2026	12/31/2026	03/01/2027	DY25Q2	DY10Q2	Narrative information	DY10Q2	N		
					Grievances and appeals	DY10Q2	n.a.		
					Other monthly and quarterly metrics	DY10Q1	Y	State has approved two-quarter lag to allow for claims run-out	DY9Q4
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY9
01/01/2027	03/31/2027	05/30/2027	DY25Q3	DY10Q3	Narrative information	DY10Q3	N		
					Grievances and appeals	DY10Q3	n.a.		
					Other monthly and quarterly metrics	DY10Q2	Y	State has approved two-quarter lag to allow for claims run-out	DY10Q1
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2027	06/30/2027	09/28/2027	DY25Q4	DY10Q4	Narrative information	DY10Q4	N		
					Grievances and appeals	DY10Q4	n.a.		
					Other monthly and quarterly metrics	DY10Q3	Y	State has approved two-quarter lag to allow for claims run-out	DY10Q2
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

[Add rows for all additional demonstration reporting quarters]

[a] **SUD demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SUD reporting schedule tab" should align with the first day of a month. If a state's SUD demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SUD reporting schedule" tab. Please see Appendix A for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each demonstration year and quarter. However, states are not expected to begin reporting any metrics data until after monitoring protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its SUD monitoring protocol. Definitions for certain rows are provided below the table. The Performance Metrics Database and Analytics (PMDA) system will populate some rows of the table. The state should complete the rest of the table. The state can revise the demonstration goals and objectives if needed. PMDA will use this information to populate part of the title page of the state's monitoring reports.

State	Utah
Demonstration name	Utah Medicaid Reform 1115 Demonstration
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 07/01/2022 *End Date:* 06/30/2027
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 07/01/2022
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 11/09/2017
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* The SUD demonstration goals and objectives are to provide a broad continuum of care to Utah's Medicaid beneficiaries who have a SUD, which will improve the quality, care and health outcomes for all Utah Medicaid state plan beneficiaries and Targeted Adults in the demonstration. The SUD program will contribute to a comprehensive statewide strategy to combat prescription drug abuse and opioid use disorders, and will expand the SUD benefits package to cover short-term residential services to all Medicaid enrollees.

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook (which can be accessed via PMDA – see Monitoring Protocol Instructions for more details) and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first SUD demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☐ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☒ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

Not applicable; monitoring protocol applies to a demonstration extension period

Serious Mental Illness and Serious Emotional Disturbance (SMI/SED)

Note: PRA Disclosure Statement to be added here

The SMI/SED monitoring protocol workbook (part A) is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned metrics (Version 2.0)

State: Utah

Demonstration Name: Utah Medicaid Reform 1115 Demonstration

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY–MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definitions, codes, target population, etc.)[a]	State plans to phase in reporting (Y/N)	SMI/SED monitoring report in which metric will be phased in (Format DY#QN; e.g., DY3Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 20 (Do not delete or edit this row)	*EXAMPLE: Beneficiaries With SMI/SED Treated in an IMD for Mental Health*	*EXAMPLE: Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year*	*EXAMPLE: Milestone 3*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other annual metrics*	*EXAMPLE: Claims*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Required*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020-12/31/2020*	*EXAMPLE: Increase*	*EXAMPLE: Consistent*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY3Q1*	*EXAMPLE: The demonstration site will be updating its EHR during the start of the demonstration. We plan to phase in reporting after the system update has been completed by mid to late 2021 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings	Two rates will be reported for this measure: 1. SUB-2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay 2. SUB-2a: Patients who received the brief intervention durine the hospital stay	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
4	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020-12/31/2021	Increase	Increase	Y		N		
7	Follow-up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • Percentage of discharges for which the child received follow-up within 30 days after discharge • Percentage of discharges for which the child received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
8	Follow-up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Percentage of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported: • Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge • Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
9	Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
10	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Milestone 2	CMS-constructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization - Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Decrease	Decrease	Y		N		
14	Mental Health Services Utilization - Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Consistent	Consistent	Y		N		
15	Mental Health Services Utilization - Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Increase	Increase	Y		N		
16	Mental Health Services Utilization - ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Decrease	Decrease	Y		N		
17	Mental Health Services Utilization - Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Consistent	Consistent	Y		N		
18	Mental Health Services Utilization - Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period	Milestone 3	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/01/2020-06/30/2021	Increase	Increase	Y		N		
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	07/1/2021-06/30/2022	Stabilize	No more than 30 days	Y	The state requires hospitals that meet the definition of an IMD to verify they are Medicare accredited before being added to our system as an approved IMD. These hospitals are identifiedas a category of service 04-psychiatric hospital. A list of providers can be found at: https://bpnmsaas.health.utah.gov/MedicaidpolicyTables/Table_XIX_-_IMD_s_Licensed_to_Provide_Treatment_for_Serious_Mental_Illness.htm Residential treatment providers must provide verification that they are are accrediied by a nationally recognized accreditation entity before being added to our system as an approved IMD who can bill for these services. If approved, they can bill code H0017. At this time, the state has not enrolled or approved any residential treatment providers.	N		
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among short-term stays (less than or equal to 60 days) • ALOS among long-term stays (greater than 60 days)	Milestone 3	CMS-constructed	Other annual metrics	Claims State-specific IMD database	Year	Annually	Required	Y	07/1/2020-06/30/2021	Stabilize	No more than 30 days	Y	The state requires hospitals that meet the definition of an IMD to verify they are Medicare accredited before being added to our system as an approved IMD. These hospitals are identifiedas a category of service 04-psychiatric hospital. A list of providers can be found at: https://bpnmsaas.health.utah.gov/MedicaidpolicyTables/Table_XIX_-_IMD_s_Licensed_to_Provide_Treatment_for_Serious_Mental_Illness.htm Residential treatment providers must provide verification that they are are accrediied by a nationally recognized accreditation entity before being added to our system as an approved IMD who can bill for these services. If approved, they can bill code H0017. At this time, the state has not enrolled or approved any residential treatment providers.	N		
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a claim for inpatient or residential treatment for mental health in an IMD during the reporting year	Milestone 3	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Increase	Increase	Y	The state requires hospitals that meet the definition of an IMD to verify they are Medicare accredited before being added to our system as an approved IMD. These hospitals are identifiedas a category of service 04-psychiatric hospital. A list of providers can be found at: https://bpnmsaas.health.utah.gov/MedicaidpolicyTables/Table_XIX_-_IMD_s_Licensed_to_Provide_Treatment_for_Serious_Mental_Illness.htm Residential treatment providers must provide verification that they are are accrediied by a nationally recognized accreditation entity before being added to our system as an approved IMD who can bill for these services. If approved, they can bill code H0017. At this time, the state has not enrolled or approved any residential treatment providers.	N		
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period	Milestone 4	CMS-constructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	07/1/2020-06/30/2021	Increase	Increase	Y		N		
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period	Milestone 4	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Increase	Increase	Y		N		
23	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) in poor control (> 9.0%)	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	N	CMS proposes the state use the Adult Core Set measure Comprehensive Diabetes Car: Hemoglobin A1c (HbA1c) Poor Control (<9.0%) – HPC-AD. However, this metric requires the use of CPT Category II codes to determine numberator compliance, which the state does not use. The state would like to propose the following alternate metric: Adult Core Set Measure SSD-DR (NCQA): Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications: Percentage of beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.	Y	DY2Q2	
24	Screening for Depression and Follow-up Plan: Age 18 and Older (CDF-AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N								
25	Screening for Depression and Follow-up Plan: Ages 12 to 17 (CDF-CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N								
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on antipsychotics who received blood glucose testing •Percentage of children and adolescents on antipsychotics who received cholesterol testing •Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
30	Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries who meet the following criteria: •age 18 years and older, and •completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2021-12/31/2021	Increase	Increase	Y		N		
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Decrease	Decrease	Y	The state uses the "MCO Paid Amount" in the encounter claim to identify amounts paid by Medicaid. The state uses FFS reimbursement amounts to identify amounts paid for FFS members.	N		

#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual or other considerations (different data source, definition, cycles, target population, etc.)	State plans to phase in reporting (Y/N)	SMI/SED monitoring report in which metric will be phased in (Format DYnQn; e.g. DY1Q3)	Explanation of any plans to phase in reporting over time
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Increase	Increase	Y	The state uses the "MCO Paid Amount" in the encounter claim to identify amounts paid by Medicaid. The state uses FFS reimbursement amounts to identify amounts paid for FFS members.	N		
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Not Inpatient or Residential	Per capita costs for non-inpatient, non-residential services for mental health, among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Decrease	Decrease	Y		N		
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED - Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/1/2020-06/30/2021	Consistent	Consistent	Y		N		
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021-12/31/2021	Consistent	Consistent	Y		N		
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED	Other SMI/SED metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2021-12/31/2021	Decrease	Decrease	Y		N		
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/01/2020-06/30/2021	Increase	Increase	Y	The state uses the "MCO Paid Amount" in the encounter claim to identify amounts paid by Medicaid. The state uses FFS reimbursement amounts to identify amounts paid for FFS members. To bill for IMD services, the state requires hospitals that meet the definition of an IMD to verify they are Medicare accredited before being added to our system as an approved IMD. These hospitals are identifiedas a category of service 04-psychiatric hospital. Residential treatment providers must provide verification that they are are accredited by a nationally recognized accreditation entity before being added to our system as an approved IMD who can bill for these services. If approved, they can bill code H0017. At this time, the state has not enrolled or approved any residential treatment providers.	N		
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year	Other SMI/SED metrics	CMS-constructed	Other annual metrics	Claims	Year	Annually	Required	Y	07/01/2020-06/30/2021	Decrease	Decrease	Y	The state requires hospitals that meet the definition of an IMD to verify they are Medicare accredited before being added to our system as an approved IMD. These hospitals are identifiedas a category of service 04-psychiatric hospital. A list of providers can be found at: https://hspnmanals.health.utah.gov/MedicaidpolicyTables/Table_XIX_-IMD_e_Licensed_to_Provide_Treatment_for_Serious_Mental_Illness.htm Residential treatment providers must provide verification that they are are accredited by a nationally recognized accreditation entity before being added to our system as an approved IMD who can bill for these services. If approved, they can bill code H0017. At this time, the state has not enrolled or approved any residential treatment providers.	N		
Q1	*Inpatient Psychiatric Facilities Connected to HIE*	Number of inpatient psychiatric facilities who have connected to the HIE	Health IT	State-specific	Other annual metrics	HIE Records	Year	Annually	Required	Y	07/01/2020-06/30/2022	Increase	Increase			N		
Q2	*Access to additional services using provider/resource directory - connecting primary care to mental health service offerings*	Number of providers managed in provider directory	Health IT	State-specific	Other annual metrics	Prepaid Mental Health Plans and Utah Medicaid Integrated Care Plans	Year	Annually	Required	Y	07/01/2020-06/30/2021	Increase	Increase			N		
Q3	*Individuals Connected to Community-Based Resources*	Number of requests for community based resources fulfilled using statewide resource e-directory. Requests for resources are submitted via phone calls and online requests through the 211 website. Call centers provide aggregated data about the calls to 2-1-1 Counts, which systematically tracks and summarizes callers' needs. Data can be accessed on the 211 website.	Health IT	State-specific	Other annual metrics	211- United Way	Year	Annually	Required	Y	07/01/2020-06/30/2021	Increase	Increase			N		
State-specific metrics																		
[Insert row(s) for any additional state-specific metrics by right-clicking on row 30 and selecting "Insert"]																		

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED definitions (Version 3.0)

State Utah

Demonstration Name Utah Medicaid Reform 1115 Demonstration

Table: Serious Mental Illness and Serious Emotional Disturbance Definitions

Narrative description of the SMI/SED demonstration population		
Adults age 21-64 with serious mental illness receiving inpatient psychiatric services in an Institution of Mental Disease.		
	Serious Mental Illness (SMI)	**Serious Emotional Disturbance (SED)**
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*The population is defined as age 21-64 years old, who have a diagnosis defined in row 10 below; and; receive at least one acute inpatient claim or encounter with a primary diagnosis within the identified range below; or at least one H0017 claim or encounter defined in row 11 below with a primary diagnosis within the identified range below.*	*N/A. Children under 21 are not included in this demostration.*
Codes used to identify population[b] *States may use ICD-10 diagnosis codes or state-specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD-10 codes with state-specific codes.*	*Major Depressive Disorder: F33-F33.9* *Bipolar Disorder: F30-F31* *Psychotic Disorder: F20-F29*	*N/A. Children under 21 are not included in this demostration.*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state-specific codes) used to identify/define service requirements.*	*The state will designate providers using NPIs and designated enrollment categories for psychiatric facilities that will provide inpatient treatment. Code H0017 will be used to identify individuals receiving mental health services in residential settings.*	*N/A. Children under 21 are not included in this demostration.*

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 3.0)

State: Utah

Demonstration Name: Utah Medicaid Reform 1115 Demonstration

Table: Serious Mental Illness and Serious Emotional Disturbance Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format comma separated)[a,b,c]	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: Age group ***(Do not delete or edit this row)***	*EXAMPLE: Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE: Required*	*EXAMPLE: Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE: CMS-provided*	*EXAMPLE: Y*	*EXAMPLE: N*	*EXAMPLE: Children/Young adults (ages 12-20), Adults (ages 21-65)*	*EXAMPLE: N*	*EXAMPLE: 11, 12, 13, 14*
Standardized definition of SMI[d]	Individuals who meet the standardized definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y			Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	Y			Y	
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y	The state uses category of aid (COA) beginning with a 'Q' from its system, to identify individuals who are dual-eligible. If the	Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
State-specific subpopulations									
[Insert row(s) for any state-specific subpopulation(s)][e]									

[a] If the state is not reporting a required subpopulation category (i.e., column F = "N"), enter explanation in corresponding row in column H.

[b] If the state is reporting on the Dual-eligible status subpopulation category, the state should use column H to outline its subpopulation identification approach as explained in Version 4.0 of the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations Monitoring Protocol Instructions.

[c] If the state is planning to phase in the reporting of any of the subpopulation categories, the state should (1) select N in column G and (2) provide an explanation and the report (SMI/SED DY and Q) in which it will begin reporting the subpopulation category in column H.

[d] "Standardized definition of SMI" and "State-specific definition of SMI" are included within the list of subpopulation categories because the state should report on these populations separately from the "Demonstration reporting" calculation for certain metrics. The state should reference Version 4.0 of the Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations: Technical Specifications for Monitoring Metrics for detailed descriptions on calculating metrics according to the standardized and state-specific definitions of SMI.

[e] Any state that claims federal financial participation (FFP) for services provided in Qualified Residential Treatment Programs (QRTPs) that are IMDs should add QRTPs that are IMDs as a state-specific subpopulation in row 19. Specifically, the state should note "QRTPs that are IMDs" in column A, "Individuals treated within QRTPs that are IMDs" in column B, and "Metrics #19a and 19b" in column D.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Reporting schedule (Version 3.0)

State: Utah

Demonstration Name: Utah Medicaid Reform 1115 Demonstration

Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All monitoring report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SMI/SED demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column F, select Y or N in column H, "Deviations from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e. column H= "Y"), the state should describe these deviations in column I, "Explanation for deviations (if column H="Y")" and use column J, "Proposed deviation in measurement period from standard reporting schedule in column G," to indicate the SMI/SED measurement periods with which it wishes to overwrite the standard schedule (column G). All other columns are locked for editing and should not be altered by the state.

Table 1. Serious Mental Illness and Serious Emotional Disturbance Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED demonstration year:	
Start date	07/01/2022
End date	06/30/2023
Dates of first quarter of the baseline period for CMS-constructed metrics:	
(SMI/SED DY and Q) (Format DY#Q#; e.g., DY1Q1)	DY3Q1
Start date	07/01/2022
End date	09/30/2022
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no broader demonstration, fill in the first SMI/SED reporting period. (Format DY#Q#; e.g., DY3Q1)	DY21Q1
First SMI/SED monitoring report due date (per STCs) (MM/DD/YYYY)	11/29/2022
First SMI/SED monitoring report in which the state plans to report annual metrics that are established quality measures (EQMs):	
EQMs (Format CY#; e.g.,	CY2022
SMI/SED DY and Q associated with monitoring report (Format DY#Q#; e.g., DY1Q1)	DY4Q1
SMI/SED DY and Q start date	07/01/2023
SMI/SED DY and Q end date	09/30/2023
Dates of last SMI/SED reporting quarter:	
Start date	04/01/2027
End date	06/30/2027

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
07/01/2022	09/30/2022	11/29/2022	DY21Q1	DY3Q1	Narrative information	DY3Q1	N		
					Grievances and appeals	DY3Q1	N		
					Other monthly and quarterly metrics		N		
					Annual availability assessment		N		
					Annual metrics that are established quality measures		Y	Utah will report EQMs in Quarter 1 Monitoring Reports.	CY2021
					Other annual metrics		Y	Reporting to continue per previous demonstration reporting schedule.	DY2
10/01/2022	12/31/2022	03/01/2023	DY21Q2	DY3Q2	Narrative information	DY3Q2	N		
					Grievances and appeals	DY3Q2	N		
					Other monthly and quarterly metrics	DY3Q1	N		
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
01/01/2023	03/31/2023	05/30/2023	DY21Q3	DY3Q3	Narrative information	DY3Q3	N		
					Grievances and appeals	DY3Q3	N		
					Other monthly and quarterly metrics	DY3Q2	Y	State has an approved two-quarter lag to allow for claims run-out. State will pause reporting for this quarter and continue reporting other monthly and quarterly metrics in its DY3Q4 monitoring report.	n.a. - not reporting in this reporting quarter
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2023	06/30/2023	09/28/2023	DY21Q4	DY3Q4	Narrative information	DY3Q4	N		
					Grievances and appeals	DY3Q4	N		
					Other monthly and quarterly metrics	DY3Q3	Y	State has an approved two-quarter lag to allow for claims run-out	DY3Q2
					Annual availability assessment	AA3	N		
					Annual metrics that are established quality measures		N		

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
					Other annual metrics		N		
07/01/2023	09/30/2023	11/29/2023	DY22Q1	DY4Q1	Narrative information	DY4Q1	N		
					Grievances and appeals	DY4Q1	N		
					Other monthly and quarterly metrics	DY3Q4	Y	State has an approved two-quarter lag to allow for claims run-out	DY3Q3
					Annual availability assessment		N		
					Annual metrics that are established quality measures	CY2022	N		
					Other annual metrics	DY3	Y		n.a. - not reporting in this reporting quarter
10/01/2023	12/31/2023	02/29/2024	DY22Q2	DY4Q2	Narrative information	DY4Q2	N		
					Grievances and appeals	DY4Q2	N		
					Other monthly and quarterly metrics	DY4Q1	Y	State has an approved two-quarter lag to allow for claims run-out	DY3Q4
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY3

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2024	03/31/2024	05/30/2024	DY22Q3	DY4Q3	Narrative information	DY4Q3	N		
					Grievances and appeals	DY4Q3	N		
					Other monthly and quarterly metrics	DY4Q2	Y	State has an approved two-quarter lag to allow for claims run-out	DY4Q1
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2024	06/30/2024	09/28/2024	DY22Q4	DY4Q4	Narrative information	DY4Q4	N		
					Grievances and appeals	DY4Q4	N		
					Other monthly and quarterly metrics	DY4Q3	Y	State has an approved two-quarter lag to allow for claims run-out	DY4Q2
					Annual availability assessment	AA4	N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2024	09/30/2024	11/29/2024	DY23Q1	DY5Q1	Narrative information	DY5Q1	N		
					Grievances and appeals	DY5Q1	N		
					Other monthly and quarterly metrics	DY4Q4	Y	State has an approved two-quarter lag to allow for claims run-out	DY4Q3
					Annual availability assessment		N		
					Annual metrics that are established quality measures	CY2023	N		
					Other annual metrics	DY4	Y		n.a. - not reporting in this reporting quarter
10/01/2024	12/31/2024	03/01/2025	DY23Q2	DY5Q2	Narrative information	DY5Q2	N		
					Grievances and appeals	DY5Q2	N		
					Other monthly and quarterly metrics	DY5Q1	Y	State has an approved two-quarter lag to allow for claims run-out	DY4Q4
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY4

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
01/01/2025	03/31/2025	05/30/2025	DY23Q3	DY5Q3	Narrative information	DY5Q3	N		
					Grievances and appeals	DY5Q3	N		
					Other monthly and quarterly metrics	DY5Q2	Y	State has an approved two-quarter lag to allow for claims run-out	DY5Q1
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
04/01/2025	06/30/2025	09/28/2025	DY23Q4	DY5Q4	Narrative information	DY5Q4	N		
					Grievances and appeals	DY5Q4	N		
					Other monthly and quarterly metrics	DY5Q3	Y	State has an approved two-quarter lag to allow for claims run-out	DY5Q2
					Annual availability assessment	AA5	N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2025	09/30/2025	11/29/2025	DY24Q1	DY6Q1	Narrative information	DY6Q1	N		
					Grievances and appeals	DY6Q1	N		
					Other monthly and quarterly metrics	DY5Q4	Y	State has an approved two-quarter lag to allow for claims run-out	DY5Q3
					Annual availability assessment		N		
					Annual metrics that are established quality measures	CY2024	N		
					Other annual metrics	DY5	Y		n.a. - not reporting in this reporting quarter
10/01/2025	12/31/2025	03/01/2026	DY24Q2	DY6Q2	Narrative information	DY6Q2	N		
					Grievances and appeals	DY6Q2	N		
					Other monthly and quarterly metrics	DY6Q1	Y	State has an approved two-quarter lag to allow for claims run-out	DY5Q4
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY5
01/01/2026	03/31/2026	05/30/2026	DY24Q3	DY6Q3	Narrative information	DY6Q3	N		
					Grievances and appeals	DY6Q3	N		
					Other monthly and quarterly metrics	DY6Q2	Y	State has an approved two-quarter lag to allow for claims run-out	DY6Q1
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
04/01/2026	06/30/2026	09/28/2026	DY24Q4	DY6Q4	Narrative information	DY6Q4	N		
					Grievances and appeals	DY6Q4	N		
					Other monthly and quarterly metrics	DY6Q3	Y	State has an approved two-quarter lag to allow for claims run-out	DY6Q2
					Annual availability assessment	AA6	N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
07/01/2026	09/30/2026	11/29/2026	DY25Q1	DY7Q1	Narrative information	DY7Q1	N		
					Grievances and appeals	DY7Q1	N		
					Other monthly and quarterly metrics	DY6Q4	Y	State has an approved two-quarter lag to allow for claims run-out	DY6Q3
					Annual availability assessment		N		
					Annual metrics that are established quality measures	CY2025	N		
					Other annual metrics	DY6	Y		n.a. - not reporting in this reporting quarter
10/01/2026	12/31/2026	03/01/2027	DY25Q2	DY7Q2	Narrative information	DY7Q2	N		
					Grievances and appeals	DY7Q2	N		
					Other monthly and quarterly metrics	DY7Q1	Y	State has an approved two-quarter lag to allow for claims run-out	DY6Q4
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		Y	State has an approved lag for CMS-constructed annual metrics to allow for claims run-out and will report in Quarter 2 instead of Quarter 1.	DY6
01/01/2027	03/31/2027	05/30/2027	DY25Q3	DY7Q3	Narrative information	DY7Q3	N		
					Grievances and appeals	DY7Q3	N		
					Other monthly and quarterly metrics	DY7Q2	Y	State has an approved two-quarter lag to allow for claims run-out	DY7Q1
					Annual availability assessment		N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		

Table 2. Serious Mental Illness and Serious Emotional Disturbance Demonstration Reporting Schedule

SMI/SED reporting quarter start date (MM/DD/YYYY)	SMI/SED reporting quarter end date (MM/DD/YYYY)	Monitoring report due (per STCs) (MM/DD/YYYY)	Broader section 1115 reporting period, if applicable; else SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	SMI/SED reporting period (Format DY#Q#; e.g., DY1Q3)	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format DY#Q#; e.g., DY1Q3)[b] SMI/SED	Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column H="Y")	Proposed deviation in measurement period from standard reporting schedule in column G (Format DY#Q#; e.g., DY1Q3)
04/01/2027	06/30/2027	09/28/2027	DY25Q4	DY7Q4	Narrative information	DY7Q4	N		
					Grievances and appeals	DY7Q4	N		
					Other monthly and quarterly metrics	DY7Q3	Y	State has an approved two-quarter lag to allow for claims run-out	DY7Q2
					Annual availability assessment	AA7	N		
					Annual metrics that are established quality measures		N		
					Other annual metrics		N		
[Add rows for all additional demonstration reporting quarters]									

[a] **SMI/SED demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration. To generate an accurate reporting schedule, the start date as listed in Table 1 of the "SMI/SED reporting schedule" tab should align with the first day of a month. If a state's SMI/SED demonstration begins on any day other than the first day of the month, the state should list its start date as the first day of the month in which the effective date occurs. For example, if a state's effective date is listed as January 15, 2020, the state should indicate "01/01/2020" as the start date in Table 1 of the "SMI-SED reporting schedule" tab. Please see Appendix A of the Monitoring Protocol Instructions for more information on determining demonstration quarter timing.

[b] The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each SMI/SED demonstration year and quarter. However, the state is not expected to begin reporting any metrics data until after protocol approval. The state should see Section B of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

AA# refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED DY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's annual monitoring report for SMI/SED DY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved monitoring protocol. If the state cannot submit its Annual Availability Assessments when it submits its annual monitoring reports, it should propose and describe a reporting deviation in Columns G and H.

Utah Medicaid Reform 1115 Demonstration: Evaluation Design Document

Report prepared by the Public Consulting Group

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Project Nos. 11-W-00145/8 and 21-W-00054/8

PUBLIC CONSULTING GROUP

TABLE OF CONTENTS

A. General Background Information

1. Demonstration Name and Timing

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration". The PCN Demonstration existed in the state for two decades and provided medical programs and benefits that were not otherwise allowable under federal rules.

The current extension is entitled "Medicaid Reform 1115 Demonstration (MRD)" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the MRD, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of adult Medicaid expansion.

2. Demonstration Goals

The Medicaid Reform 1115 Demonstration (hereafter, "the Demonstration" or "the 1115 Demonstration") expands coverage for populations not traditionally eligible for Medicaid through direct coverage or premium subsidies. By providing access to preventive care and enhanced services to vulnerable populations, the Demonstration aims to improve health outcomes and to reduce cost of care.

DHHS outlined the following goals in their Demonstration application:

1. Provide health care coverage for low-income Utahns eligible under the Demonstration who would not otherwise have access to, or be able to afford, health care coverage;
2. Improve beneficiary health outcomes and quality of life;
3. Lower the uninsured rate of low income Utahns;
4. Provide continuity of coverage for individuals eligible under the Demonstration;
5. Increase access to primary care;
6. Reduce uncompensated care provided by Utah hospitals;
7. Reduce barriers to health care and housing, an important social determinant of health;
8. Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
9. Improve access to services across the continuum of care;
10. Provide for better care coordination for individuals transitioning to community-based care;
11. Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
12. Reduce the overdose death rate; and
13. Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders

With the addition of the Substance Use Disorder (SUD) and Serious Mental Illness (SMI) Institution for Mental Diseases (IMD) amendment approvals, the state has expanded its objectives to include the following for individuals with SUD and/or SMI:

1. Improve access to services across the continuum of care;
2. Provide for better care coordination for individuals transitioning to community-based care;

3. Reduce the utilization of emergency departments and inpatient hospital settings for treatment, where utilization is preventable or medically inappropriate;
4. Reduce the overdose death rate; and
5. Improve access to care for physical health conditions for these individuals.

3. DESCRIPTION

Utah's 1115 Demonstration was first implemented in 2002 and has transformed over the last twenty years through extensions and amendments that have added new authorities and Demonstration populations.

The original PCN Demonstration focused on providing a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit has been phased out. The Current Eligible population will phase out in this Demonstration period (by December 31, 2023), eliminating disparities in benefit packages by parental status, and most relics of the original waiver.

The 1115 Demonstration has historically served as a vehicle to provide premium assistance to adults with household incomes above Medicaid eligibility requirements. In 2006, the Utah Department of Health (and Human Services DHHS) amended the 1115 Demonstration to establish the Health Insurance Flexibility and Accountability Employer Sponsored Insurance (HIFA-ESI) program, which provides premium assistance to adults with household incomes up to and including 150 percent of the FPL and CHIP-eligible children with family incomes up to 200 percent of the FPL. This was later amended to include adults with incomes up to 200 percent of the FPL and programmatically eligible adults and children obtaining coverage through COBRA[1]. Under the current 1115 Demonstration, premium assistance helps pay the individual's or family's share of monthly premium costs of ESI or COBRA and is aggregated under Utah's Premium Partnership for Health Insurance Program (UPP). Individuals in the Adult Expansion population with access to employer-sponsored insurance are required to enroll, with few exceptions. The state also increased the maximum assistance reimbursement amount in July 2021 making this program more substantial and potentially increasing the number of individuals covered by UPP. In February 2024, CMS approved an increase in the premium subsidy for children that would otherwise receive CHIP services under the state plan from $120 to $180. If a plan offers dental coverage, the premium subsidy amount will increase from $140 to $200.

In recent years, Utah's Demonstration has emphasized improving the behavioral health (BH) continuum of care. In November 2017, during the previous waiver period, the state received approval to provide Demonstration coverage to the Targeted Adult Medicaid (TAM) population. The TAM population consists of vulnerable adults ages 19-64, whose incomes are at or below 5 percent of the FPL, and who meet the detailed eligibility criteria within one of three targeted categories: chronically homeless, involved in the justice system and in need of BH treatment, or simply are in need of BH treatment. As of June 2022, enrollment in TAM was 9,384 individuals.

In March 2022, CMS approved the Housing Related Services and Supports (HRSS) amendment, allowing Utah to provide housing support services, such as tenancy supports, community transition services, and supportive living services to TAM individuals who meet additional eligibility criteria and exhibit one of seven risk factors. In an amendment approved in February 2024, an additional four risk factors were added to the HRSS program eligibility criteria to align eligibility with the sub-groups of the Targeted Adult group. The HRSS are paid on a fee-for-service basis. Providers are required to enroll and are evaluated to ensure they meet HRSS qualifications which includes being a certified case management provider. Once care plans

[1] Consolidated Omnibus Reconciliation Act of 1986

have been approved, providers can submit claims for HRSS and receive reimbursement. As the program ramps up in the current waiver period, the state anticipates that HRSS will serve approximately 5000 individuals each year. By addressing crucial health related social needs in a high-needs population, the state hopes that the HRSS program will improve participant health outcomes or quality of life and reduce non-housing related Medicaid costs.

The 1115 Demonstration also includes components that focus on individuals with SUD and/or SMI, and youth with significant emotional disorder (SED) and/or behavioral challenges. Utah received approval of the SUD Implementation plan in November 2017. The Opioid Use Disorder (OUD) and SUD Program provides state plan behavioral health benefits to Demonstration participants. The state also received authority to provide residential and inpatient OUD/SUD treatment services to all Medicaid beneficiaries while they are short term residents in treatment settings that qualify as IMDs.

The SMI/SED Implementation plan was approved in December 2020, and is similar in expenditure authority to the OUD/SUD program. The state is taking action to meet key milestones of the SMI/SED program including, ensuring quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to community-based care, increasing access to the continuum of care including crisis stabilization services, and earlier identification and engagement in treatment and increased integration. Together, the SUD and SMI components expand access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services. The 1115 Demonstration supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including crisis stabilization services.

In February 2019, Utah received CMS approval to provide state plan Medicaid coverage to Former Foster Care Youth from another state (FFCYAS) who were ever enrolled in Medicaid in another state and are not otherwise Medicaid eligible in Utah. State plan coverage is provided to this population until 26 years of age.

In November 2019, Utah received CMS approval for the provision of intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS program provides both state plan BH services and home and community-based services (HCBS) that are not currently authorized through the state plan.

Other benefits under the current 1115 Demonstration include dental coverage for vulnerable populations and premium assistance for individuals with access to employer-sponsored insurance. The PCN Demonstration first provided an adult dental benefit to the Current Eligibles population in November 2006. CMS approved dental benefits for adults with disabilities or blindness in 2017. In 2019, the state chose to provide comprehensive dental benefits to TAM adults receiving SUD treatment because research showed that dental coverage could increase initiation and engagement in treatment for individuals living with SUD. Finally, in 2020 dental benefits were extended to Medicaid eligible individuals aged 65 and older and to TAM adults in need of porcelain or porcelain-to-metal crowns.

In February 2024, CMS approved an amendment to the current 1115 Demonstration enabling the state to receive expenditure authority for fertility preservation services provided to certain individuals diagnosed with cancer, as well as for in vitro fertilization (IVF) and genetic testing services for certain individuals. Under the IVF and genetic testing amendment, the state may provide genetic testing services to eligible individuals, preimplantation genetic testing of embryos, and IVF services to eligible individuals, ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy. Under the fertility treatment for individuals diagnosed with cancer amendment, the state is now enabled to provide fertility preservation for eligible individuals diagnosed with cancer and requiring treatment that may cause a substantial risk of

sterility or iatrogenic infertility (i.e., infertility caused by treatment for cancer). Services covered under this once per lifetime benefit include the collection and storage of eggs or sperm and coverage for cryopreservation storage. Coverage for cryopreservation storage is covered as a single payment in five-year increments.

Larger populations covered in the current 1115 Demonstration period are the Adult Expansion (AE) population, consisting of adults 19-64 with incomes up to 133 percent of the FPL, and the AE members enrolled in integrated care plans authorized under the Utah Medicaid Integrated Care (UMIC) amendment. The UMIC members are a sub-group of the AE population. These, and the smaller Demonstration populations listed in Table 1, are the subject of the current evaluation. The independent evaluator (IE) will include research questions and hypotheses and measures for each of these populations in this design.

4. POPULATIONS

Table 1 provides a summary of the populations covered during the Demonstration period subject to the current evaluation. The Demonstration also authorized the Clinically Managed Residential Withdrawal Pilot from May 1, 2019, to April 1, 2021; this benefit became available statewide as of April 1, 2021 to all eligible Medicaid members. As a result, the State received approval on July 23, 2021, to remove this pilot project from the 1115 Demonstration and CMS is not requiring the State to evaluate this population. Additionally, the Current Eligibles population will phase out entirely by the end of 2023 and thus is not a focus of the current evaluation.

Table 1: Summary of Demonstration Populations Under Evaluation

Demonstration Population	Eligibility[2]	Benefits[2]	Estimated Number of Annual Enrollees[3]
Adult Expansion (AE)	Adults, age 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL.	Expansion adults will receive state plan benefits. Expansion adults also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services (mental health services in residential treatment settings).	115,584
Utah Medicaid Integrated Care (UMIC- subset of Adult Expansion Population)	Adult Expansion members enrolled in the Utah Medicaid Integrated Care program, which operates in Utah's most populous counties: Davis, Salt Lake, Utah, Washington, and Weber.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services.	82,110
Utah Premium Partnership Program (UPP)	**Demonstration Population III**- includes working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes up to and including 200 percent of the FPL and participate in Utah's Premium Partnership for Health Insurance (UPP). **Demonstration Population V-** includes adults aged 19 through 64 with countable gross family income up to and including 200 percent of FPL, and the individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage.	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	1,288

[2] ut-cms-amndmnt-aprvl.pdf (medicaid.gov)

[3] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments are taken from the state's amendment applications to CMS.

Demonstration Population	Eligibility[2]	Benefits[2]	Estimated Number of Annual Enrollees[3]
	Current Eligible CHIP Children- includes children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. **Demonstration Population VI**-includes children up to age 19 with family income up to 200 percent of the FPL who would meet the definition of a low-income child.		
Targeted Adult Medicaid (TAM)	Includes adults, ages 19 through 64, with incomes below five percent of the FPL and no dependent children, who meet detailed criteria in one of three major categories: ● Chronic homelessness ● Involved in the criminal justice system and in need of BH treatment. ● In need of BH treatment	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	9,384
TAM members receiving Housing Related Services and Supports (HRSS)	TAM members meeting the needs-based criteria and at least one of the following risk factors: ● Living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously; ● Currently living in supportive housing, but has previously met the definition of chronically homeless; ● Successfully completed a substance use disorder treatment program while incarcerated;	Individuals enrolled in TAM who meet HRSS eligibility criteria receive full Medicaid state plan benefits, plus tenancy support services, community transition services, and supportive living services.	5,000

Demonstration Population	Eligibility[2]	Benefits[2]	Estimated Number of Annual Enrollees[3]
	• Admitted to (and discharged from) the Utah State Hospital due to an alleged criminal offense; • Involved in drug court or mental health court, including tribal court; • Receives general assistance from the Utah Department of Workforce Services and has a substance use or mental health disorder diagnosis; • Civilly committed to (and discharged from) the State Hospital. • Is 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; • 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; • Currently on probation or parole with a serious mental illness or substance use disorder; and • Court ordered to receive substance use or mental health treatment through a district or tribal court.		
Aged, Blind, Disabled	**Dental Benefits for Aged Individuals**- includes individuals who are age 65 and older, and are eligible for Medicaid, who are eligible to enroll in the state plan under Section 1902(a)(10)(C) of the Act and 42	Individuals that are enrolled in this eligibility category will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual,	Blind/ Disabled

Demonstration Population	Eligibility[2]	Benefits[2]	Estimated Number of Annual Enrollees[3]
Dental (ABD Dental)	CFR 435.320 and 435.330. They receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns. **Dental Benefits for Individuals with Blindness or Disabilities**- includes individuals who are blind or disabled, 18 and older, who are enrolled in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.322, 435.324 and 435.330. They receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	Dental 45,306 Aged Dental 398
TAM Dental	Individuals who are eligible for the Targeted Adult Medicaid program and are receiving SUD treatment, to receive state plan dental benefits, as well as porcelain or porcelain-to metal crowns.	Individuals enrolled in TAM who are receiving SUD treatment will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	262
Serious Mental Illness (SMI) IMD	Medicaid recipients, age 21 through 64 receiving SMI services in IMD treatment settings.	Individuals will receive state plan services, including mental health treatment services provided in residential and inpatient treatment settings that qualify as an IMD.	8
Substance Use Disorder (SUD) IMD	Medicaid recipients, receiving OUD/SUD treatment services provided in a residential or IMD treatment setting.	Individuals will receive state plan services, including SUD treatment services provided in residential treatment settings that qualify as an IMD.	767
Intensive Stabilizations Services (ISS)	Medicaid eligible children and youth under age 21, who are in state custody, or at risk of state custody, and experiencing significant emotional and/or behavioral challenges.	Individuals eligible for this category will receive state plan and home community-based services.	Anticipate 20

Demonstration Population	Eligibility[2]	Benefits[2]	Estimated Number of Annual Enrollees[3]
Former Foster Care Youth from Another State (FFCYAS)	Individuals under age 26, who were in foster care under the responsibility of a state other than Utah, or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.	Individuals will receive state plan services.	17
In Vitro Fertilization and Genetic Testing	IVF: Medicaid recipients ages 18-35 diagnosed by a physician or qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition. Has been diagnosed by a physician or qualified health professional as having a genetic trait associated with myotonic dystrophy. Genetic testing: Medicaid recipients who have a familial medical history or are in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.	In vitro fertilization services, genetic testing services, and preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus.	50
Fertility Treatment for Individuals Diagnosed with Cancer	Medicaid recipients diagnosed by a physician or qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility. Post pubertal and under age 40.	Individuals can receive egg and sperm collection and storage, preimplantation genetic testing prior to cryopreservation storage, cryopreservation storage. These benefits are available once per lifetime.	226

5. CONTEXT

This Demonstration occurs in the years following the implementation of Medicaid Expansion, as Utah Medicaid continues its progression to managed care, and continues efforts to strengthen and integrate the behavioral health care continuum. In December 2019, Utah received authority to move a subset of their plans into integrated care models. The Utah Medicaid Integrated Care (UMIC) plan amendment enrolled beneficiaries in four new Integrated Managed Care Plans that manage both physical and behavioral health benefits for the Adult Expansion population. Prior to this time, Utah had separate physical health and behavioral health plans only. The intent is for the UMIC plans to provide more holistic care to the beneficiaries. Since these plans are new to Utah, outcome data is still being gathered. The Utah 1115 Waiver Demonstration Summative Report covering the previous waiver period is expected to investigate differences in quality metrics between ACO managed care plans and UMIC plans and will detail promising practices of the new integrated plans identified through qualitative interviews.

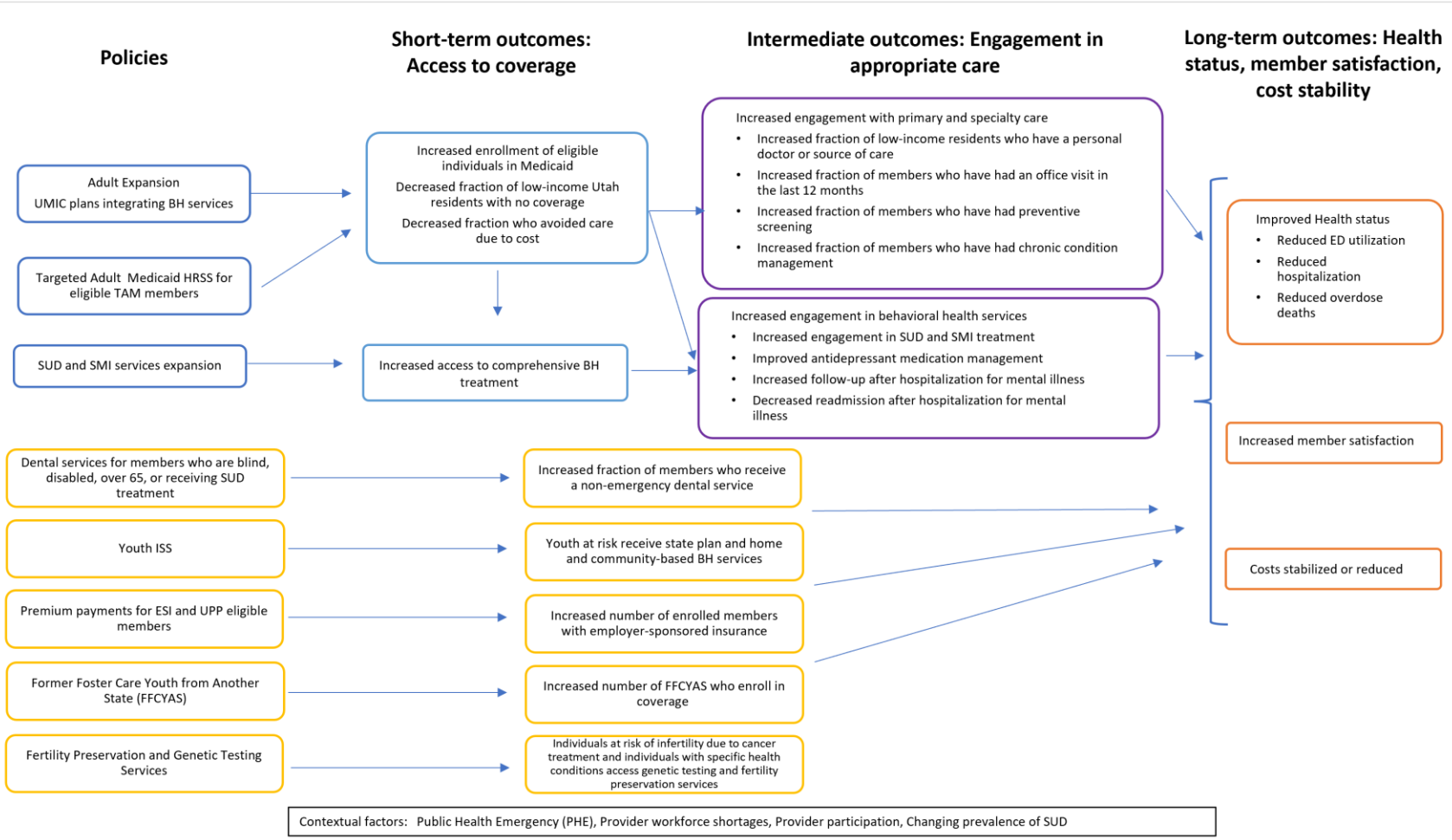
The Utah Medicaid 1115 Demonstration also coincides with the unwinding of the Medicaid Continuous Enrollment requirement associated with the Covid-19 pandemic beginning in 2020. Enrollment in Medicaid has remained high as states have been required to keep current Medicaid beneficiaries enrolled. The unwinding of continuous eligibility for Medicaid is set to begin on March 1, 2023.[4] Under Utah's unwinding plan[5], every member's case is slated for a full review, with cases spread over a 12-month period. Cases most likely to change programs or coverage are prioritized for review, and those most likely to remain Medicaid eligible deferred to later in the year. DHHS has begun communicating with providers and beneficiaries about the redetermination process. Members are urged to update their contact information and check the unwinding website[6] to learn their anticipated review date. Redetermination will likely affect enrollment numbers in the Demonstration, as some individuals move from one eligibility category to another, and individuals above income limits are transitioned off Medicaid coverage. This evaluation design includes qualitative interviews and process metrics on implementation as it will be a moderating factor that may affect Demonstration outcome.

[4] 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision | KFF
[5] https://medicaid.utah.gov/unwinding/
[6] https://jobs.utah.gov/mycase/

B. Evaluation Questions and Hypotheses

1. Logic Model

Figure 1: Medicaid Reform Demonstration Overall Logic Model



2. Hypotheses and Research Questions

The logic model above illustrates how the Demonstration objectives are expected to be achieved by program activities, following a natural progression from proximate to distal outcomes as the Demonstration goes on. Each outcome is represented by a testable hypothesis, listed below, about the impact of the Demonstration activities, and a corresponding research question. Tables 9-16 specify the measures that will be used to assess each hypothesis.

The hypotheses are organized by population, and the evaluator was focused on the broad themes of increasing health care coverage, improving health outcomes and quality of life, increasing access to primary care, reducing utilization of ED visits and inpatient utilization, and reducing the cost of uncompensated care.

The first objective of the 1115 Demonstration, providing health care coverage for low-income Utahns eligible under the Demonstration who would not otherwise have access to healthcare coverage, is achieved through enrollment in a number of the Demonstration populations, including the Adult Expansion, TAM, UPP, and ISS. Individuals in these populations would not otherwise be eligible for Medicaid without the presence of the Demonstration in Utah.[7] The first hypothesis is thus focused on the impact of the 1115 Demonstration overall on the population of low-income UT residents. A larger fraction of low-income UT residents are expected to report having access to coverage and will demonstrate engagement in healthcare through national survey data, relative to reported access and engagement in other states. Similarly, the cost of uncompensated care is expected to go down relative to comparison states, as more low-income individuals in the state gain access to Medicaid. Engagement in care is expected to improve member satisfaction and lead to reductions in inappropriate care utilizations, measured as Low Value Care.

The second hypothesis is similar to the first hypothesis, but it focuses on the Adult Expansion population, specifically. The second hypothesis is that the Demonstration will improve healthcare access and engagement for the Adult Expansion population. The state hypothesizes that providing coverage to members covered under Medicaid expansion will cause members to engage in acute care, which will subsequently lead to a reduction in inpatient care and ED utilization. The Utah Medicaid Integrated (UMIC) population, which is a subpopulation of the Adult Expansion population, enrolls members in Utah's five-most populous counties in integrated care plans that integrate care for both their physical and behavioral health needs. Thus, the UMIC research questions are specific to the outcomes produced when members gain access to behavioral health care that is managed by managed care plans. It is anticipated that UMIC will reduce ED utilization and improve engagement in BH services among UMIC members.

The third hypothesis focuses on the TAM population. TAM members are eligible for Medicaid under the Demonstration, and thus the state hypothesizes that the Demonstration will continue to improve healthcare access and engagement for this population.

The fourth hypothesis addresses the HRSS program, which is a recent addition to the Medicaid Reform 1115 Demonstration. It is anticipated that the HRSS program will reduce severity of social needs and prevalence of risk factors, increase continuity of BH treatment and improve health outcomes for eligible members. Research questions include whether the services provided under the HRSS program are being received, care manager perspectives on incorporating this new benefit, whether there is unmet need, and whether HRSS improves perceived health status. Other research questions about the HRSS program focus on how HRSS affects engagement in acute care, reducing ED utilization, and whether it has an impact on the cost of care for eligible members.

The fifth and sixth hypotheses speak to BH services provided to Demonstration participants and Medicaid beneficiaries with SMI and SUD treated in Institutions of Mental Disease (IMD). The state anticipates that

[7] Individuals in the Current Eligibles population received expanded benefits through the waiver, although they would have received coverage regardless of the presence of the waiver.

BH coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. The state also anticipates this will lessen unmet need and increase engagement in treatment to reduce overdose deaths in the long-term. The IE will monitor the impact of the state's efforts to increase access to crisis stabilization services. Greater utilization of non-hospital, non-residential services should lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.

Finally, the seventh hypothesis addresses smaller Demonstration populations, which include UPP/ESI, ISS, Blind and Disabled Dental, Aged Dental, TAM Dental, and FFCYAS. The state anticipates that utilization for the services provided to these populations will increase and total cost of care will decrease, as these members engage in acute and preventive care. Although the number of Adult Expansion members enrolled in Employer Sponsored Insurance will grow due to the new provision present in this waiver requiring enrollment in ESI for all Adult Expansion members who have access to insurance through their employers, the number of members enrolled in ESI is not projected to exceed 1,385 members during this Demonstration period. As a result, the ESI population by itself is unlikely to lead to reductions in uncompensated care and inappropriate care utilization. In addition, the number of individuals in the FFCYAS population, and the number receiving ISS, were both very small in the prior Demonstration period. Therefore, the evaluation will include counts and a qualitative summary of program implementation.

1. Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.

    - Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?
    - Primary research question 1.2: Did the cost of uncompensated care decrease relative to comparison states?
    - Primary research question 1.3: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?
    - Primary research question 1.4: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?
    - Primary research question 1.5: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?
    - Primary research question 1.6: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?
    - Primary research question 1.7: Did member satisfaction increase, relative to baseline?
    - Primary research question 1.8: Did Low Value Care decrease among Demonstration participants, relative to baseline?

2. Hypothesis 2: The Demonstration will improve healthcare access and engagement for the Adult Expansion population.

    - Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?
    - Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?
        - Subsidiary research question 2.2a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?
        - Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?

- Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?
- Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?
    - Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for the Adult Expansion population, relative to FFS or physical health-only ACO plans?
- Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?
- Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?

3. Hypothesis 3: The Demonstration will improve healthcare access and engagement for the TAM population.

    - Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?
    - Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?
        - Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?
    - Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?
    - Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?

4. Hypothesis 4: The HRSS program for the TAM population will increase continuity of BH treatment and improve health outcomes for eligible members.

    - Primary research question 4.1: Did eligible individuals receive the intended HRSS services?
    - Primary research question 4.2: Did engagement in HRSS program mitigate participants' social needs in the measurement period?
    - Primary research question 4.3: Did ED visits decrease, relative to baseline, for HRSS recipients?
        - Subsidiary research question 4.3.a: Did ED visits for BH conditions decrease, relative to baseline, for HRSS recipients?
    - Primary research question 4.4: Did engagement in primary and ambulatory care increase, relative to baseline, for HRSS recipients?
    - Primary research question 4.5: Did engagement in behavioral health care increase, relative to baseline, for HRSS recipients?
    - Primary research question 4.6: Was the total cost of care, exclusive of HRSS, reduced for HRSS participants?
    - Primary research question 4.7: From participants' perspective, did the HRSS services meet their housing-related needs and support their engagement in behavioral health care?

5. Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.

    - Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?
    - Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?
    - Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?
    - Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?
    - Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?
    - Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?
    - Primary research question 5.7: Did the number of individuals needing but not receiving SUD treatment decrease among low-income residents, relative to comparison states?
    - Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?
    - Primary research question 5.10: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services[8]?

6. Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.

    - Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?
        - Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?
        - Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?
    - Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?
        - Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?
        - Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?

7. Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.

    <u>UPP/ESI</u>

    - Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?
    - Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?

[8] This includes services made available through crisis call centers, mobile crisis units, and coordinated community response services as defined in STC 12.4 SMI/SED Financing Plan.

- Primary research question 7.3: Did the pmpm cost for enrollees change over time?

ISS

- Primary research question 7.4: Did the number of individuals receiving ISS increase relative to baseline?

Aged, Blind and Disabled Dental (ABD), TAM Dental

- Primary research question 7.5: Did dental service provision increase relative to baseline?
- Primary research question 7.6: Did the rate of ED visits for dental conditions decrease relative to baseline?
- Primary research question 7.7: What was the average cost of dental services?

Former Foster Care Youth from Another State (FFCYAS)

- Primary research question 7.8: How many FFCYAS received coverage?

Fertility and Genetic Testing Services

- Primary research question 7.9 : Did the number of individuals receiving fertility preservation services increase relative to baseline?
- Primary research question 7.10 Did the number of individuals receiving genetic testing services increase relative to baseline?

C. Methodology

1. Evaluation Approach

The Independent Evaluator (IE) will use a mixed-methods evaluation approach that will combine administrative and survey data as well as qualitative data to address the goals and hypotheses presented in the Demonstration application and answer all research questions listed above.

The evaluation will employ multiple comparison strategies, both in-state and out-of-state. For the adult expansion and TAM populations, and the SUD and SMI waiver populations, Interrupted Time Series (ITS) will be used to compare trends during the Demonstration period to baseline (regression analysis will be conducted if there are enough members in these groups to support it). To assess the impact of introduction of UMIC plans, regression analysis will compare members in three plan types – fee for service, physical health-only ACO, and UMIC.

Results will be stratified by demographic characteristics SMI/SUD status, and plan type, when sufficient numbers are available to permit comparisons. A summary of the characteristics of the Demonstration populations as of the end of the previous waiver period (June 30, 2022) is provided in Table 9 in the Subgroup Analyses section.

Comparisons to Medicaid beneficiaries in other states also provide valuable context. A difference-in-difference (DiD) comparison, and a synthetic control method (SCM), will be used to compare the impact of the Demonstration as a whole on the aggregate Medicaid population to Medicaid beneficiaries in other states. Out-of-state comparisons will address the research question “Did the Demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?”

Member perspectives will be collected through a customized member survey, and through interviews of members receiving HRSS services. Where a survey provides a broader and more representative sample, individual interviews allow for in-depth understanding of member experiences. Additional qualitative data will be collected through key informant interviews with stakeholders. Together, these complementary methods will enable a comprehensive evaluation of the Demonstration.

2. Target and Comparison Populations

As summarized in Table 1, the Demonstration provides coverage and services for multiple populations. Out-of-state comparison using national survey data and other publicly available data sources will be used for investigating the impact of the Demonstration as a whole on the full Medicaid eligible population. For specific populations, the comparison will be to pre-Demonstration trends. For UMIC plans, the comparison will be to other plan types without integrated BH services. The Demonstration populations (the target groups) and the approach to comparisons are shown below in Table 2.

Table 2: Demonstration Populations and Comparisons

Demonstration (target) Population	Program Start	Baseline Years	Comparison[1]	Analytic Approach
Substance Use Disorder (SUD) IMD	November 1, 2017	November 1, 2017 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Targeted Adult Medicaid (TAM)	November 1, 2017	November 1, 2017 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Adult Expansion Population	July 1, 2018 (partial expansion, up to 100% of the FPL)	July 1, 2018- June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Utah Medicaid Integrated Care (UMIC- subset of the Adult Expansion Population)	January 1, 2020	N/A	Three plan types: FFS, ACO, UMIC	Multiple Linear Regression
Serious Mental Illness (SMI) IMD	December 1, 2020	December 1, 2020 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series

[1] The term "pre-demonstration baseline" refers to the time period before the start of the current Demonstration period; before July 1, 2022.

Several demonstration populations are too small to feasibly conduct a comparison to a baseline period. The analytic approaches for these demonstration populations are primarily trend over time and descriptive statistics due to low enrollment.

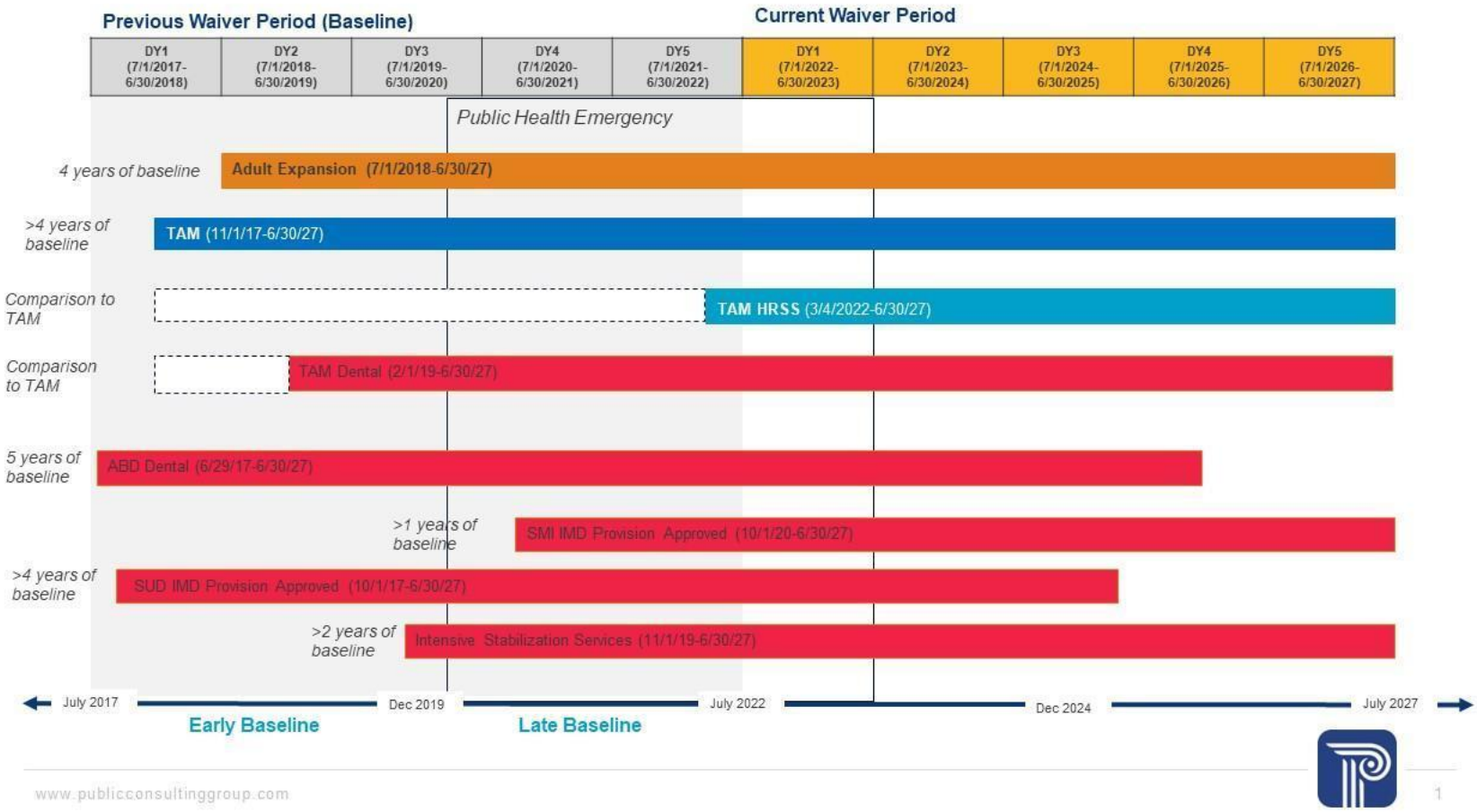
Table 3: Small Demonstration Populations

Demonstration (target) Population	Program Start	Analytic Approach
Utah Premium Partnership Program (UPP)	May 30, 2003	Trend over time, descriptive statistics
Aged, Blind, Disabled Dental (ABD Dental)	June 29, 2017	Trend over time, descriptive statistics
TAM Dental	February 1, 2019	Trend over time, descriptive statistics
Former Foster Care Youth from Another State (FFCYAS)	February 1, 2019	Counts (small population size)
Intensive Stabilizations Services (ISS)	November 1, 2019	Counts (small population size)
TAM members receiving Housing Related Services and Supports (HRSS)	March 4, 2022	Trend over time, descriptive statistics, qualitative interviews and analysis
Fertility and Genetic Testing Services	February 29, 2024	Counts (small population size)

3. Evaluation Period

This evaluation will cover the five-year Demonstration period from July 1, 2022, through June 30, 2027. The pre-Demonstration baseline will be the previous waiver period from July 1, 2017- June 30, 2022. The IE acknowledges that many policies authorized under this waiver are continuations of policies implemented in previous waiver periods. The goal of this evaluation is to quantify any gains realized in the current waiver period. As a result, the baseline period for each analysis will be specific to program start dates listed in Table 2. Please see Figure 2 below for more information. Sensitivity analysis will be conducted to determine whether excluding part of 2020 due to the Covid-19 PHE is appropriate.

FIGURE 2: PERFORMANCE PERIOD AND BASELINE BY POPULATION



4. Evaluation Measures

Evaluation hypotheses and corresponding measures are listed in Section F.4., Evaluation Tables.

5. Data Sources

The evaluation will use the following quantitative and qualitative data sources:

- National Surveys and Other Publicly Available Data Sources:
  - Behavioral Risk Factor Surveillance System (BRFSS)
  - National Survey of Drug Use and Health (NSDUH)
  - National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT)
- Utah Specific Data Sources:
  - Medicaid Administrative Data
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
  - Custom member survey
  - Participant interviews with TAM members receiving HRSS
  - Key Informant Interviews (KIIs)

National Surveys and Other Publicly Available Data Sources

Measures employing national survey data and other publicly available data sources for an out-of-state comparison will use a three-year pre-Demonstration baseline.

BRFSS

The BRFSS is a large, high-quality federal survey that may be used to measure outcomes of interest for out-of-state comparison groups. Importantly, the BRFSS contains respondents' state identifiers and demographic variables needed for comparison purposes. The IE will use the BRFSS data to inform research questions related to coverage and access to care among low-income residents (Table 6).

The BRFSS insurance coverage question outcome does not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) for years prior to 2022. In order to approximate which respondents are Medicaid eligible and who fall below 138 percent of the FPL, a continuous value for household income will be imputed using the midpoint of BRFSS income category. Using imputed income with household size allows the ability to link to annual thresholds for 138 percent FPL in each state. This method will be employed for the years prior to 2022 only.

The IE has also conducted power analysis for using the BRFSS. Our analyses will have high statistical power due to the large sample sizes involved. We estimated the minimum detectable effect sizes for each of our outcomes using Hu & Hoover's (2018) power equation for non-randomized longitudinal difference-in-difference studies:

$$MDES = \frac{T(1-\rho)\sigma}{bkn} \times \left(z_{1-\frac{\alpha}{2}} + z_{1-\beta}\right)^2$$

Where:

MDES = the minimum detectable effect size, defined as a percentage point change in outcome
T = the total number of time periods
b = the number of pre-intervention periods
k = the number of post-intervention periods
n = sample size
σ = standard deviation
ρ = serial correlation

$z_{1-\frac{\alpha}{2}}$ = The critical z-value for statistical significance

$z_{1-\beta}$ = desired statistical power

The final analysis will include 5 pre-intervention years and three post-intervention years. We used BRFSS data to identify serial correlations, standard deviations, and sample sizes for each study outcome. Serial correlation is the relationship between state-level means in consecutive years. We then calculated minimum detectable effect sizes (MDES) at 80% power for and α=0.05. The MDES ranges from 0.41% to 0.58% for our access outcomes. For preventive service outcomes, the MDES ranges from 0.54% (receipt of annual checkup) to 2.29% (receipt of HPV test in past 12 months). The sexual and reproductive health questions are only asked of female respondents in even years, which limits our ability to detect smaller effects.

Table 4. Minimum Detectable Effect Sizes

Outcome	Serial correlation	Standard deviation	Sample size	MDES
Insurance Coverage	0.891	0.478	116,482	0.41
Having a personal doctor	0.840	0.488	116,893	0.48
Avoided care due to cost	0.796	0.460	117,000	0.58
Receipt of annual checkup	0.809	0.482	115,376	0.54
Receipt of mammogram in past 12 months	0.758	0.430	26,814	1.41

Notes: SD = Standard deviation. MDES = Minimum detectable effect size (percentage point change) at 80% for a difference-in-differences analysis with α=0.05.

NSDUH

To investigate the SUD and SMI waiver impact, the IE will use the NSDUH public use dataset. NSDUH collects data annually on incidence and treatment of mental health and substance use conditions. Key NSDUH questions address whether individuals have experienced BH conditions, and whether they have received treatment. The NSDUH public use dataset does not contain enough information to conduct a power analysis.

NASHP HCT

To investigate the Demonstration's impact on uncompensated care costs, the IIE will use the NASHP HCT. The HCT provides a range of measures for hospital revenue, costs, profitability, and break-even points across over 4,600 hospitals nationwide. The underlying dataset includes variables extracted and calculated from the national Healthcare Cost Report Information System (HCRIS).

Table 5. National Surveys and Other Publicly Available Data

Survey	Topic	Survey Questions
BRFSS	Health Risk Factors	• Insurance Coverage • Having a personal doctor • Avoided care due to cost • Receipt of annual checkup • Receipt of mammogram in past 12 months
NSDUH	BH Needs and Services	• Received treatment for SUD in the last 12 months

		• Received treatment for mental health condition in the last 12 months • Needed, but did not receive, treatment for BH condition
NASHP Hospital Cost Tool	Uncompensated Care Cost	• Uncompensated care/bad debt as a percentage of net patient revenue, and as a percentage of operating expenditures

Medicaid Administrative Data

The IE anticipates receiving claims and other Medicaid administrative data, such as eligibility files, from the state on an annual basis. Administrative data is expected to be of high quality, in terms of completeness and accuracy.

The IE anticipates having access to aggregate CAHPS data collected by the health plans and reported to DHHS. Health plans are able to distinguish between ACO and UMIC plan enrollment in CAHPS data and report this information to the state. This data will allow for comparisons of plan types.

CAHPS data will also be used to analyze differences in access to care coordination and patient satisfaction between subgroups. Because CAHPS data will be available only in aggregate, subgroup analysis will be limited to the available demographic stratifications: age, race (White and Other), ethnicity (Hispanic/ Not Hispanic), and gender.

Custom member survey

The member survey will be applied to previously enrolled as well as current members in the adult expansion and TAM populations.

Beneficiaries will be surveyed in one wave during the evaluation period. Examples of survey topics are summarized below in Table 3: Member Survey Topics.

Table 6: Member Survey Topics

Research Question	Example topics
Did members' self-report of ability to obtain care change?	• Perceived impact of coverage on the ease of obtaining care • Ease of obtaining BH services • Barriers to engaging in care
Did members receive person-centered care management?	• Perceptions of care coordination • Perceptions of shared decision-making with providers
Did members' self-report of overall health status change?	• Perceived impact of coverage on health status • Stability of individuals in recovery for SUD or SMI
How do members experience the eligibility process?	• Knowledge of eligibility requirements • Experience with enrollment • Experience with eligibility redetermination

Survey Design

The IE will design the survey to assess the impact of the Demonstration on members' access to and engagement in health care. The survey will cover key topic areas related to members' recent history of health care coverage, access to health care (whether they have a primary care provider, if they have seen a specialist when needed, the regularity with which they obtain preventive care, etc.), and experience with

care coordination. Being mindful of respondent burden, the IE aims for the survey length to not exceed 12 minutes when administered by phone.

Sample Frame Development and Sampling

The IE will work with DHHS to obtain the necessary member data, from which the IE will select a sample of members to survey. The sample will be comprised of 4,000 members. Assuming an approximately 35% response rate, we expect n=1,400 completed surveys (expected confidence interval of +/-2.54 at the 95% confidence level). To ensure that the sample accurately reflects the member population, the IE will conduct implicit random sampling using the appropriate variables available in the Pathways member database, such as gender, age, race/ethnicity, income, and length of enrollment in the program.

Assuming equal propensity for non-response between subgroups, we expect that this sample size will allow for reliable estimates for some subgroups of interest within a margin of error of +/- 5 percentage points, including by age group (individuals aged 19-26 years, aged 27-44 years, and aged 45-64 years), sex, and some racial and ethnic groups (Asian, White, Hispanic, Black, American Indian/Alaska Native and individuals of multiple races).

The ability to detect a significant difference between two groups is in part dependent on the measured prevalence of an outcome, and it will vary for each variable captured in the survey. Generally, if the prevalence of an outcome is around 50% in one group, this study is powered to detect a difference of 6.7 to 15.7 percentage points between respondents of different age groups, genders and racial and ethnic groups, with probability (power) of 80% at the 95% confidence level. If the prevalence of an outcome is very rare or very common (e.g., prevalence of 5% or 95%), this study is powered to detect smaller differences of 2.5 to 9.4 percentage points.

Survey Preparation

To maximize response rates, the IE will prepare the survey for three modes of data collection – mail, online (via smartphone/tablet device/PC), and phone. Each version will be thoroughly tested for quality control. The survey will also be translated into Spanish for interviewing respondents whose preferred language may be Spanish. Additional languages may be added if a need is identified.

Survey Administration

The IE will send the survey by mail to all members in the selected sample together with a cover letter (which will include an online link to the survey), and postage paid business reply envelope. For beneficiaries for whom email addresses are available, we will also send an email invitation with a link to the survey, followed by weekly reminder emails. After 21 days from the mailing, the IE will begin phone follow-up to non-respondents to administer the survey over the phone. To maximize response rates, the IE will make up to five phone attempts to each non-respondent at different times of day and during different days of the week including weekdays and weekends.

Data Analysis and Reporting

The IE will apply weights to the survey data to ensure that the weighted distribution of survey respondents accurately reflects the distribution of the member population on key population metrics, including gender, age, race/ethnicity, income, and length of enrollment in the program. Analysis of the survey data will focus on understanding members' access to health care, availability of employer-sponsored health insurance, and plans to transition to commercial health insurance. The IE will include analysis by key subgroups of interest, such as gender, age, and race/ethnicity.

Participant interviews with members receiving HRSS

Participant interviews will provide a necessary understanding of the experience of members receiving HRSS, including facilitators and barriers impacting the key outcome measures. The IE will conduct phone interviews to directly capture the input of participants, with privacy protections in accordance with CMS guidelines. One wave of interviews will be conducted, with 75-80 individuals in each wave (based on projected enrollment of approximately 5000 individuals). For this component of the evaluation, the IE is

partnering with a doctoral-level social worker and researcher with expertise in interviewing individuals experiencing housing insecurity and BH conditions, Dr. Palmira Santos. Dr. Santos will lead development of the interview guides, conduct interviews, and analyze results.

Potential interviewees will be approached by their case managers, who will explain that the purpose of the evaluation is to improve the program and ask for permission to release their phone number. If an individual chooses to participate, the interviewer will receive only a first name (or chosen alias) and phone number for each participant. When a participant is reached by phone the interviewer will explain the evaluation and seek informed consent before beginning the interview.

Interviewees will be given a gift card as a thank-you, in a small amount for a store that does not sell alcohol or cigarettes.

Table 7: HRSS Beneficiary Interview Topics

Research Question	Example topics
How do participants' interaction with care managers happen? In what ways is it helpful, or not helpful?	Outreach approach, engagement, and follow through. Understanding of your needs and perspective – took steps to assist or explained limitations of service
What role did the HRSS case manager have in participants' housing situation?	Addressing specific patient needs, timeliness, role of other housing liaisons
What factors enhance or inhibit participants' engagement in behavioral health care?	Factors (barriers/facilitators) to access, coordination, continuity, and outcome
Are participants experiencing unmet needs for health care, including SUD and SMI treatment?	Participation in behavioral and physical health services and support. Use of the ED and hospitalizations (avoidable and/or BH related) – perspective on alternatives. Participation in preventive, acute and chronic condition services
Do participants perceive their life circumstances have changed since receiving HRSS services?	Previous and current life (SDOH, family, work etc.) situation

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews (KIIs) with providers and state administrators. A total of 25-30 KIIs are planned; three at each of the four health plans, five state employees participating in implementation, at least three community-based providers, and case managers supporting HRSS.

In addition to the administrative contacts from the ACOs and MCOs, the IE will interview at least three community-based providers, such as primary care providers and behavioral health clinicians, who directly serve Medicaid patients at sites such as community health centers, in order to capture the perspective of front-line clinicians working through the UMIC Demonstration. These providers will be asked about topics including integration of behavioral health care, barriers to access, and their perceptions of patients' engagement in care.

Because HRSS is a new component of the Demonstration, interviews with case managers will provide essential insights into the challenges and successes during implementation. Case managers will be asked about topics including their observations regarding communication with members and providers, ways in which HRSS services are effective or not, and promising practices in care coordination for a population with housing instability.

Semi-structured key informant interviews lasting 30-45 minutes per contact will be conducted by phone or videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. The IE will develop Interview guides in collaboration with DHHS for providers, health plans, and for state administrators involved in implementation of the Demonstration. The interview guide and questions will be tailored to the interviewee role. For example, state administrators will be invited to discuss the program rollout and feedback received from plans, health plan representatives will be asked about the plan's approach to integrating BH services, and questions regarding telehealth experiences will be directed towards clinicians.

As appropriate, interviews will explore successes and challenges with regard to program implementation, especially in light of the PHE, and other topics drawn from the logic model; examples are shown in Table7.[9] Interview guides will include questions that address disparities and health equity as appropriate for the interviewee's role. This may include population health analysis strategies, language services, and targeted outreach programs.

Table 8: Topics for Key Informant Interviews

Research Question	Example topics
Was the Demonstration implemented effectively?	• Perceived successes and challenges in implementation ○ Care integration with behavioral health • Perceived steps towards integrating behavioral health with physical health services, e.g., screening and referrals • Perceived impact of the PHE/pandemic on member engagement • Perceptions about the role of telehealth in achieving Demonstration goals
To what extent are BH services integrated with physical health services?	• Screening and referrals • Care coordination for members with BH conditions • Sharing of patient data across practices
Did enrollment or outcomes differ by demographic factors?	• Perceptions of barriers to access and participation in care • Steps health plans/providers are taking to identify, understand, and address disparities in access and engagement

6. Analytic Methods

Quantitative Analyses

The evaluation design includes multiple analytic strategies to answer the research questions and provide robust conclusions. The proposed approach is to use quasi-experimental analyses, employing descriptive statistics, trends over time, interrupted time-series analysis (ITS), regression, difference-in-differences (DiD), and synthetic control methods (SCM) Quasi-experimental analyses will be conducted where data is available. Multivariate regression will be used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the Demonstration populations as members enter and leave the Populations. For example, for Hypotheses 4, 5, and 6, interrupted time series will be used where data is available over the time period of interest.

For smaller Demonstration populations and small subgroups where regression analysis is not feasible, the evaluation will focus on trends over time. For example, Hypothesis 6 focuses on the smaller demonstration populations; most research questions for this hypothesis will be addressed with description statistics, such as service counts and cost over time

The specific analytic method for each research question is provided in section F.4 Evaluation Tables.

[9] KIIs will cover topics relevant to the evaluation of the Adult Expansion and ESI components of the Demonstration as well; these are covered in separate evaluation designs.

Table 9: Summary of Analytic Tactics to be used for Evaluation

Method	Comparison	Data sources
Subgroup comparison	Demonstration participants stratified by demographic and health factors	Encounter data, Administrative data
Event study/ time series	Trend during Demonstration vs baseline	Encounter data, Administrative data
Difference in difference; Synthetic Control Methods	Pre/Post change in Utah vs Pre/Post change in other states; predicted outcomes for 'synthetic UT'	National surveys and other Public data sources

Descriptive statistics

The evaluation will provide summary tables of population size and characteristics, and outcomes for the three groups of Demonstration participants. Data will be analyzed using standard tests as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Prior to performing regression analysis of the plan types within AE, the composition of the beneficiary population in the three groups (FFS, ACO, and UMIC) will be compared to identify differences in demographic or clinical characteristics. ANOVA/MANOVA tests will be used as a first pass comparison of mean outcomes for the three groups. For metrics derived from BRFSS survey data, results for Utah will be compared to national averages for each year.

Trend over time and linear regression modeling

Outcomes of interest will be plotted over time for the duration of the Demonstration. The trend for each evaluation group will be modeled using multivariate linear regression and compared. The null hypothesis will be that the three groups have identical trends. In order to account for demographic characteristics such as age and gender that may differ among the three groups, the IE will use inverse probability of treatment weighting. Individuals in the two intervention groups will be assigned weights based on the composition of the reference group, producing three groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[10]

For the measures with binary outcomes the models will be logistic; Poisson models will be used for count-based outcomes. The mixed effects logistic regression model accommodates for both fixed and random effects. In this case, it allows for the fact that members can appear multiple times in the datasets and that they can appear different numbers of times resulting in unbalanced data. The models will include the 'client id' variable as a random effect. The outcome variable will be the binary or count outcome. To assess changes over time for each population a fixed effects for measurement year and population will be included in addition to an interaction term between them. Measurement year will be included as a continuous variable after plotting raw trends to assess linearity. Adjusted models will include the

[10] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

covariates gender, race/ethnicity, age as a continuous variable, region, and SMI/SUD diagnosis group, as appropriate. When adjustment variables besides age, gender and race are not statistically significantly associated ($p < 0.05$) we will proceed with a stepwise selection to reduce the number of covariates in the model. We will also run stratified mixed models by gender, age group and race/ethnicity with the same adjustment procedures, if subgroup size is adequate. Models are described in the following formulas.

Mixed logistic regression model

$$logit(Y = 1_{ij}) = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i}$$

Mixed Poisson regression model

$$\log(Y)_{ij} = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i} + \ln(offset)$$

Where Y corresponds to outcome of interest with a different expression depending on its distribution, β_0 to the overall intercept of the model, $\beta_1 Pop_i$ to the effect of belonging to a certain population group compared to the reference group (current eligible), $\beta_2 MY_{ij}$ to the effect of measurement year as a continuous variable, $\beta_3 MY_{ij} * Pop_i$ is the interaction effect between population and measurement year which allows us to estimate change over time between populations, $\beta_x X_i$ corresponds to individual level adjustment covariates, and γ_{0i} corresponds to the random intercept of each client to account for the clustering effect of appearing in more than one measurement year. In the case of Poisson models, the model includes an offset, for EDU corresponding the total number of clients and for IPU to the total member-months.

Difference-in-difference

To examine the impact of the demonstration on its overarching aim of improved access, PCG will conduct a difference-in-difference (DiD) analysis to model the effect of the demonstration in Utah relative to comparison states. The comparison states are those states not exposed to the treatment of interest – in this case, all other states that either (1) have not expanded Medicaid, or (2) expanded Medicaid before the pre-intervention period (July 1st 2017 – June 30th 2022) The parallel trends assumption will be tested over the five years before the demonstration period. Sensitivity analysis will be conducted to determine whether the PHE influences the baseline or the parallel trends assumption.

The DiD model equation is:

$$Y_{its} = \boldsymbol{\alpha_s} + \boldsymbol{\beta_t} + \beta_2 Expansion_s + \beta_3 Post_t + \beta_4 Intervention_s \times Post_t + \boldsymbol{\delta X_{it}} + \varepsilon_{ist}$$

Where:

Y_{its} = Our outcome(s) of interest
α_s = A vector of state fixed effects
β_t = A vector month and year fixed effects
$Intervention_s$ = A binary indicator for residence in our treated state (Utah)
$Post_t$ = A binary indicator for whether the outcome occurred during the demonstration period
δX_{it} = A vector of observed individual-level characteristics

Covariates will include respondent age, education, employment status, household size, veteran status, sex, household income, homeownership status, presence of children in the household, survey month, and whether the survey was conducted via landline or cell phone. The regression coefficient β_4 thus represents our regression-adjusted estimates of changes in outcomes associated with Utah's Medicaid expansion, after controlling for state, month, year, and observed covariates.

Synthetic control method

In addition to the DiD approach, the IE will use synthetic control methods (SCM) to estimate the association between implementation of the Demonstration and study outcomes. SCM have been employed to evaluate state-level policy impacts because they are particularly useful when estimating the impact of a policy change that affects a small number of treatment groups (i.e., a state).[11,12,13,14] These methods are a quasi-experimental approach similar to traditional difference-in-difference (DID) estimation but require fewer assumptions to obtain estimates of association. DID assumes that any differential changes in outcomes between treated and control groups are attributable to the policy change. Yet treated and control groups are often nonequivalent in terms of pre-treatment outcome levels, trends in outcomes, and other important covariates. To mitigate this limitation, researchers typically attempt to control for observed variables that may be associated with both treatment likelihood and the outcome of interest. However, treatment and control groups may still differ in terms of outcome pre-trends and levels due to unobserved factors. This introduces potential selection issues, which may bias any estimates of association.

In contrast, SCM constructs a synthetic control. The synthetic control is constructed using a weighted average of the states included, with weights determined through a fully empirical process; weights for individual control units may range from 0 to 1 and are assigned so the synthetic control is as similar as possible to the treated group in terms of outcome pre-trends. Unlike traditional regression, inclusion of covariates is not required to achieve equivalence between treated and control groups.

Public Health Emergency; Sensitivity Analysis

The pre-Demonstration baseline period to be used for all quasi-experimental methods includes the period where the Covid-19 pandemic had a profound impact on health care utilization. First, trends for UT and controls will be modeled with and without the most affected months in 2020 and 2021. This sensitivity analysis will help to identify whether the groups have been impacted differentially. If the pattern changes observed in the first quarter of the Public Health Emergency are similar for all evaluation groups, then confounding of the results by pandemic impacts is less likely. The most affected quarters may be omitted from the baseline depending on the results.

Subgroup Analyses

The evaluation will seek to understand how different subgroups of participants are impacted by the Demonstration. Analyses will partition participants by gender, race/ethnicity, age, and SMI/ SUD diagnosis status. Where possible, race will include White, Black, Asian, Latinx, and Native American populations and Ethnicity will be characterized as Hispanic/Not Hispanic Due to the low prevalence of some subgroups, it may be necessary to combine racial and ethnic groups for purposes of stratification. As seen in Table 10 below, 45% of race/ethnicity data gathered during the previous waiver period was missing. It is unlikely the evaluation will be able to identify racial/ethnic disparities in outcomes due to the high amount of missing data unless there is substantial improvement in the availability of this data. While data on region is available (urban, rural, frontier), the state does not plan to conduct subgroup analyses by geographic location because the geography variable is confounded with Plan Type. Specifically, Adult Expansion members in 5 counties *must* enroll in the UMIC plans with integrated physical and behavioral health benefits. In 8 other

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[11] Abadie, A., 2012. *Synthetic control methods for comparative case studies: estimating the effect of California's tobacco control program. J Am Stat Assoc* 105(490):493-505. https://www.tandfonline.com/doi/abs/10.1198/jasa.2009.ap08746

[12] Rudolph, K.E., *et al.*, 2015. *Association between Connecticut's Permit-ti-Purchase handgun law and homicides. Am J Public Health* 105(8):e49-e54. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302703

[13] Santella-Tenorio, J. *et al.*, 2020. *Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities. JAMA* 180 (8):1061-1068. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2767647

[14] Bhatt, A. *et al.* 2020. *Association of changes in Missouri firearm laws with adolescent and young adult suicides by firearms. JAMA Netw Open* 3(11). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772526

counties, Adult Expansion *must* enroll in an ACO and a Prepaid Mental Health Plan. In the remaining counties of the state, members may enroll in an ACO or stay with FFS.

Table 10: Previous Waiver Demonstration Period; Population Characteristics

Demographic / Health Characteristic		Adult Expansion (N= 92,026)	Targeted Adult Medicaid (N=9,582)
Gender	Male	44,703 (48.6%)	7,223 (75.4%)
	Female	47,323 (51.4%)	2,359 (24.6%)
Age	19-44	62,781 (68.2%)	6,948 (72.5%)
	45-54	15,821 (17.2%)	1,791 (18.7%)
	55-64	13,424 (14.6%)	843 (8.8%)
Race/ethnicity	Other/Missing	41,772 (45.4%)	3,840 (40.1%)
	White (non-Hispanic)	14,963 (16.3%)	1,634 (17.1%)
	Hispanic, Black, AIAN, Pacific Islander	35,291 (38.3%)	4,108 (42.9%)
SMI/SUD Diagnosis	None	66,539 (72.3%)	1,781 (18.6%)
	SMI Only	3,155 (3.4%)	171 (1.8%)
	SUD Only	16,658 (18.1%)	5,652 (59.0%)
	Both SMI/SUD	5,674 (6.2%)	1,978 (20.6%)

NOTE: The characteristics shown above represent every person ever enrolled during the previous waiver demonstration period (7/1/2017--6/30/2022), as of their last appearance in the claims data.

Cost Analyses for SUD and SMI Demonstrations

The analytic methods for the SUD Demonstration cost analysis are detailed below. *The same approach will be taken for the SMI Demonstration.* The only difference being the target group and the dates of the pre-demonstration baseline periods (outlined in Section C. Methodology, Table 2).

SUD demonstration target group beneficiaries will be identified based on claims and encounters with an SUD diagnosis and/or procedure code. Pharmacy claims and encounters with a dispensed drug for Medication Assisted Treatment (MAT) will also be used to identify the population of interest. Once a beneficiary has been identified, they will remain in the population of interest until 11 months pass without another qualifying SUD claim or encounter.

There will be three levels of cost analyses:

I. Total Cost of Care = Total Medicaid Costs (claims and managed care capitation payments) + federal costs (Total Medicaid Costs * the Utah specific Federal Financial Participation rate)

II. Costs related to the diagnosis and treatment of SUD = SUD-IMD costs + other SUD costs + non-SUD costs

III. Source of care cost drivers = inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care

The Total Cost of Care will not include administrative costs, as the State does not currently track administrative costs specific to these demonstrations. Given the large number of waivers and amendments in Utah, it is not possible to estimate administrative costs separately.

Within each of the three levels, the results will be stratified by: SUD diagnosis only; SMI/SUD dual diagnosis. Given the lack of a comparison group, an interrupted time series model will be used to estimate the linear effects of the SUD demonstration. The IE will conduct both a logit model for estimating zero-cost months and a generalized linear model [GLM] for estimating non-zero cost months. The GLM model will use log costs to account for costs that are not normally distributed.

Qualitative analysis

Qualitative analysis will be used for key informant interview transcripts. The research questions to be addressed, with corresponding example topics, are listed in Table 10 (Attachment 4). Interviews will address these questions by probing for perspectives from providers and from administrators involved in implementing the Demonstration. Thematic analysis using a coding tree derived from the Demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results of provider interviews will be used to add context to the quantitative findings regarding experience of care, beneficiary engagement, and barriers to engagement. Results of provider and administrator interviews will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

D. METHODOLOGICAL LIMITATIONS

1. **Lack of a true comparison group.** The Demonstration is implemented statewide, making a perfect comparison group impossible. To mitigate this limitation, the IE plans to use both in-state comparison among benefit groups, and out-of-state comparisons using national survey data sources.

2. **Sample size.** Full UMIC participation is projected to be around 60,000 individuals. The data set for specific outcomes may not have sufficient size statistical analysis on all subgroups of interest. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient. To further investigate health equity, KII interview guides will include questions about health plan efforts to identify and remediate disparities in access, such as population health analyses and targeted outreach. TAM and other populations are smaller. For the smallest populations, regression analysis is unlikely to be feasible, so descriptive and trend over time analyses will be used and stratification will be limited. For the ISS population and the FFCYAS population, the number of individuals may be too small to support significance testing, in which case descriptive results will be provided.

3. **Health Plan Reporting.** The independent evaluator will receive aggregate CAHPS data reported in aggregate by the health plans, stratified by gender, age, and race/ethnicity. Patient-level data is not available for privacy reasons. Data aggregation will limit the available subgroup analyses that can be performed. The current age and race/ethnicity reporting buckets for CAHPS data are limited and are not standardized across health plans. In order to aggregate data across the population, the IE will combine categories as needed, creating wider age bands, and characterizing race as White/Other.

4. **Lack of data on source of insurance coverage in national survey data.** The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the Demonstration. As noted in Section C.5 the BRFSS insurance coverage outcome does not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) As a result, it is not possible to identify individuals enrolled in Medicaid and thus not possible to determine if respondents fall into the Demonstration group or are enrolled in Medicaid in comparison states. While an approximation will be achieved by using income and household size to define a sample representing Demonstration participants as closely as possible, the inclusion of respondents who may not be part of the Demonstration group or be Medicaid enrolled in comparison states is expected to attenuate the effect estimates. While differences in BRFSS responses between Utah and the comparison states are of interest, the evaluation's results should be interpreted as associations and may not necessarily be directly attributed to the Demonstration.

5. **Historic effects.** The impacts of the Covid-19 pandemic/PHE were profound in 2020 and 2021 and are likely to continue to influence health care delivery well into the current Demonstration period. Analytic techniques described above will be used to minimize confounding by PHE effects during the baseline period. The PHE unwinding will take place during the Demonstration period, with eligibility redeterminations beginning in April 2023, and may lead to unusual levels of disenrollment and enrollment category changes. Ongoing direct and indirect impacts of the PHE such as staffing shortages will be considered in interpreting findings.

6. **Data availability for national surveys and other publicly available data sources.** The evaluation design includes national surveys and other publicly available data sources for some research questions that involve comparisons between states and over time. The design plan is contingent on data release schedules, the elements included in public use files, the timing and process for accessing restricted data, and the comparability of the surveys to previous years. The NASHP HCT utilizes cost reports submitted by hospitals; as such, hospital reporting errors may be introduced. Should barriers be encountered, the IE will explore other options.

F. ATTACHMENTS

1. INDEPENDENT EVALUATOR

As required by the Centers for Medicare & Medicaid Services (CMS) and the Section 1115 Demonstration's Special Terms and Conditions (STCs), DHHS conducted an open solicitation process to secure a third-party evaluator to conduct an evaluation of the State of Utah's Section 1115 Demonstration.

The State issued one contract for all evaluation activities and the production of required CMS reports.[15] As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

- Experience conducting program evaluations for programs administered by the federal department of Health and Human Services.
- Ability to provide at least two examples of program evaluations conducted meeting the above criterion.
- Experience with Medicaid claims data.
- Experience complying with human subjects' protection and data confidentiality laws (state and federal)
- Experience with quantitative and qualitative evaluation design, implementation, analysis, and reporting, and impact evaluations in public health and social services settings.

Consistent with the requirements of the State of Utah Division of Purchasing, DHHS selected and retained PCG as an independent evaluator to complete the independent evaluation of the Demonstration. DHHS contracted with the evaluator, PCG, to promote an independent evaluation, following the general requirements for each state contractor as well as project-specific standards.

The third-party evaluator, PCG, will conduct an evaluation following guidelines set forth by DHHS and CMS. The Department retains responsibility for monitoring the Demonstration activities and providing oversight of the evaluation design and overall approach for the contractor. To ensure a fair and impartial evaluation and mitigate any potential conflict of interest, the independent evaluator, PCG, will:

- Conduct an evaluation of the 1115 Demonstration hypotheses for the Adult Expansion, Current Eligible, Targeted Adult Medicaid (TAM), Targeted Adult Dental (TAM-Dental), Blind and Disabled Dental (BDD), Aged Dental, Employer-Sponsored Insurance (ESI), Utah Premium Partnership (UPP), Intensive Stabilization Services (ISS), and Former Foster Care Youth from Another State (FFCYAS) populations of the 1115 waiver, as well as for the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) components[16], to determine if the goals and objectives of the Demonstration have been achieved.
- Meet the evaluation requirements of the 1115 Demonstration STCs.
- Follow the CMS approved evaluation design.
- Provide DHHS with the required annual interim evaluation report and summative evaluation report at the end of the 1115 Demonstration approval period, by the due dates outlined in the contract.
- Provide future evaluations as required by the contract, at the option of DHHS, and develop the evaluation design and implement the design upon CMS approval.
- Complete any required IRB applications, data sharing agreements, or other documents needed to protect human subjects and data confidentiality.
- Appropriately safeguard evaluation data in compliance with HIPAA requirements, protection of human subjects, data sharing agreements, state or federal laws, and other applicable regulations.

[15] This procurement sought an Independent Evaluator for all the components of the current waiver period which runs from July 1, 2022, through June 30, 2027. PCG was awarded a five-year contract covering these components.

[16] The Utah Department of Health requested that PCG develop a single comprehensive Evaluation Design for the Utah Medicaid Reform 1115 Demonstration encompassing all evaluation populations and waiver components

The 1115 Demonstration evaluation conducted by PCG will determine if the goals and objectives of the 1115 Demonstration have been achieved. The evaluation will meet the requirement of the 1115 Demonstration STCs, follow the CMS approved evaluation design, and provide required deliverables.

DHHS staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, DHHS is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.

2. Evaluation Budget

Table 11: Estimated Evaluation Budget

Evaluation Activity	DY22 (7/1/2023 – 6/30/2024)	DY23 (7/1/2024 - 6/30/2025)	DY24 (7/1/2025 - 6/30/2026)	DY25 (7/1/2026 - 6/30/2027)	DY26 (7/1/2027 - 6/30/2028)	(7/1/2028 - 6/30/2029)	(7/1/2029 - 6/30/2030)	Total
	Renewal Yr1	*Renewal Yr2*	*Renewal Yr3*	*Renewal Yr4*	*Renewal Yr5*	*Post Yr1*	*Post Yr2*	
Project Management	$49,500	$49,500	$55,688	$61,875	$61,875	$61,875	$61,875	**$402,188**
Evaluation Design	$90,000	$16,875	$0	$0	$0	$0	$0	**$106,875**
Quantitative Data Collection, Cleaning and Analysis	$0	$45,000	$226,350	$0	$0	$282,938	$16,875	**$571,163**
Key Informant Interviews (Administrators, service providers) Data Collection, Cleaning and Analysis	$0	$0	$67,500	$64,688	$0	$0	$0	**$132,188**
HRSS Participant Interviews One Wave of 75-80	$75,000	$50,000	$0	$0	$0	$0	$0	**$125,000**
Beneficiary survey (One wave AE and TAM)	$0	$180,000	$0	$0	$0	$0	$0	**$180,000**
Midpoint Assessment of SUD and SMI waivers (Due June 2025)	$71,100	$71,100	$0	$0	$0	$0-	$0	**$142,200**
Interim Report (Due June 2026)	$0	$0	$56,250	$11,250	$0	$0	$0	**$67,500**
Summative Report	$0	$0	$0	$22,500	$22,500	$22,500	$101,250	**$168,750**
Total	**$285,600**	**$412,475**	**$405,788**	**$160,313**	**$84,375**	**$367,313**	**$180,000**	**$1,895,863**

3. Timeline and Major Milestones

Figure 3: Evaluation Timeline

4. Evaluation Tables

Table 12: Evaluation Summary, Hypothesis 1, Low-income UT residents

Hypothesis 1: The 1115 Demonstration overall improved access to coverage and engagement in health care for low-income UT residents.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?				
Comparison states	Any coverage	Fraction with any health insurance coverage	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.2: Did the cost of uncompensated care decrease relative to comparison states?				
Comparison states	Uncompensated care cost	Uninsured/bad debt as a percentage of net patient revenue, and as a percentage of operating expenditures	NASHP HCT	Difference-in-difference Synthetic control model
Primary research question 1.3: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?				
Comparison states	Avoided care due to cost	Fraction who delayed or avoided needed care because of cost	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.4: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?				
Comparison states	Has a personal doctor	Fraction who says they have one person they think of as their person doctor or provider	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.5: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?				
Comparison states	Had a primary or specialty appointment	Had a checkup or visit with a specialist in the last 12 months	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.6: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?				
Comparison states	Had a preventative screening	Fraction who reported having a mammogram in the last 12 months	BRFSS	Difference-in-difference Synthetic control model

Primary research question 1.7: Did member satisfaction increase, relative to baseline?				
Pre-Demonstration baseline	Member satisfaction	Getting needed care Getting needed care quickly How well doctors communicate	CAHPS	Descriptive statistics; Trend over time
Primary research question 1.8: Did Low Value Care decrease among Demonstration participants, relative to baseline?				
Pre-Demonstration baseline	Low Value Care	List of low value care scenarios appropriate for the Demonstration will be developed	Claims	Trend over time Interrupted Time Series

Table 13: Evaluation Summary, Hypothesis 2, Adult Expansion / UMIC

Hypothesis 2: The Demonstration will improve healthcare access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Multiple linear regression; ANOVA

Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Trend over time Interrupted Time Series
Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims	Trend over time Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Trend over time Interrupted Time Series
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Trend over time Interrupted Time Series
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims	Multiple linear regression; ANOVA

Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Multiple linear regression; ANOVA
Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?				
Baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Trend over time
Pre-Demonstration baseline	Engagement in Diabetes Care (EDC)	Adults with type 1 or type 2 diabetes who had at least two A1C tests in the year	Claims	Trend over time Interrupted Time Series
Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Breast Cancer Screening (BCS)	Women 50 years and over who had at least one mammogram to screen for breast cancer in the past two years	Claims	Trend over time

Table 14: Evaluation Summary, Hypothesis 3, TAM

Hypothesis 3: The Demonstration will improve healthcare access and engagement for the TAM population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED-BH visits	ED visits for BH condition per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Trend over time Interrupted Time Series
Baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Trend over time

Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Trend over time Interrupted Time Series
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Trend over time Interrupted Time Series

Table 15: Evaluation Summary, Hypothesis 4, TAM HRSS

Hypothesis 4: The Demonstration will improve healthcare access and engagement for the TAM HRSS population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 4.1: Did eligible individuals receive the intended HRSS services?				
N/A	Service counts	HRSS services received	Claims	Descriptive statistics; Trend over time
N/A	Found housing	Fraction of HRSS participants who moved into housing.	Administrative	Descriptive statistics; Trend over time

Primary research question 4.2: Did engagement in HRSS program mitigate participants' social needs in the measurement period?				
N/A	Health-related social needs	Reduced acuity on needs-based criteria (such as assistance with one or more Activities of Daily Living (ADLs))	Administrative	Health-related social needs
Primary research question 4.3: Did ED visits decrease, relative to baseline, for HRSS recipients?				
N/A	ED visits (EDU)	ED visits per member per year	Claims	Trend over time
Subsidiary research question 4.3.a: Did ED visits for BH conditions decrease, relative to baseline, for HRSS recipients?				
N/A	ED-BH visits	ED visits for BH condition per member per year	Claims	Trend over time
Primary research question 4.4 Did engagement in primary and ambulatory care increase, relative to baseline, for HRSS recipients?				
Baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Trend over time
Baseline	Monitoring for persistent medications	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Trend over time

Primary research question 4.5: Did engagement in behavioral health care increase, relative to baseline, for HRSS recipients?				
Baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time
Baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Trend over time
Baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Trend over time
Primary research question 4.6: Was the total cost of care, exclusive of HRSS, reduced for HRSS participants?				
Baseline	Cost of care	PMPM cost, exclusive of HRSS	Claims	Trend over time Interrupted Time Series
Primary research question 4.7: From participants' perspective, did the HRSS services meet their housing-related needs and support their engagement in behavioral health care?				
N/A	How do participants' interaction with care managers happen? In what ways is it helpful, or not helpful?	Participants' Perceptions	Participant Interviews	Qualitative analysis
N/A	How easy or difficult is it to find appropriate housing with HRSS assistance? Are	Participants' Perceptions	Participant Interviews	Qualitative analysis

	participants satisfied with their housing arrangements?			
N/A	What factors enhance or inhibit participants' engagement in behavioral health care?	Participants' Perceptions	Participant Interviews	Qualitative analysis
N/A	What factors enhance or inhibit participants' engagement in behavioral health care?	Participants' Perceptions	Participant Interviews	Qualitative analysis
N/A	Do participants perceive their health has changed since receiving HRSS services?	Participants' Perceptions	Participant Interviews	Qualitative analysis

Table 16: Evaluation Summary, Hypothesis 5, SMI/SUD

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?				
Baseline year (DY1)	Service Counts: SUD	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time
Baseline year (DY1)	Service Counts: SMI	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time

Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	ED-BH visits	ED visits for BH condition per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 5.3 Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	Inpatient days	Inpatient days PMPY, exclusive of IMD stays	Claims	Trend over time Interrupted Time Series
Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?				
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Trend over time Interrupted Time Series
Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?				
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time Interrupted Time Series
Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?				
Comparison states	Mental health treatment	Percentage who reported receiving mental health (non-SUD) treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model

Primary research question 5.7: Did the number of individuals needing but not receiving SUD service decrease among low-income residents, relative to comparison states?				
Comparison states	SUD treatment	Percentage who reported receiving SUD treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model
Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?				
Pre-Demonstration baseline	Overdose deaths	State rate of overdose deaths	Administrative	Trend over time Interrupted Time Series
Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services)?				
Pre-Demonstration baseline	Crisis stabilization services	Crisis Stabilization service count	Claims	Trend over time Interrupted Time Series

Table 17: Evaluation Summary, Hypothesis 6, SMI/SUD Cost of Care

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).	Claims	Interrupted time series

Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series
Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care	Claims	Interrupted time series
Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).	Claims	Interrupted time series
Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series
Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include *inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care*	Claims	Interrupted time series

Table 18: Evaluation Summary, Hypothesis 6, Small Demonstration Populations: UPP/ESI, ISS, ABD Dental & TAM Dental, ISS, FFCYAS, Fertility and Genetic Testing Services

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
UPP/ESI				
Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?				
Baseline year (DY1)	Enrollment	Number of unique individuals enrolled in each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?				
Baseline year (DY1)	Total cost of care	Total cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
Primary research question 7.3: Did the pmpm cost for enrollees change over time?				
Baseline year (DY1)	Average pmpm expenditure	Total per member per month cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
ISS				
Primary research question 7.4 Did the number of individuals receiving ISS increase relative to baseline?				
Baseline year (DY1)	ISS Service Recipients	Number of unique individuals who received ISS	Claims	Counts

ABD Dental, TAM Dental				
Primary research question 7.5: Did dental service provision increase relative to baseline?				
Baseline year (DY1) Stratify by Dental type: Aged, Blind/Disabled, TAM	Dental Service Recipients	Number of unique individuals who received dental services	Claims	Descriptive statistics Trend over time
Baseline year (DY1) Stratify by Dental type: Aged, Blind/Disabled, TAM	Dental Services	Number of dental services provided	Claims	Descriptive statistics Trend over time
Primary research question 7.6: Did the rate of ED visits for dental conditions decrease relative to baseline?				
Baseline year (DY1) Stratify by Dental type: Aged, Blind/Disabled, TAM	ED Visits for Dental diagnoses	Number of ED visits with a primary diagnosis for a dental condition	Claims	Descriptive statistics Trend over time
Primary research question 7.7: What was the average cost of dental services?				
Baseline year (DY1) Stratify by Dental type: Aged, Blind/Disabled, TAM	Cost of Dental Claims	Total cost of claims paid for dental services	Claims	Descriptive statistics Trend over time
FFCYAS				
Primary research question 7.8: How many FFCYAS received coverage?				
Baseline year (DY1)	Number of FFCYAS	Number of unique individuals in FFCYAS coverage group	Required Monitoring Reports	Counts
Fertility and Genetic Testing Services				
Primary research question 7.9: Did the number of individuals receiving fertility preservation services increase relative to baseline?				
Baseline year (DY1)	Fertility services	Number of unique individuals receiving fertility preservation services	Claims	Counts

Primary research question 7.10: Did the number of individuals receiving genetic testing services increase relative to baseline?				
Baseline year (DY1)	Genetic testing services	Number of unique individuals receiving genetic testing services	Claims	Counts

Attachment J: Intensive Stabilization Services (ISS) for Children/Youth Claiming Methodology Protocol

Introduction

The Special Terms and Conditions (STCs) of Utah's Section 1115(a) Demonstration #11-W-00145/8 approved by the Centers for Medicare and Medicaid Services (CMS) on November 25, 2019, includes expenditure authority for Utah's ISS Medicaid Eligible Children/Youth Program. The ISS Program is a specific set of state plan and home and community-based services provided during the first eight-weeks of the intensive program to support a customized service approach to keep families together while effectively helping children with emotional and/or behavioral needs thrive in their homes, schools, and communities resulting in reduced visits to the emergency room, psychiatric hospitalizations, and residential treatment services. These services are provided on a FFS basis using a daily bundled rate. Accordingly, Utah Medicaid established the protocols herein to define the claimable expenditures.

Intensive Stabilization Services (ISS) for Children/Youth Bundled Rate

Only those providers that meet the criteria set forth in STC 74 may be reimbursed for ISS. A description of the services included in the bundled rate is located at Table 2c. A provider may not receive separate reimbursement for ISS for the same individual for which the bundled rate was claimed. Medicaid providers delivering other Medicaid-covered services outside of the service bundle may bill in accordance with the state's Medicaid billing procedures. A provider must provide at least one of the services included in the bundle within the service payment unit in order to bill the daily bundled rate. The following provides a description of how the rate methodology was developed.

The ISS bundled rate is based on a similar Department of Health and Human Services program, Families First, which is an intensive in-home services program. The Families First rate is $100 per hour. The Department of Human Services conducted an in depth review of the Family First Rate in 2015. The cost inputs included: number of families served; average number of hours of services provided per family; actual face to face time, and indirect staff time. Families First had calculated the anticipated number of hours of service per week per family and then adjusted the number of service hours based on the percentage of families anticipated to complete the program. A sample of 20 cases from the Division of Child and Family Services, Juvenile Court and the Division of Juvenile Justice Services was used. Based on the sampling, the state calculated the average number of hours provided per family per week. The assumption was that a family would receive 48-52 face-to-face hours to complete the Families First program. The state then reviewed the billable hours per family and took the total costs divided by billable hours to calculate the cost of providing services, which was $80 per hour in 2015 and $90 per hour in 2016. Given the single year projected jump of $10, the state felt a rate of $100 was reasonable. The general breakdown of calculations:

For FYE 2015, $80 per hour ($1,802,045 in total costs divided by 22,454 hours) Hours were calculated at 436 families served x 51.5 billable hours per family = 22,454 hours.
For FYE 2016, $90 per hour ($2,374,701 in total program costs divided by 26,368 hours) Hours were calculated at 512 families served x 51.5 billable hours per family = 26,368 hours.

Since ISS are also intensive in-home services, the Families First rate is being used as a proxy for $100 per hour. The ISS bundle rate was based on the assumption that a family would receive an average of 42 face-to-face hours to complete the Stabilization Services program. The state examined and considered provider costs, which included: employee's level of education, training and experience; fringe benefits; administrative costs; and on-going training. The eight weeks of the ISS program include:

Week 1: 7.5 hours @$100
Week 2: 7.5 hours @$100
Week 3: 6 hours @$100
Week 4: 6 hours @$100
Week 5: 4.5 hours @$100
Week 6: 4.5 hours @$100
Week 7: 3 hours @$100
Week 8: 3 hours @$100
Grand Total $4,200

Providers will submit an invoice to ISS Teams for services provided. The ISS Teams will make appropriate payment to the provider. Any discrepancies will be resolved before payment is issued to the provider and payment is received from the Medicaid agency to the sister agency, Department of Human Services. The ISS Teams will audit the service provider(s) quarterly to ensure compliance with all stabilization service requirements and reconcile billings with documentation of services. States can only report expenditures for which all supporting documentation is available (i.e. date of service, name of recipient, Medicaid identification number), in readily reviewable form, which has been compiled and is immediately available when the claim for expenditures is filed on the CMS-64.

The state will conduct an annual review of the actual provision of services paid under the bundled rate to ensure that beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and ensure the rates remain economic and efficient based on the services that are actually provided as part of the bundle. The rate does not include costs related to room and board or any other unallowable facility cost, or other non-covered Medicaid services

Attachment K: Non-Traditional Benefit Package

State Name: Utah Attachment 3.1-L- OMB Control Number: 0938-1148 Transmittal Number: - -

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected: PEHP Utah Basic Plus

Adult Medicaid Expansion

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved 1115 Waiver

■ 1. Essential Health Benefit: Ambulatory patient services Collapse All ☐

Benefit Provided: Outpatient Hospital Services
Source: Secretary-Approved Other
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Some services require prior authorization

Benefit Provided: Clinic Services
Source: Secretary-Approved Other
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Includes ambulatory surgical centers and dialysis

Benefit Provided: Family Planning Services
Source: Secretary-Approved Other
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Physician Services

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Medical and Surgical Services by a Dentist

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Podiatry

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Varies

Duration Limit: Varies

Scope Limit:

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

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

Benefit Provided: Optometry Services

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 exam

Duration Limit: 12 months

Scope Limit:

Eyeglasses are not covered

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

Benefit Provided: Services Provided by Licensed Nurse Practitioners

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Benefit Provided: Home Health Services

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

Benefit Provided:

Hospice

Source:

Secretary-Approved Other

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Audiology

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

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

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

Benefit Provided:

Personal Care Services

Source:

Secretary-Approved Other

Remove

Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	**Duration Limit:**
60 hours	30 days

Scope Limit:

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

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

Add

■ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Hospital Services
Source: Secretary-Approved Other
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Benefit Provided: Ambulance Transportation
Source: Secretary-Approved Other
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:
□ Life of the member is in immediate danger
□ Life support equipment or medical care is required during travel
□ Other means of transportation would endanger the member's health or be medically contraindicated

Add

■ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided:
Inpatient Hospital Services

Source:
Secretary-Approved Other

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

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

Add

■ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided: Extended Services to Pregnant Women

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Perinatal Care Coordination

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

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

Benefit Provided: Prenatal and Postnatal Home Visits

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 Visits

Duration Limit: 12-month period

Scope Limit:

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

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

Remove

Benefit Provided:

Group Prenatal/Postnatal Education

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

8 Units

Duration Limit:

12-month period

Scope Limit:

None

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

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

Remove

Benefit Provided:

Prenatal and Postnatal Psychosocial Counseling

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

12 Visits

Duration Limit:

12-month period

Scope Limit:

None

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

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

Remove

Benefit Provided:

Nutritional Assessment Counseling

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

14 Visits

Duration Limit:

12-month period

Scope Limit:

None

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

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

Remove

Benefit Provided:

Freestanding Birthing Clinics

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Remove

Benefit Provided:

Extended Services for Pregnant Women-Other Service

Source:

Secretary-Approved Other

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Add

Collapse All

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

Remove

Benefit Provided:
Psychiatric Diagnostic Evaluation

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Remove

Benefit Provided:
Mental Health Assessment

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Remove

Benefit Provided:
Psychological Testing

Source:
Secretary-Approved Other

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided: Psychotherapy

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Pharmacologic Management-Rehabilitative Mental Hea

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Nurse Medication Management

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Benefit Provided:

Therapeutic Behavioral Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Psychosocial Rehabilitative Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Peer Support Services

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Inpatient Hospital-Mental Health

Source:

Secretary-Approved Other

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Residential and Inpatient Treatment for SUD

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 days

Duration Limit:

12 months

Scope Limit:

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

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.
SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD.

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

Add

☐ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		

Coverage that exceeds the minimum requirements or other:

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Physical Therapy and Occupational Therapy

Source: Secretary-Approved Other

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 16

Duration Limit: 12 months

Scope Limit: Limitations are combined for physical therapy and occupational therapy visits

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

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

Benefit Provided: Prosthetic Devices

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Durable Medical Equipment and Supplies

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Varies

Duration Limit: Varies

Scope Limit: Varies

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

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

Add

☐ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided:
Other Laboratory and X-Ray Services

Source:
Secretary-Approved Other

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Add

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

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

Benefit Provided: Diabetes Self-Management Training

Source: Secretary-Approved Other

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 10 hours

Duration Limit: 12-month period

Scope Limit:

Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients.

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

Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.

Benefit Provided: Tobacco Cessation

Source: Secretary-Approved Other

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 7

Duration Limit: 12 months

Scope Limit:

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

Within the State Plan this benefit is entitled 'Face-to-face Tobacco Cessation Counseling Services for Pregnant Women." Tobacco cessation services are not only covered for pregnant women. The State provides tobacco cessation services under the State Plan benefits including Physician Services, Outpatient Hospital Services, Prescribed Drugs, and Clinic Services. Utah Medicaid offers a total of 7 sessions in a 12-month period.

Add

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Through age 20

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

Add

11. Other Covered Benefits from Base Benchmark Collapse All

12. Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All

Base Benchmark Benefit that was Substituted:	Source:	
Adoption: Substitution	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Primary Care Visit to Treat an Injury: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Specialist Visit: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Other Practitioner Office Visit: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Facility Fee: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Surgery Physician/Surgical Services: Du	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted: Hospice Services: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Urgent Care Centers: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Home Health Care: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Dialysis: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Chemotherapy and Radiation: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Infusion Therapy: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Reconstructive Surgery: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Emergency Room Services: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Emergency Transportation/Ambulance: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Rehabilitation Services: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted: Habilitation Services: Duplication

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: Substitution

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: Durable Medical Equipment/Supply: Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Durable Medical Equipment and Medical Supplies in EHB7. Medicaid Limitations: The following items are excluded from coverage as benefits of the Medicaid program:
1. First aid supplies with the exception of supplies used for post- surgical need, accidents, decubitus treatment, and long-term dressing.
2. Surgical stocking if ordered by a non-physician.
3. Syringes in excess of 100 per month.
4. Beds, when the recipient is not bed-confined.
5. Variable height beds.
6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.
7. Oxygen systems provided more frequently than monthly.
8. Spring-loaded traction equipment.

9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.
a. Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs require prior authorization and review.
Base Benchmark: Except for oxygen, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require preauthorization. Maximum limits apply on many items. Sleep Disorder equipment is not covered. TENS units, Neuromuscular stimulator, H-Wave electronic devices, Sympathetic therapy stimulators are not covered.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility/Rehabilitation:See Notes

Source: Base Benchmark

Remove

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

Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year. Requires preauthorization. This services is not detailed as a covered service for this benefit package.

Base Benchmark Benefit that was Substituted: Inpatient Hospitalization: Duplication

Source: Base Benchmark

Remove

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

Covered under Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Medicaid Limitations: 1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State
of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.
2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.
3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.
4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.
5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.
6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.
7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).
8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval.
Base Benchmark: The following are Exclusions of the policy:
1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community

reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications., unless legally required and approved by PEHP.
12. Mastectomy for gynecomastia.
13. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
14. Breast reduction.
15. Tests and treatment for infertility.
16. Blepharoplasty (or other eyelid Surgery).
17. All facility claims related to a Hospital stay when the Member is discharged against medical advice.
18. Sclerotherapy of varicose veins.
19. Microphlebectomy (stab phlebectomy).
20. Blood clotting factor.
21. Inpatient or outpatient dental hospitalization.

Base Benchmark Benefit that was Substituted: MH-Substance Facility and Hospital Services-Duplic

Source: Base Benchmark

Remove

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

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Preauthorization required for many services. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed. Day treatment or intensive outpatient programs require Preauthorization. If approved, Benefit applied is the same as inpatient.

Base Benchmark Benefit that was Substituted: MH-Substance Inpatient Provider Visits-Duplication

Source: Base Benchmark

Remove

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

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Only one visit per Provider of the same specialty per day is payable.
1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member’s plan.
2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.

5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
13. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted: MH-Substance Outpatient Provider Visits-Duplicatio

Source: Base Benchmark

Remove

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

Covered under Secretary Approved 1115 Waiver as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5. Base Benchmark Plan: Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. Only one visit per Provider of the same specialty per day is payable.
1. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
2. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Wilderness programs.
4. Inpatient treatment for behavior modification, enuresis, or encopresis.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or Recreational Therapy.
7. Sodium amobarbital interviews.
8. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
9. Tobacco abuse.

Base Benchmark Benefit that was Substituted: Lab, X-Ray, and Diagnostic Imaging: Duplication

Source: Base Benchmark

Remove

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

Covered under Secretary Approved 1115 Waiver as Other Laboratory and X-Ray Services in EHB8. Base Benchmark:
1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to

the potential diagnosis.
2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.
3. Drug screening, up to 2 times in a 30-day period.
4. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.
The following are Exclusions of the policy:
1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.
2. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological counseling and testing.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
11. Sleep Studies for sleep disorders.
12. Services in conjunction with diagnosing infertility.
13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.
14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.
15. Whole exome and whole genome sequencing for the diagnosis of genetic disorders.
16. Chromosomal Microarray Analysis (CMA) for Autism Spectrum Disorder.

Base Benchmark Benefit that was Substituted: Preventive Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care: Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Extended Services for Pregnant Women and Prenatal and Postnatal Home Visits in EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient for Maternity: Duplicat

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Allergy Testing: Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Diabetes Education-Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Diabetes Self-Management Education in EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Transplant-Duplication

Source: Base Benchmark

Remove

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

Covered under the Secretary Approved 1115 Waiver as Inpatient Hospital Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Speech Language Pathology-Substitution

Source: Base Benchmark

Remove

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

Speech Language Pathology Services was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Physical, Occupational, and Speech Therapy limited to 10 visits per plan year for all therapy types combined. Speech therapy requires preauthorization.

Add

13. Other Base Benchmark Benefits Not Covered Collapse All

14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All

Other 1937 Benefit Provided: Optometry Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Other:

Prior authorization is not required.

Other 1937 Benefit Provided:
Targeted Case Management for Tuberculosis

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

Other 1937 Benefit Provided:
Routine Patient Cost in Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
This benefit is subject to the provisions set forth for qualifying clinical trials as found in the "Consolidated Appropriations Act, 2021" amendment to Section 1905 of the Social Security Act (42 U.S.C. 1396d). See Supplement to Attachment 3-A, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials in Utah's Medicaid State Plan.

Other 1937 Benefit Provided:	Source:	Remove
Medication-Assisted Treatment (MAT)	Section 1937 Coverage Option Benchmark Benefit Package	

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

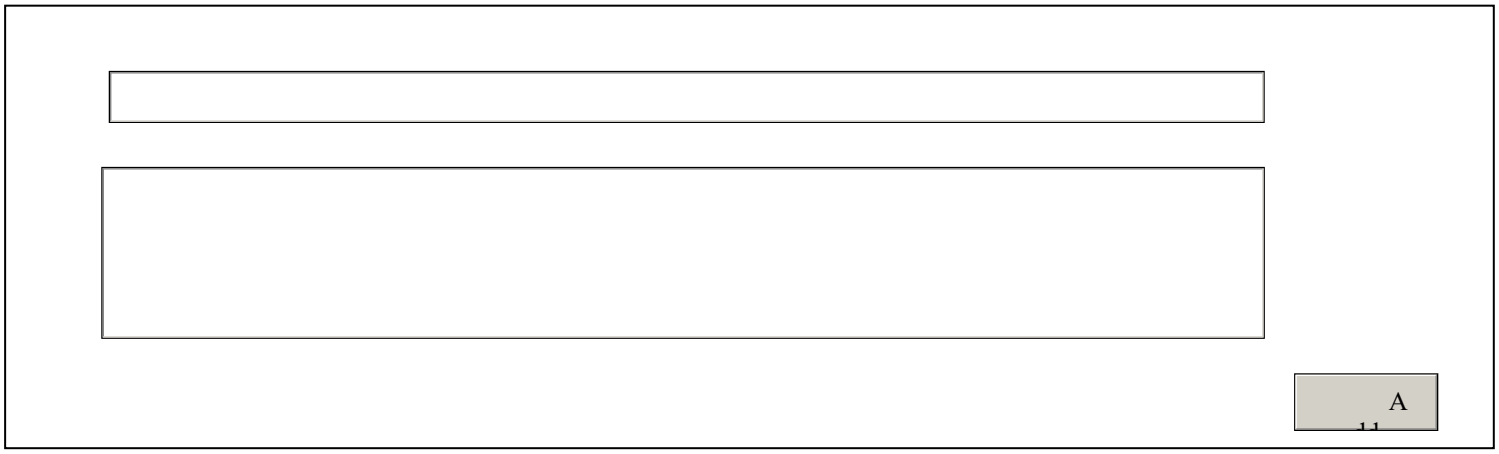
Other

Scope Limit:

None

Other:

This benefit is subject to the provisions set forth for medication-assisted treatment pursuant to Section 1006(b) of the SUPPORT Act, an amendment to Section 1905(a)(29) of the Social Security Act (42 U.S.C. 1396d). MAT is provided as defined in the approved State Plan 3.1-A and, if applicable, 3.1-B pages. MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.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☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Attachment L: Traditional Benefit Package

State Name: Utah Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: - -

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

PEHP Utah Basic Plus
Adult expansion population who are childless adults or non-custodial parent
Targeted Adults

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

■ 1. Essential Health Benefit: Ambulatory patient services

Collapse All ☐

Benefit Provided: Outpatient Hospital Services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Some services require prior authorization. Reconstructive surgery is covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

Benefit Provided: Clinic Services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Some services require prior authorization. Services includes ambulatory surgical centers and dialysis.

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Some services require prior authorization. Reconstructive surgery is covered when performed to correct deformity resulting from disease, trauma, congenital anomaly, or previous therapeutic intervention.

Benefit Provided:

Services Provided by Licensed Nurse Practitioners

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Some services require prior authorization.

Benefit Provided:

Personal Care Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

60 hours

Duration Limit:

30-day period

Scope Limit:

None

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

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

Add

■ 2. Essential Health Benefit: Emergency services

Collapse All ☐

Benefit Provided: Emergency Hospital Services

Authorization: None

Amount Limit: None

Scope Limit: None

Source: State Plan 1905(a) Provider Qualificat

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None

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

Benefit Provided: Ambulance Transportation

Authorization: None

Amount Limit: None

Scope Limit: None

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a) Provider Qualifications:

c) Applicable State Plan and Duration Limit: None

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

Ambulance services (ground, air or water) are covered for transportation in the following circumstances:
1. Life of the member is in immediate danger
2. Life support equipment or medical care is required during travel
3. Other means of transportation would endanger the member's health or be medically contraindicated

Add

■ 3. Essential Health Benefit: Hospitalization

Collapse All ☐

Benefit Provided:

Inpatient Hospital Services

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

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

Benefit Provided:

Inpatient Physician Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Transplant

Source:

State Plan 1905(a)

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount

Limit: None

Duration Limit:

None

Scope Limit:

None

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

A

■ 4. Essential Health Benefit: Maternity and newborn care

Collapse All ☐

Benefit Provided: Extended Services to Pregnant Women

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Some services require prior authorization.

Benefit Provided: Inpatient Care for Maternity and Newborn

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Physician Services for Maternity and Newborn

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided:
Prenatal/Postnatal Care

Source:
State Plan

Authorization:
Authorization required in excess of limitation

1905(a)

Amount Limit: Varies

Provider Qualifications:
Medicaid State Plan

Scope Limit: Varies

Duration Limit:
Varies

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

Services include the following:
1. Prenatal and postnatal home visits, 6 visits in a 12-month period. This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.
2. Group prenatal/postnatal education, 8 units in a 12-month period. This services is provided through certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.
3. Prenatal/postnatal psychosocial counseling, 12 visits in a 12-month period. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.
4. Nutritional assessment counseling, 14 visits in a 12-month period. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occur.

Add

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

Collapse All

☐

☑

Remove

Benefit Provided:
Psychiatric Diagnostic Evaluation

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Utah does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided:
Mental Health Assessment

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Remove

Benefit Provided:
Psychological Testing

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

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

Benefit Provided: Psychotherapy

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Pharmacologic Management-Rehabilitative Mental Hea

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Nurse Medication Management

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Benefit Provided:

Therapeutic Behavioral Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Psychosocial Rehabilitative Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Peer Support Services

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Benefit Provided:

Inpatient Hospital-Mental Health

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Services are not provided for members in Institutions for Mental Disease for those ages 21-64.

Benefit Provided:

Inpatient Treatment for SUD

Source:

Secretary-Approved Other

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Medical detoxification only

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

Benefit Provided:

Residential Treatment

Source:

Secretary-Approved Other

Remove

Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	**Duration Limit:**
60 days	12-month period

Scope Limit:

None

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

Utah Medicaid's 1115 Primary Care Network Demonstration Waiver waives federal Institution for Mental Disease (IMD) exclusions for licensed SUD residential treatment programs with 17 or more beds. This means that licensed SUD residential treatment programs with 17 or more beds are eligible for Medicaid reimbursement. This also means that Medicaid members age 22 through 64 in these larger programs are now eligible for Medicaid reimbursement.
SUD residential treatment in these programs means face-to-face services that are a combination of Medically Necessary Services. Services are provided according to each Medicaid member's ASAM assessment and treatment plan and are provided to treat the individual's documented SUD. These programs are responsible to ensure appropriate transitions to other levels of outpatient SUD services either by directly providing the level of care needed or by coordinating the transition to the needed level of care with another provider.

A

☐ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

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

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☐ Limit on number of prescriptions
- ☒ Limit on brand drugs
- ☒ Other coverage limits
- ☒ Preferred drug list

Authorization:	Provider Qualifications:
Yes	State licensed

Coverage that exceeds the minimum requirements or other:

The State of Utah's ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices Collapse All ☐

Benefit Provided: Skilled Nursing Facility Services
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

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

Utah assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Rehabilitative and habilitative limits are combined, limits may be exceeded based on medical necessity.

Benefit Provided: Physical Therapy-Rehabilitative and Habilitative
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: 20
Duration Limit: 12-month period
Scope Limit: None

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

Benefit Provided: Durable Medical Equipment and Supplies
Source: State Plan 1905(a)
Remove

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: Varies
Duration Limit: Varies
Scope Limit: Varies

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

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

Remove

Benefit Provided: Occupational Therapy-Rehabilitative and Habilitati

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 20

Duration Limit: 12-month period

Scope Limit: None

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

Remove

Benefit Provided: Speech Language Pathology-Rehab and Habilitative

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Varies

Duration Limit: Varies

Scope Limit: Varies

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

Limitation:
1. One speech evaluation per client per year is a covered service.

Benefit Provided: Home Health Services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Services include home health nursing services and home health aide services.

Benefit Provided: Physical Therapy in the Home

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

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

Benefit Provided: Hospice

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

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

Services include the following:
1. Routine home care
2. Continuous home care
3. Inpatient respite care
4. Room and board
5. General inpatient care

A

☐ 8. Essential Health Benefit: Laboratory services

Collapse All ☐

Remove

Benefit Provided:

Other Laboratory and X-Ray Services

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

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

Some services require prior authorization.

Add

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

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

Benefit Provided:
Diabetes Self-Management Training

Source:
State Plan

Authorization:
Authorization required in excess of limitation

1905(a)

Amount Limit: 10 hours

Provider Qualifications:
Medicaid State Plan

Scope Limit:

Duration Limit:
12-month period

Instructors eligible to provide diabetes self-management training will include registered nurses, registered pharmacists and certified dieticians licensed by the state who are eligible under their scope of practice to provide counseling for patients.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Diabetes self-management is limited to that certified by the physician, under a comprehensive plan, as essential to ensure successful diabetes management by the individual patient.

Benefit Provided: Tobacco Cessation

Source:
State Plan

Authorization: None

1905(a)

Amount Limit: 7

Scope Limit: None

)

Provider Qualifications:

Medicaid State Plan and Duration Limit:

12-month period

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

Add

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

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Through age 20

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

Add

11. Other Covered Benefits from Base Benchmark Collapse All

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

Remove

Base Benchmark Benefit that was Substituted:	Source:
Inpatient Physician and Surgical Services: Duplica	Base Benchmark

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

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services and Inpatient Physician Services, under EHB3 and Physician Services, under EHB1.
Base Benchmark: The following are exclusions of the surgical policy:
1. Breast Reconstructive Surgery, augmentation or implants solely for cosmetic purposes.
2. Capsulotomy, replacement, removal or repair of breast implant originally placed for cosmetic purposes or any other complication(s) of cosmetic or non-covered breast surgery.
3. Obesity Surgery such as Lap Band, gastric bypass, stomach stapling, gastric balloons, etc., including any present or future complications.
4. Any service or Surgery that is solely for cosmetic purposes to improve or change appearance or to correct a deformity without restoring a physical bodily function, with the following exceptions:
a. Breast Reconstructive Surgery as allowed underWHCRA for Cosmetic purposes: and
b. Reconstructive Surgery made necessary by an Accidental injury in the preceding five years.
5. Rhinoplasty for Cosmetic reasons is excluded except when related to an Accidental injury occurring in the preceding five years and requires preauthorization.
6. Assisted reproductive technologies: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body.
Any related services performed in conjunction with these procedures are also excluded.
7. Surgical treatment for correction of refractive errors.
8. Expenses incurred for Surgery, pre-operative testing, treatment, or Complications by an organ or tissue donor, where the recipient is not an eligible Member, covered by PEHP, or when the transplant for the PEHP Member is not eligible.
9. Reversal of sterilization.
10. Gender reassignment Surgery.
11. Rhytidectomy.
12. Dental services, except when the result of an accident, including surgery, care, and treatment of the teeth, gums, or alveolar process, extraction of teeth; dental implants and crowns or pontics over implants, re-implantation or splinting, endodontia,
periodontia, and orthodontia, including anesthesia
or supplies used in such care.
13. Complications as a result of non-covered or
ineligible Surgery, regardless of when the Surgery was performed or whether the original Surgery was covered by a health plan.
14. Injection of collagen, except as approved for urological procedures.
15. Lipectomy, abdominoplasty, panniculectomy, unless any of these procedures are medically necessary to treat an unintended adverse event of an eligible surgery.
16. Repair of diastasis recti.
17. Sperm banking system, storage, treatment, or other such services.
18. Non-FDA approved or experimental or investigational procedures, drugs and Devices.
19. Hair transplants or other treatment for hair loss or restoration.
20. Chemical peels.
21. Treatment for spider or reticular veins.
22. Liposuction.
23. Orthodontic treatment or expansion appliance in conjunction with jaw Surgery.
24. Chin implant, genioplasty or horizontal symphyseal osteotomy.
25. Unbundling or fragmentation of surgical codes.

26. Any Surgery solely for snoring.
27. Otoplasty.
28. Abortions, except if the pregnancy is the result of rape or incest, or if necessary to save the life of the mother.
29. Surgical treatment for sexual dysfunction.
30. Subtalar implants.
31. Additional fees charged because a robotic surgical system was used during surgery.
32. Mastectomy for gynecomastia.
33. Elective home delivery for childbirth.

Base Benchmark Benefit that was Substituted:	Source:	
Primary Care Visit to Treat an Injury: Duplication	Base Benchmark	Remove

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

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Specialist Visit: Duplication	Base Benchmark	Remove

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

Covered under the Utah Medicaid State Plan as Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Other Practitioner Office Visit: Duplication	Base Benchmark	Remove

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

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

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Facility Fee: Duplication	Base Benchmark	Remove

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

Covered under the Utah Medicaid State Plan as Clinic Services including ambulatory surgical centers, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted:	Source:	
Outpatient Surgery Physician/Surgical Services: Du	Base Benchmark	Remove

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

Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Hospice Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Hospice Services, under EHB 7. Base Benchmark Plan: Limitation of 6 months per 3 years. The following are Exclusions of the policy:
1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to provider's offices or elsewhere, or food services.
7. Total Parenteral Nutrition through Hospice.
8. Enteral nutrition, unless obtained through the pharmacy card.

Base Benchmark Benefit that was Substituted: Urgent Care Centers: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations.

Base Benchmark Benefit that was Substituted: Home Health Care: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Home Health Services under EHB 7, under EHB 1. Base Benchmark Plan: Limitation 30 visits per benefit period. The following are Exclusions of the policy:
1. Nursing or aide services which are requested by or for the convenience of the Member or family, which do not require the training, judgment, and technical skills of a nurse, whether or not another person is available to perform such services. This Exclusion applies even when services are recommended by a Provider.
2. Private duty nursing.
3. Home health aide.
4. Custodial Care.
5. Respite Care.
6. Travel or transportation expenses, escort services to provider's offices or elsewhere, or food services.

7. Total Parenteral Nutrition through Hospice.
8. Enteral Nutrition, unless obtained through the pharmacy card.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility: Duplication
Source: Base Benchmark
Remove

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

Covered under the Utah Medicaid State Plan as Skilled Nursing Facility Services under EHB 7. Base Benchmark Plan: Limitation 30 days per plan year

Base Benchmark Benefit that was Substituted: Dialysis: Duplication
Source: Base Benchmark
Remove

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

Covered under the Utah Medicaid State Plan as Clinic Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Chemotherapy and Radiation: Duplication
Source: Base Benchmark
Remove

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

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Infusion Therapy: Duplication
Source: Base Benchmark
Remove

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

Covered under the Utah Medicaid State Plan as Outpatient Hospital Services, Clinic Services, under EHB 1, and Home Health Services, under EHB7. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Reconstructive Surgery: Duplication
Source: Base Benchmark
Remove

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

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3, Outpatient Hospital Services, and Physician Services, under EHB 1. Base Benchmark Plan: Covered when performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, which restores bodily function. While the Medicaid limitation language, found under Inpatient Hospital Services, Outpatient Hospital Services, and Physician Services listed above in EHB 1 and EHB 3 is more succinct, the scope of the benefit is equal. Infection and tumors can be classified under disease and a developmental anomaly is a broad term used to define conditions which are

present at conception or occur before the end of pregnancy (also classified as congenital), those that occur after are due to things such as cerebral palsy and can be classified as disease-related.

Base Benchmark Benefit that was Substituted: Emergency Room Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Emergency Hospital Services, under EHB 2. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Ambulance Transportation, under EHB 2. Base Benchmark Plan: Limitation medical emergencies only, as determined by PEHP

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted: Habilitation Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 10 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted: Cardiac Rehabilitation: Substitution

Source: Base Benchmark

Remove

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

Cardiac rehabilitation was removed and replaced in EHB 7 by substitution with the actuarial value of additional Physical Therapy and Occupational Therapy visits and unlimited Physical Therapy in home health with prior authorization which are not covered in the Base Benchmark Plan. Base Benchmark Plan: Cardiac Rehabilitation, Phase 2, following heart attack, cardiac surgery, severe angina (chest pain), and

Pulmonary Rehabilitation, Phase 2, resulting from chronic pulmonary disease or Surgery, are payable up to 5 visits combined per plan year.

Base Benchmark Benefit that was Substituted: Durable Medical Equipment/Supply: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Durable Medical Equipment and Medical Supplies, under EHB7.
Base Benchmark: Except for oxygen, DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require preauthorization. Maximum limits apply on many items. Sleep Disorder equipment is not covered. TENS units, Neuromuscular stimulator, H-Wave electronic devices, Sympathetic therapy stimulators are not covered.
The following are excluded:
1. Training and testing in conjunction with Durable Medical Equipment or prosthetics; 2. More than one lens for each affected eye following Surgery for corneal transplant; 3. Durable Medical Equipment that is inappropriate for the patient's medical condition; 4. Diabetic supplies, i.e. insulin, syringes, needles, etc., are a pharmacy benefit; 5. Equipment purchased from non-licensed Providers; 6. Used Durable Medical Equipment; 7. TENS Unit; 8. Neuromuscular Stimulator; 9. H-wave Electronic Device; 10. Sympathetic Therapy Stimulator (STS); 11. Limb prosthetics; 12. Machine rental or purchase for the treatment of sleep disorders; 13. Support hose for phlebitis or other diagnosis. 14. Foot orthotics.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility and Rehabilitation: Dupli

Source: Base Benchmark

Remove

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

Covered under Utah Medicaid State Plan as Skilled Nursing Facility Services in EHB7. Base Benchmark Plan: Non-custodial. Up to 30 combined days per plan year.

Base Benchmark Benefit that was Substituted: Inpatient Hospitalization: Duplication

Source: Base Benchmark

Remove

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

Covered under Utah Medicaid State Plan as Inpatient Hospital Services in EHB3.
Base Benchmark:
The following are Exclusions of the policy:
1. Ineligible Surgical Procedures or related Complications.
2. Treatment programs for enuresis or encopresis.
3. Services or items primarily for convenience, contentment, or other non-therapeutic purpose, such as: guest trays, cots, telephone calls, shampoo, toothbrush, or other personal items.
4. Occupational therapy or other therapies for activities of daily living, academic learning, vocational or life skills, developmental delay, unless authorized by PEHP for the treatment of Autism.
5. Care, confinement or services in a nursing home, rest home or a transitional living facility, community reintegration program, vocational rehabilitation, services to re-train self care, or activities of daily living.
6. Recreational therapy.
7. Autologous (self) blood storage for future use.
8. Organ or tissue donor charges, except when the recipient is an eligible Member covered under a PEHP

plan, and the transplant is eligible.
9. Nutritional analysis or counseling, except in conjunction with diabetes education, anorexia, bulimia, or as covered under the Affordable Care Act Preventive Services.
10. Custodial Care and/or maintenance therapy.
11. Take-home medications., unless legally required and approved by PEHP.
12. Mastectomy for gynecomastia.
13. Any eligible Surgical Procedure when performed in conjunction with other ineligible Surgery.
14. Breast reduction.
15. Tests and treatment for infertility.
16. Blepharoplasty (or other eyelid Surgery).
17. All facility claims related to a Hospital stay when the Member is discharged against medical advice.
18. Sclerotherapy of varicose veins.
19. Microphlebectomy (stab phlebectomy).
20. Blood clotting factor.
21. Inpatient or outpatient dental hospitalization.

Base Benchmark Benefit that was Substituted: Lab, X-Ray, and Diagnostic Imaging: Duplication

Source: Base Benchmark

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

Covered under the Utah Medicaid State Plan as Other Laboratory and X-Ray Services, under EHB8. Base Benchmark:
1. Lab and x-rays are only eligible for diagnosing or treating symptomatic illness and must be specific to the potential diagnosis.
2. Laboratory typing/testing for organ transplant donors is eligible only when recipient is an eligible Member, covered under a PEHP plan, and the transplant is eligible.
3. Drug screening, up to 2 times in a 30-day period.
4. Drug confirmatory laboratory tests, up to 2 codes in a 30-day period.
The following are Exclusions of the policy:
1. Charges in conjunction with ineligible procedures, including pre- or post- operative evaluations.
2. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
3. Sublingual or colorimetric allergy testing.
4. Charges in conjunction with weight loss programs regardless of Medical Necessity.
5. Epidemiological counseling and testing.
6. Probability and predictive analysis and testing.
7. Unbundling of lab charges or panels.
8. Medical or psychological evaluations or testing for legal purposes such as paternity suits, custodial rights, etc., or for insurance or employment examinations.
9. Hair analysis, trace elements, or dental filling toxicity.
10. Assisted reproductive technologies, including but not limited to: invitro fertilization; gamete intra fallopian tube transfer; embryo transfer; zygote intra fallopian transfer; pre-embryo cryopreservation techniques; and/or any conception that occurs outside the woman's body. Any related services performed in conjunction with these procedures are also excluded.
11. Sleep Studies for sleep disorders.
12. Services in conjunction with diagnosing infertility.
13. Amniocentesis or chorionic villi sampling, except for high risk pregnancy or as allowed under the Affordable Care Act Preventive Services.
14. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted: Preventive Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Preventive Services, under EHB9. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Extended Services for Pregnant Women and Prenatal/ Postnatal Care under EHB4. Base Benchmark Plan: No Limitations

Base Benchmark Benefit that was Substituted: Delivery and All Inpatient for Maternity: Duplicat

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Inpatient Hospital Services, under EHB3 and Inpatient Care for Maternity and Newborn in EHB4. Base Benchmark Plan: No limitations

Base Benchmark Benefit that was Substituted: Allergy Testing: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Physician Services, under EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Diabetes Education: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Diabetes Self-Management Education, under EHB9. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Transplant: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Transplant Services in EHB3, Outpatient Hospital Services and Physician Services in EHB1. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Physical Therapy, Occupational Therapy, and Speech Therapy, under EHB7. Base Benchmark Plan: Limited to 20 visits per plan year for all therapy types combined.

Base Benchmark Benefit that was Substituted: Imaging (CT/PET Scans, MRIs)

Source: Base Benchmark

Remove

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

Covered under Utah Medicaid State Plan as Other Laboratory and X-Ray Services in EHB8. Base Benchmark: No limitations

Base Benchmark Benefit that was Substituted: Nutritional Counseling: Duplication

Source: Base Benchmark

Remove

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

Covered under Utah Medicaid State Plan as Physician Services and Services Provided by Licensed Nurse Practitioners in EHB1. Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted: Inherited Metabolic Disorder-Duplication

Source: Base Benchmark

Remove

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

Covered under Physician Services and Outpatient Hospital Services in EHB1 and Inpatient Hospital Services in EHB3. Base Benchmark: No limitations.

Base Benchmark Benefit that was Substituted: MH-Substance Outpatient Provider Visits-Duplicatio

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication

Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, and Peer Support Services in EHB5 Tobacco Cessation, under EHB9. Base Benchmark Plan: 8 visits per plan year combined mental health and substance abuse disorder outpatient services. Outpatient treatment by a licensed psychologist, licensed clinical social worker, medical Provider or licensed psychiatric nurse specialist is eligible. Only one visit per Provider of the same specialty per day is payable.
1. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
2. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
3. Wilderness programs.
4. Inpatient treatment for behavior modification, enuresis, or encopresis.
5. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
6. Occupational or Recreational Therapy.
7. Sodium amobarbital interviews.
8. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
9. Tobacco abuse.

Base Benchmark Benefit that was Substituted: MH-Substance/Facil and Hospital Svcs-Duplic/Substi

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Inpatient Hospital-Mental Health, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, Inpatient Treatment for SUD, and Peer Support Services, under EHB5. The base benchmark benefit for inpatient treatment for SUD has a greater scope than the Medicaid benefit, therefore, the State submits Residential Treatment, under EHB5 as a substitution for the difference in scope.
Base Benchmark Plan: 30 days per plan year combined mental health and substance abuse disorder services. Preauthorization required for many services. Inpatient Provider visits are payable only in conjunction with authorized inpatient days, and will apply to benefits in effect under the plan year on the actual date of service billed. Day treatment or intensive outpatient programs require Preauthorization. If approved, Benefit applied is the same as inpatient.

Base Benchmark Benefit that was Substituted: MH-Substance/Inpatient Provider Visits-Dupl/Substi

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Psychiatric Diagnostic Evaluation, Mental Health Assessment, Psychological Testing, Psychotherapy, Pharmacological Management, Nurse Medication Management, Therapeutic Behavioral Services, Psychosocial Rehabilitative Services, Inpatient Treatment for SUD, and Peer Support Services, under EHB5. The base benchmark benefit for inpatient treatment for SUD has a greater scope than the Medicaid benefit, therefore, the State submits Residential Treatment, under EHB5 as a substitution for the difference in scope.
Base Benchmark Plan: Only one visit per Provider of the same specialty per day is payable.
1. Inpatient treatment for Mental Health without Preauthorization, if required by the Member's plan.

2. Milieu therapy, marriage counseling, encounter groups, hypnosis, biofeedback, parental counseling, stress management or relaxation therapy, conduct disorders, oppositional disorders, learning disabilities, and situational disturbances.
3. Mental or emotional conditions without manifest psychiatric disorder or non-specific conditions.
4. Wilderness programs.
5. Inpatient treatment for behavior modification, enuresis, or encopresis.
6. Psychological evaluations or testing for legal purposes such as custodial rights, etc., or for insurance or employment examinations.
7. Occupational or Recreational Therapy.
8. Hospital leave of absence charges.
9. Sodium amobarbital interviews.
10. Unless Provider meets PEHP's defined network needs and meets the PEHP specific credentialing and quality standards, services, procedures, medications, or Devices received at or from a residential treatment center which is not providing in-patient services, including but not limited to, services for residential treatment, day treatment and/or intensive outpatient treatment.
11. Tobacco abuse.
12. Routine drug screening, except when ordered by a treating physician and done for a medical purpose, as determined by PEHP, or unless otherwise allowed by the Master Policy.
13. Drug screening in conjunction with PEHP authorized treatment are considered inclusive to the treatment and are not payable separately.

Base Benchmark Benefit that was Substituted: Adoption: Substitution

Source: Base Benchmark

Remove

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

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

Base Benchmark Benefit that was Substituted: MH-Substance for Tobacco Abuse: Duplication

Source: Base Benchmark

Remove

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

Covered under the Utah Medicaid State Plan as Tobacco Cessation, under EHB 9. Base Benchmark: Covered under Mental Health and Substance Abuse Disorder Treatment, outpatient visits are limited to 8 per plan year.

Add

13. Other Base Benchmark Benefits Not Covered Collapse All

14. Other 1937 Covered Benefits that are not Essential Health Benefits

Collapse All

Other 1937 Benefit Provided:

Family Planning Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Targeted Case Mgmt - Chronically Mentally Il

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Specialized services for mentally ill individuals means the services from an individualized plan of care that:
a. Are prescribed only for persons experiencing an acute episode of serious mental illness, which necessitates supervision of trained mental health personnel;
b. Are developed and supervised by an interdisciplinary team, which includes a physician and qualified mental health professionals;
c. Are directed toward reducing behavioral symptoms and improving his or her level of independent functioning level that permits reduction in the intensity of mental health services; and
d. Are usually limited to inpatient psychiatric hospital care and care in an institution for mental diseases. Certain individuals, as applicable, are not precluded from receiving such services in a nursing facility

Other 1937 Benefit Provided:

Nursing Facility Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Amount Limit:
None

Scope Limit:
Long term custodial care

Other:
Must meet institutional level of care

Provider Qualifications: Medicaid State Plan

Duration Limit: None

Other 1937 Benefit Provided:
Targeted Case Management for Tuberculosis

Authorization: Other

Amount Limit: None

Scope Limit: None

Other:

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Provider Qualifications: Medicaid State Plan

Duration Limit:

N n
o e

Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

Other 1937 Benefit Provided: Optometry Services

Source:
Section 1937 Coverage Option
Benchmark Benefit Package

Authorization:
Other
Amount Limit:
None
Scope Limit:
None
Other:
Prior authorization is not required.

Provider Qualifications:
Medicaid State Plan
Duration Limit:
None

Other 1937 Benefit Provided:
Medical and Surgical Services by a Dentist

Authorization: Other
Amount Limit: None
Scope Limit: None
Other:

Source:
Section 1937 Coverage Option
Benchmark Benefit Package

Provider Qualifications:
Medicaid State Plan

Duration:

Limit: None

Remove

Services include emergency dental. Emergency dental services are the treatment of a sudden and acute onset of a dental condition that requires immediate treatment, where delay in treatment would jeopardize or cause permanent damage to a person's dental or medical health.

Other 1937 Benefit Provided: Podiatry

Authorization: Other

Amount Limit: Varies

Scope Limit: None

Other:

Source:
Section 1937 Coverage Option
Benchmark Benefit Package

Provider Qualifications

: Medicaid State Plan and Duration Limit: Variies

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

Other 1937 Benefit Provided:

Audiology

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Varies

Other:

Hearing aids are non-covered.

Other 1937 Benefit Provided:

Perinatal Care Coordination

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Other

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

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

Other 1937 Benefit Provided:

Freestanding Birthing Clinics

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Birthing center maternal patients shall be limited to women initially determined to be at low maternity risk

and evaluated regularly throughout pregnancy to ensure they remain at low risk for a poor pregnancy outcome.

Other 1937 Benefit Provided:
Long Term Acute Care-Rehabilitative

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Other 1937 Benefit Provided:
Routine Patient Cost in Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
This benefit is subject to the provisions set forth for qualifying clinical trials as found in the "Consolidated Appropriations Act, 2021" amendment to Section 1905 of the Social Security Act (42 U.S.C. 1396d). See Supplement to Attachment 3-A, Item 30. Coverage of Routine Patient Cost in Qualifying Clinical Trials in Utah’s Medicaid State Plan.

Other 1937 Benefit Provided:
Medication-Assisted Treatment (MAT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
Other

Scope Limit:

None

Other:

This benefit is subject to the provisions set forth for medication-assisted treatment pursuant to Section 1006(b) of the SUPPORT Act, an amendment to Section 1905(a)(29) of the Social Security Act (42 U.S.C. 1396d). MAT is provided as defined in the approved State Plan 3.1-A and, if applicable, 3.1-B pages. MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

A

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20160722

Attachment M: Modified Adjusted Gross Income (MAGI) Conversion Table

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*		Converted Standard
	A	B	C	D	E	F		G
		Conversions for FMAP Claiming						
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state)	**NO**	**Converted in Part 1 and described there.**	**NO**	% FPL _____ **or** Fixed dollar standards Family size 1_ $382_____ 2_ $468___ 3_ $583_ 4_ $682_ 5_ $777___ 6_ $857_ 7_ $897_ 8 $938 9 $982 10 $1023 11 $1066 12 $1108 13 $1150 14 $1192 15 $1236 16 $1277 Add-on for additional family members if relevant $42	% FPL **or** FPL% by family size (Fixed dollar standards) 1 – 16.0-41.0% 2 – 12.1-37.1% 3 – 11.6-36.6% 4 – 10.5-35.5% 5 – 9.5-34.5% 6 – 8.2-33.2% 7 – 5.8-30.8% 8 – 3.9-28.9% 9 – 2.5-27.5% 10 – 1.2-26.2% 11 – 0.2-25.2% 12 – 0-24.3% 13 – 0-23.5% 14 - 0-22.8% 15 - 0-22.3% 16 - 0-21.7% Add-on for additional family members if relevant_____		% FPL _____ **or** Fixed dollar standards Family size 1_ $438_____ 2_ $544___ 3_ $678_ 4_ $797_ 5_ $912___ 6 $1012_ 7 $1072_ 8 $1132 9 $1196 10 $1257 11 $1320 12 $1382 13 $1443 14 $1505 15 $1569 16 $1630 Add-on for additional family members if relevant $62
2	Non-institutionalized disabled adults	**YES**	**N/A**	**N/A**	% FPL 100% % SSI FBR ___ **or** Dollar Standards Single_____ Couple_____	%FPL _____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____		% FPL 102% % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____ Conversion based on: __ Average disregard __ Median disregard

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion*		Converted Standard
	A	B	C	D	E	F		G
3	Institutionalized disabled adults (This is a gross income category: fill in column G **only**)							% FPL _____ % SSI FBR _300%____ **or** Dollar Standards Single_____ Couple_____
4	Children age 19 and/or 20 **Specify age limit as of 12/1/09 (19 or 20):** _____ _	**N/A**			% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ _ 3_____ _ 4_____ _ 5_____ _ 6_____ _ 7_____ _ Add-on for additional family members if relevant_____	% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ _ 3_____ _ 4_____ _ 5_____ _ 6_____ _ 7_____ _ Add-on for additional family members if relevant_____		% FPL _____ or Fixed dollar standards Family size 1_____ 2_____ _ 3_____ _ 4_____ _ 5_____ _ 6_____ _ 7_____ _ Add-on for additional family members if relevant_____
5	Childless Adults	**N/A**			% FPL _____	% FPL _____		% FPL _____

Attachment N: Claiming Methodologies

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on December 20, 2019. In general, and subject to any adjustments described in this attachment, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Feature

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	Resource Proxy	Enrollment Cap	Special Circumstances	Other Adjustments
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C		D	
Parent/Caretaker Relatives	Attachment 1, Column C, line 1 of part 2 of the CMS approved MAGI Conversion Plan	No	No	No	No
Non-institutionalized Disabled Persons	Attachment 1, Column C, line 2 of part 2 of the CMS approved MAGI Conversion Plan	No	No	No	No
Institutionalized Disabled Person	Attachment 1, Column C, line 3 of part 2 of the CMS approved MAGI Conversion Plan	No	No	No	No
Children Age 19-20	Not covered	n/a	n/a	n/a	n/a
Childless Adults	Attachment 1, Column C, line 5 of part 2 of the CMS approved MAGI Conversion Plan	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The State:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ☒ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment 2.

2. Data source used for resource proxy adjustments:

   The State:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment 2.

3. Resource Proxy Methodology: Attachment 2 describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1.

   ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ☒ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment 3 describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009, that are applicable to populations that the State covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in

alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The State applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment 3
   ☐ No.

4. Enrollment Cap Methodology: Attachment 3 describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The State:

☐ Applies a special circumstances adjustment(s).

☒ Does not apply a special circumstances adjustment.

2. The State:

☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

☒ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment 4 describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment 5, and where applicable, is subject to any special circumstances or other adjustments described in Attachment 4.

☐ The State does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The State:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The State:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The State will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this attachment:

☒ Attachment 1 – Conversion Plan Standards Referenced in Table 1

☐ Attachment 2 – Resource Criteria Proxy Methodology

☐ Attachment 3 – Enrollment Cap Methodology

☐ Attachment 4 – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

☒ Attachment 5 – Transition Methodologies

Attachment 1: Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan**

	Population Group	Net Standard as if 12/1/09	Converted Standard for FMAP Claiming	Same as Converted Eligibility Standard?	Source of Information in Column C	Data Source for Conversion (SIPP or State Data)
	A	B	C	D	E	F
1	Parent/Caretaker Relatives	1 - $382 2 - $468 3 - $583 4 - $682 5 - $777 6 - $857 7 - $897 8 - $938 9 - $982 10 - $1,023 11 - $1,066 12 - $1,108 13 - $1,150 14 - $1,192 15 - $1,236 16 - $1,277 Add-on for additional family members - $42	1 - $438 2 - $544 3 - $678 4 - $797 5 - $912 6 - $1,012 7 - $1,072 8 - $1,132 9 - $1,196 10 - $1,257 11 - $1,320 12 - $1,382 13 - $1,443 14 - $1,505 15 - $1,569 16 - $1,630 Add-on for additional family members- $62	no	Table 1 of Approved MAGI Conversion Plan	State Data – Standardized Methodology
2	Non-institutionalized Disabled Persons	100%	102%	n/a	New SIPP conversion	SIPP
3	Institutionalized Disabled Person	300%	300%	n/a	ABD conversion template	n/a
4	Children Age 19-20	n/a	n/a	n/a	n/a	n/a
5	Childless Adults	150%	$0	no	n/a	n/a

*Parent/Caretaker Relative group is a fixed income standard.

**The numbers in this summary chart will be updated automatically in the case of modification in the CMS

approved MAGI Conversion Plan.

Attachment 5

Utah Adult Medicaid FMAP, Eligibility and Transition Plan
Populations Transitioning from Utah's 1115 Waiver to the New Adult Group

Population and MAGI Eligibility Levels	Enhanced FMAP Post Transition	Traditional FMAP Post Transition
Adult Expansion up to 95% FPL	X	
Non-institutionalized Disabled Persons up to 102% FPL		X
Targeted Adults up to 5% FPL and up to 133% FPL during continuous eligibility period	X	
Targeted Adults above 133% FPL during continuous eligibility period		X
Demonstration Population III & V (Utah's Premium Partnership for Health Insurance-UPP) up to 133% FPL	X	
Targeted Adults Dental ("TAD") up to 5% FPL and up to 133% FPL during continuous eligibility period	X	
Targeted Adults Dental ("TAD") above 133% FPL during continuous eligibility period		X
Mandatory Employer Sponsored Insurance for Adult Expansion up to 95% FPL	X	
Mandatory Employer Sponsored Insurance for Non-institutionalized Disabled Persons up to 102% FPL		X

Withdrawal Management for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL	X	
Withdrawal Management for non-Adult-Expansion; non-Targeted Adults groups; and Targeted Adults above 133% FPL during continuous eligibility period		X
Substance Use Disorder for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL	X	
Substance Use Disorder for non-Adult Expansion; non-Targeted Adults groups; and Targeted Adults above 133% FPL during continuous eligibility period		X

Under the 1115 Waiver, Utah covers seven demonstration populations that will transition to the new adult group.

- Adult Expansion individuals with income at or below 95% of FPL who are not part of the 1115 "Current Eligibles Demonstration Population" - These individuals currently receive a traditional or non-traditional state plan benefits equivalent to the ABPs.
- Targeted Adult (TAM) individuals with income at or below 5% of FPL and income at or below 133% of FPL during continuous eligibility period - These individuals currently receive traditional state plan benefits equivalent to the ABP. They will retain 12-month continuous eligibility, as allowed under the 1115 waiver.
- Targeted Adults Dental ("TAD") with income at or below 5% of FPL and income at or below 133% of FPL during continuous eligibility period.
- Demonstration Population III & V (UPP) with income at or below 133% FPL- These individuals currently receive premium assistance to help pay for the individual's or family's share of the monthly premiums costs of employer sponsored insurance or COBRA. These individuals will receive a traditional or non-traditional state plan benefits equivalent to the ABPs.
- Mandatory Employer Sponsored Insurance for Adult Expansion up to 95% FPL.
- Withdrawal Management for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL
- Substance Use Disorder for Adult Expansion up to 95% FPL and Targeted Adults up to 133% FPL

This eligibility transition will be completed administratively and will be effective January 1, 2020. Eligibility under the 1115 Waiver had already been determined using MAGI methodology so no MAGI conversion is necessary. The transition will be seamless for the member and there will be no disruption in coverage. Members will be sent a notice advising them of the change in their coverage to the more robust benefit package under the ABP, when applicable. Members will be advised of their appeal rights.

Attachment O: Reentry Demonstration Initiative Implementation Plan

[To be incorporated after CMS Approval]

Attachment P: Reentry Demonstration Initiative Reinvestment Plan

[To be incorporated after CMS approval]