Utah Section 1115 Demonstration Application

Per Capita Cap

Section I. Program Description and Objectives

During the 2019 General Session, the Utah State Legislature passed, and Governor Herbert signed into law, Senate Bill 96 "Medicaid Expansion Adjustments". This legislation directed the Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF) to seek 1115 waiver approval from the Centers for Medicare and Medicaid Services (CMS) to implement specific proposals. Some of these proposals had been previously approved by CMS on March 29, 2019 as part of the State's "Bridge Plan" for Medicaid expansion.

With this application, the State is seeking approval to implement the following new proposals for its Medicaid expansion as directed by Senate Bill 96:

- Authority to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion demonstration group, which will include the Targeted Adult demonstration group, as well as any components approved for this population
- A per capita cap funding mechanism
- Lock out from the Medicaid expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports
- Up to 12-months continuous Medicaid eligibility
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion demonstration group
- Additional flexibility for providing managed care

The State is also requesting to administer the following components and programs under this new waiver application, which are currently authorized under the State's 1115 Primary Care Network (PCN) Demonstration Waiver:

- Adult Expansion Population, which are adults age 19-64 who have household income up to 95 percent of the federal poverty level (FPL) using the modified adjusted gross income (MAGI) methodology, which includes a five percent of FPL disregard
- Targeted Adult Medicaid Population, including state plan dental benefits provided to Targeted Adults who are receiving Substance Use Disorder (SUD) treatment
- Clinically Managed Residential Withdrawal Pilot for the populations covered under this waiver application
- Substance Use Disorder treatment provided in an Institution for Mental Disease (IMD) for the populations covered under this waiver application

- Implementing a community engagement requirement for the Adult Expansion Population
- Authorizing the ability for the State to impose an enrollment cap
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults
- Requiring individuals with employer-sponsored insurance to enroll in the available insurance.

Components and demonstration populations authorized under the State's 1115 PCN Demonstration Waiver that are not indicated above as transitioning to the new Per Capita Cap waiver will remain in the State's current 1115 PCN Demonstration Waiver.

The proposals included in this request will apply only to the Adult Expansion Population described in Section II. "Program Overview and Demonstration Eligibility" below, unless otherwise noted. With this application, the State is requesting the Targeted Adult Population be considered a subgroup of the Adult Expansion Population, thus including Targeted Adults in the Adult Expansion Population.

The table below summarizes the new requests included in this waiver application. It also includes currently approved 1115 PCN Demonstration Waiver populations and components the State is requesting to transition to this application, as well as approved populations and components remaining the 1115 PCN Demonstration Waiver.

Table 1: Summary List of Waiver Requests

New Waiver Requests	Approved 1115 PCN Waiver Populations/ Components Transitioning to this Waiver	Approved 1115 PCN Waiver Populations/ Components Remaining in the 1115 PCN Waiver	Approved 1115 PCN Waiver Populations/ Components Remaining in the 1115 PCN Waiver for other Medicaid Members
● Authority to Receive Increased FMAP ● Per Capita Cap Funding Mechanism ● Lock-Out for Intentional Program Violation ● Housing-Related Supports and Services	● Adult Expansion Population ● Targeted Adult Population, including dental benefits for Targeted Adults who qualify for dental ● Clinically Managed Residential Withdrawal Pilot (Adult Expansion and Targeted Adults only) ● Substance Use Disorder Treatment	● Current Eligibles ● Demonstration Population III (Utah's Premium Partnership for Health Insurance - UPP) ● Demonstration Population V & VI (UPP COBRA) ● Dental Benefits for Individuals who are Blind or Disabled	● Substance Use Disorder Treatment Benefits (Medicaid Members other than Adult Expansion and Targeted Adults) ● Clinically Managed Residential Withdrawal Pilot (Medicaid Members other than Adult

● Up to 12-Months Continuous Eligibility ● Not Allowing Presumptive Eligibility Determined by a Hospital ● Managed Care Flexibilities	Benefits (Adult Expansion and Targeted Adults only) ● Community Engagement Requirement ● Enrollment Limits ● Waiver of Early and Periodic Screening, Diagnostic and Treatment ● Employer Sponsored Insurance Requirement	● Former Foster Care Youth From Another State ● Services for High Risk Youth (Request Pending with CMS) ● Dental Benefits for Individuals Age 65 and Older (Request to be Submitted in June 2019)	Expansion and Targeted Adults)

Table 1

A. Goals and Objectives

Under section 1115 of the Social Security Act, States may implement "experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]". The State believes the projects requested in this proposal are likely to promote the following goals and objectives:

- Providing health care coverage for low-income Utahns that would not otherwise have access to, or be able to afford health care coverage
- Improving participant health outcomes and quality of life
- Lowering the uninsured rate of low income Utahns
- Supporting the use of employer-sponsored insurance by encouraging community engagement and providing premium reimbursement for employer-sponsored health plans
- Providing continuity of coverage for individuals
- Providing fiscal sustainability through new financing models and state flexibility

Approval of this Demonstration will allow the State to provide coverage to uninsured adults who have limited options for affordable health coverage. These individuals fall in the coverage gap because their incomes are below 100 percent FPL and therefore are not eligible for subsidies to purchase coverage through the Marketplace.

The program components contained in this waiver application, both new and those transitioning from the State's 1115 PCN Demonstration Waiver, will be implemented together to meet the proposed goals and objectives listed above. This demonstration will allow the State to test the effectiveness of policy that is designed to improve health outcomes of demonstration individuals, as well as promote their financial

independence. The Demonstration will provide the needed support of up to 12-months continuous Medicaid eligibility and housing supports and services, while encouraging individuals to obtain or sustain employment.

In addition, this waiver request seeks to provide this increased coverage to Utahns in a fiscally sustainable manner. Section 1901 of the Social Security Act states that the purpose of the Medicaid program is to enable "each State, as far as practicable under the conditions in such State," to provide medical assistance to certain populations. In Utah, the State Constitution requires that income taxes be spent on education. As a result, the sales tax is the primary source of funding for the State's General Fund. Medicaid, transportation, higher education, public health, other social services, etc. all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's share of General Fund expenditures has grown from 12.7 percent to 26.1 percent. These growing costs occurred while Utah served the original populations targeted by Title XIX - families with dependent children and individuals that are aged, blind, or disabled. With the waiver approved in March 2019 and with this waiver request, the State has included additional adults with dependent children and adults without dependent children who historically have not been served by Medicaid. While the State of Utah has been able to allocate existing resources to accommodate current Medicaid needs, and has authorized an increase in sales tax to fund this waiver request, it may not be "practicable" in the State of Utah for Medicaid expenditures to continue to grow at this rapid pace, or to continue devoting this large share of the State's General Fund to this program. Therefore, due to the current and potential budget conditions that may arise in the State of Utah, this waiver proposal includes a request that the State have the ability to cap enrollment based on available state appropriations.

With Medicaid continuing to consume a growing share of Utah's General Fund, the State's ongoing fiscal sustainability is dependent on finding fiscal sustainability for Medicaid. Rising health care costs and increasing enrollment in the Medicaid program drive the State to find efficiencies in operating the program. Several provisions of this waiver request (i.e., housing supports, community engagement requirement, and enrollment in employer sponsored insurance) are specifically designed to help individuals gain employment, increase their income, and join the majority of Utahns in receiving their health care through employer sponsored insurance. By helping these individuals move off of Medicaid and on to other coverage, these program features help Utah ensure the overall fiscal sustainability of its Medicaid program.

B. Operation and Proposed Timeframe

The Demonstration will operate statewide. The State intends to implement the Demonstration as soon as possible after receiving CMS approval, and is targeting an October 1, 2019 implementation. The State requests a five-year approval period for this Demonstration.

Section II. Program Overview and Demonstration Eligibility

A. Approved Demonstration Populations and Components

As stated above, the State is requesting to administer the following components and programs under this new waiver application, which are currently authorized under the State's 1115 PCN Demonstration Waiver:

1. Adult Expansion Population

The State proposes to administer the Adult Expansion Population under this waiver application. Individuals eligible for this demonstration group must meet the following criteria:

- Adults ages 19 through 64
- A U.S. Citizen or qualified alien
    - Non-qualified non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
- A resident of Utah
- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 95 percent of FPL using the MAGI methodology which includes a five percent FPL disregard
- Ineligible for other Medicaid programs that do not require a spenddown to qualify
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act

Under this demonstration application, the State does not intend to apply 42 CFR § 435.119(c)(1), which states that a State may not provide Medicaid coverage under this section to a parent or other caretaker relative living with a dependent child under the age of 19 unless the child is receiving Medicaid, the Children's Health Insurance Program (CHIP), or otherwise enrolled in minimum essential coverage. The State is seeking this exception with the goal of reducing unintentional churn for parents and caretaker relatives should their children lose coverage for administrative reasons. When a family applies for coverage, the State believes both parents and children should be considered for medical programs.

2. Targeted Adult Population

The State requests authority to administer the Targeted Adult Population under this new waiver application, including the provision to allow 12-months continuous eligibility, as approved under the State's 1115 PCN Demonstration Waiver. Individuals eligible for the Targeted Adult subgroup must meet the following criteria:

- Adults age 19-64, without a dependent child
- A U.S. Citizen or qualified alien
- A resident of Utah, and not in a public institution
- Household income at or below five percent of the FPL
- Ineligible for other Medicaid programs that do not require a spenddown
- Must not be eligible for Medicare under parts A or B of title XVIII of the Act
- Must also meet at least one of the following criteria:

    - Chronically homeless- this is defined as: (1) living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12- months or on at least 4 separate occasions in the last 3 years; and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability; or (2) currently living in supportive housing, but who has previously met the definition of chronically homeless defined in (1).

    - Involved in the justice system AND in need of substance use or mental health treatment- this is defined as: (1) an individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in Utah Administrative

Code); (2) an individual discharged from the State Hospital who was admitted to the hospital due to an alleged criminal offense; or (3) an individual involved in a Drug Court or Mental Health Court, including Tribal courts.

- Needing substance abuse or mental health treatment- this is defined as: (1) An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for 6 months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder; (2) an individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder. The General Assistance program provides time limited cash assistance and case management services to adults that have no dependent children. General Assistance customers must verify they have a physical or mental health impairment that prevents them from working; or (3) an individual discharged from the State Hospital who was civilly committed.

3. Targeted Adult Dental Benefits

The State also requests authority under this new demonstration application to continue to administer dental benefits for individuals who are eligible for the Targeted Adult Population, and who are actively receiving substance use disorder treatment. This benefit is currently authorized under the State's 1115 PCN Demonstration Waiver. In order to be eligible for dental benefits, individuals must:

- Be eligible for the Targeted Adult demonstration group
- Be actively receiving treatment for a substance use disorder as defined in Utah State Code Section 40 62A-2-101, licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities.

Dental benefits for this group are delivered through a fee for service payment model, and by contracting with an entity that:

- Has demonstrated experience working with individuals who are being treated for both a substance use disorder and a major oral health disease;
- Operates a program, targeted at the individuals described in this amendment, that has demonstrated, through a peer-reviewed evaluation, the effectiveness of providing dental treatment to those individuals;
- Is willing to pay for an amount equal to the program's non-federal share of the cost of providing dental services to the population described.

Benefits

Individuals eligible for dental benefits under this demonstration will receive state plan dental benefits.

4. Clinically Managed Residential Withdrawal Pilot

Clinically managed residential withdrawal management services are currently approved in the State's 1115 PCN Demonstration Waiver for all Medicaid eligible adults residing in Salt Lake County. As part of this waiver request, the State proposes to provide these services for the Adult Expansion and Targeted Adult Populations residing in Salt Lake County through this new waiver. For all other eligible adults, these services will continue to

be provided under the State's 1115 PCN Demonstration Waiver. The service will be provided to Medicaid eligible adults residing in Salt Lake County, through Volunteers of America's Adult Detoxification Center and Center for Women and Children (VOA).

Benefits

The specific withdrawal management services provided include:

- Assessment of substance use disorder and treatment needs
- Observation of the beneficiary's course of withdrawal
- Medication services
- Psychoeducation services
- Discharge services to prepare for reentry into the community.

5. Substance Use Disorder Treatment

The State currently has approval through its 1115 PCN Demonstration Waiver to administer a benefit package for all Medicaid recipients that includes substance use disorder 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 Federal Financial Participation (FFP) for Medicaid recipients residing in an IMD under the terms of the demonstration for coverage of medical assistance and SUD benefits, which would otherwise be matchable if the recipient were not residing in an IMD. This benefit is available to all Medicaid eligible individuals, including those in the Adult Expansion and Targeted Adult Populations.

With this application, the State is requesting to administer this benefit package under this demonstration application for the Adult Expansion and Targeted Adult Populations. The State requests to continue to administer this benefit package for all other eligible Medicaid groups, as well as all required reporting requirements, under the approved 1115 PCN Demonstration Waiver.

Benefits

Under this demonstration, beneficiaries will receive the following SUD services:

- Early intervention (Screening, Brief Intervention and Referral to Treatment
- Outpatient therapy
- Intensive outpatient program
- Partial hospitalization treatment
- Residential treatment
- Withdrawal management
- Medication-assisted treatment (MAT)
- Peer support
- Crisis intervention
- Residential crisis stabilization.

6. Enrollment Limits

The State requests to continue to apply enrollment limits to the Adult Expansion and Targeted Adult Populations under this demonstration application. Enrollment limits for these populations are currently

approved under the State's 1115 PCN Demonstration Waiver that was amended on March 29, 2019. The State proposes to apply enrollment limits when projected costs exceed annual state appropriations. There will not be a set enrollment cap, but rather it will be based on available funding. When enrollment is closed, the State will continue to accept and review applications to determine if individuals are eligible for other Medicaid programs. If the individual is not eligible for any other Medicaid program, other than Adult Expansion, eligibility will be denied. The State will not have a waitlist to automatically enroll individuals when enrollment is re-opened. Individuals will need to apply during the next open enrollment period. All eligible individuals that apply before an enrollment limit is in place will be enrolled in the program. Individuals already enrolled in the program at the time enrollment is closed will remain enrolled.

The State will post information on its website, and distribute information to community partners, state agencies, and the media when the State has determined an open enrollment period will occur.

The State is requesting to continue to apply enrollment limits for these populations to allow the State to be able to continue to furnish medical assistance to approved populations in a fiscally sustainable manner and within the budget conditions that the State faces now and may face in the future.

Enrollment Limit Exception

The State proposes to exempt individuals with verified membership in a federally recognized tribe from the enrollment limit for the Adult Expansion and Targeted Adult Populations. Enrollment for these populations will continually remain open for individuals who meet this exception.

Impact to Enrollment

Although the State is requesting an enrollment limit, the projected enrollment and associated expenditures for this waiver are not expected to exceed budgeted State funds within the time period of the waiver demonstration and therefore the State does not estimate any impact on enrollment from this provision within the waiver period.

Individuals already enrolled in the Demonstration at the time enrollment is closed will remain enrolled.

7. Community Engagement through a Self Sufficiency Requirement

With this waiver application, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion Population, not to include Targeted Adults. The community engagement requirement was originally approved for this population, as part of the Medicaid expansion authorized in the March 29, 2019 amendment to the State's 1115 PCN Demonstration Waiver. The community engagement requirement applies to Adult Expansion individuals who do meet an exemption and do not show good cause, as outlined in the sections below. Participation requirements and activities are outlined in the "Community Engagement Participation" section below.

Many studies have concluded that employed individuals have better physical and mental health, and are more financially stable than unemployed individuals.[1] Recognizing the connection between employment and health, the State proposes that the community engagement requirement will; increase an individual's health and well-being through incentivizing work and community engagement, increase their sense of purpose, help to build a

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[1] Karsent I. Paul, Klaus Moser, (2009), Unemployment Impairs Mental Health: Meta-Analyses*, Journal of Vocational Behavior,* 74 (3), 264-282. McKee-Ryan, Z.Song, C.R. Wanbert, and A.J. Kinicki. (2005). Psychological and physical well-being during employment: a meta-analytic study. *Journal of Applied Technology*, 90 (1), 53-75.

healthy lifestyle, and increase employment and wage earnings of able-bodied adults, while focusing funding on the State's neediest individuals. The State will align closely with the work requirements and activities of the Supplemental Nutrition Assistance Program (SNAP) program, as well as Temporary Assistance for Needy Families (TANF) work activities to ensure consistency and reduce complexity for individuals who must participate.

Community Engagement Exemptions

The State recognizes that not all individuals may be able to participate in the community engagement requirement, or they may already be participating in work or training activities that meet the goals of the Demonstration. Therefore, the State will exempt certain individuals from the requirement, as approved under the State's 1115 PCN waiver. The exemptions are largely aligned with federal SNAP exemptions. The exemptions are:

1. Age 60 or older;

2. Pregnant or up to 60 days postpartum;

3. Physically or mentally unable to meet the requirements as determined by a medical professional or documented through other data sources;

4. A parent or other member of household with the responsibility to care for a dependent child under age six;

5. Responsible for the care of a person with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act ;

6. A member of a federally recognized tribe;

7. Has applied for and is awaiting an eligibility determination, or is currently receiving unemployment insurance benefits, and has registered for work at DWS;

8. Participating regularly in a substance use disorder treatment program, including intensive outpatient treatment;

9. Enrolled at least half time in any school (including, but not limited to, college or university) or vocational or apprenticeship program;

10. Participating in refugee employment services offered by the state, which include vocational training and apprenticeship programs, case management, and employment planning;

11. State Family Employment Program (FEP) recipients who are working with an employment counselor;

12. Beneficiaries in compliance with or who are exempt from SNAP and/or TANF employment requirements; or

13. Working at least 30 hours a week, or working and earning at least what would equal the federal minimum wage earned working 30 hours a week.

An individual can claim an exemption at any time. Individuals meeting one or more of the above listed exemptions will not be required to complete the community engagement participation requirement within the 12-month certification period in which the exemption is claimed in order to maintain continued coverage.

Community Engagement Participation

Individuals who do not meet an exemption, and do not show good cause, and are required to participate will be referred for participation on the first of the month following approval for the Adult Expansion program. This will be month one of the three-month participation period. This is the same participation period used for the SNAP program. Individuals will be required to complete participation requirements within the three-month period. Once they have met the requirement, they will be eligible for the remainder of their eligibility period. Eligibility periods are 12 months. The individual must complete participation requirements every 12 months to continue to receive Medicaid.

Individuals who do not meet an exemption, or who are not eligible for good cause must complete the following participation activities:

- Register for work through the state system
- Complete an evaluation of employment training needs
- Complete the job training modules as determined to be relevant to the individual through the assessment of employment training needs
- Applying for employment with at least 48 potential employers

Activities will be completed through the DWS, using the same online evaluation, training, and search resources offered to Utah SNAP recipients.

Closure Due to Non-Participation

Failure to comply with the community engagement requirement will result in a loss of Medicaid eligibility, unless good cause is demonstrated, or the individual meets an exemption. If an individual fails to participate by the end of the third month, a notice will be sent in the following month stating they will no longer be eligible for Medicaid at the end of that month.

The following will apply:

- Only those individuals who fail to participate will lose eligibility.
- If an individual completes all activities within the notice month, the individual will not lose eligibility, and will remain eligible without having to reapply.

Regaining Eligibility

- Individuals who lose eligibility may become eligible again by completing all required activities OR by meeting an exemption.
- After completing all required participation activities, the individual must reapply for Medicaid. Benefits will be effective the first day of the month in which they reapply.
- As long as the individual applies for benefits in the month following the month they complete all required activities, open enrollment requirements will not apply if enrollment limits are approved under this Demonstration.

- If the individual meets the qualifications for an exemption or demonstrates good cause for the earlier non-compliance, or becomes eligible for Medicaid under an eligibility category that is not subject to the community engagement requirement, the individual can re-enroll immediately and their eligibility will have an effective date of the first of the month of application

Good Cause Exemptions

The State will waive loss of eligibility if an individual claims good cause for failure to participate in the community engagement requirement. The good cause exemption will exempt the individual as long as the good cause reason exists. Good cause exemptions include, but are not limited to:

1. The individual has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act, and was unable to meet the requirement for reasons related to that disability; or has an immediate family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the individual or an immediate family member who was living in the home with the individual experiences a hospitalization or serious illness;
2. The individual experiences the birth, or death of a family member living with the individual;
3. The individual experiences severe inclement weather (including natural disaster) and therefore was unable to meet the requirement;
4. The individual has a family emergency or other life-changing event (e.g. divorce or domestic violence);
5. The individual is not able to participate due to a lack of internet or transportation;
6. There are fewer than 48 employers in the individual's geographic area that potentially could offer employment to the individual or from whom the individual reasonably could be expected to accept an offer of employment; in this case the number of required employer contacts shall be reduced to an appropriate level so that the individual is not required to make applications for employment that would likely be futile;
7. The individual is the primary caretaker of a child age 6 or older and is unable to meet the requirement due to childcare responsibilities.

Reasonable Modifications

The State will provide reasonable modifications related to meeting the community engagement requirement for beneficiaries with disabilities protected by the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The State will also provide reasonable modifications for program requirements and procedures, including but not limited to, assistance with demonstrating eligibility for an exemption from community engagement requirements on the basis of disability; demonstrating good cause; appealing disenrollment; documenting community engagement activities and other documentation requirements; understanding notices and program rules related to community engagement requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. Reasonable modifications must include exemptions from participation where a beneficiary is unable to participate for disability-related reasons and provision of support services necessary to participate, where participation is possible with supports.

Beneficiary Supports

The State will work with DWS and other community partners to make a good faith effort to connect participating individuals to existing community supports that are available to assist individuals in meeting the community engagement requirement. This may include non-Medicaid assistance with transportation, childcare, language access services, and other supports; and connect individuals with disabilities as defined in

the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services to enable them to participate.

Impact to Beneficiaries

Based on the State's experience with SNAP work requirements, the State estimates approximately 70 percent of Adult Expansion beneficiaries (49,000-63,000 individuals) will meet an exemption to community engagement participation. Among individuals who do not meet an exemption or good cause reason, the State projects that approximately 75-80 percent will comply with the community engagement requirements.

8. Employer Sponsored Insurance (ESI) Reimbursement

As approved on March 29, 2019 under the State's 1115 PCN Demonstration waiver, the State proposes to require individuals who are eligible for the Adult Expansion Population, and have access to ESI, to purchase such plans. The State will reimburse the eligible individual for the health insurance premium amount for that individual. Failure to enroll in, and purchase, the insurance plan will result in ineligibility for Medicaid.

ESI Benefit Package

Eligible individuals will be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified plan. In addition, the individual will receive wrap-around benefits through the State's fee for service (FFS) Medicaid program.

Qualified Plan

In order to be eligible for reimbursement, the health insurance plan must meet the criteria for a qualified health plan, as defined by the State. The State is proposing to establish the criteria for a qualified health plan through state administrative rule. The state administrative rule for the Adult Expansion Population would likely follow similar criteria to that already established through state administrative rule for the 1115 PCN Demonstration Waiver - Demonstration Group III – UPP Adults (see R414-320-2 (12)). The state administrative rule would likely define a qualified health plan for the Adult Expansion Population as a health plan offered by an employer to employees or their dependents that meets the following criteria:

1. The plan covers physician visits, hospital inpatient services, pharmacy, well child exams and child immunizations.
2. The network deductible is less than $4,000 per person.
3. The plan pays at least 70% of an in network inpatient stay (after deductible).
4. The plan does not cover abortion services; OR the plan only covers abortion services in the case where the life of the mother would be endangered if the fetus were carried to term, or in the case of incest or rape.
5. The employer pays at least 50 percent of the premium for the primary insured individual.

Verification of Coverage

Verification of ESI coverage and the individual's premium amount will be verified at initial application, routinely between recertifications, and at recertification.

9. Early and Periodic Screening, Diagnostic, and Treatment

Through the State's 1115 PCN Waiver Demonstration, the State currently has authority to waive Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for adults age 19 and 20 years old in the Adult Expansion

and Targeted Adult Population. The State requests to continue this authority for the Adult Expansion and Targeted Adult Population, if approved under this demonstration application.

B. New Demonstration Waiver Requests

As stated previously, with this application the State is seeking approval to implement the following proposals as directed by Senate Bill 96. These proposals apply to the Adult Expansion Population, including the Targeted Adult subgroup, unless otherwise noted:

1. Authority to Receive Increased FMAP

The State is requesting a waiver of the income level specified in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to allow the State to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y), which is 93 percent for 2019, and 90 percent for 2020 and each year thereafter, for this Demonstration group. The State is requesting this waiver for the Adult Expansion demonstration group, which includes adults with dependent children with household income using the 2014 Parent Caretaker Relative income standard up to 95 percent of the FPL, and adults without dependent children with household income between zero percent and 95 percent of the FPL. The State is also requesting to include the Targeted Adult Population in this request.

2. Lock-Out due to Intentional Program Violation

The State proposes to apply a six-month period of ineligibility if an individual commits an intentional program violation (IPV) to become, or remain eligible for Medicaid. Only the individual who commits the IPV will be disqualified. This request applies to the Adult Expansion Population, including Targeted Adults.

An IPV is defined as:

- Knowingly making false or misleading statements;
- Misrepresenting, concealing or withholding facts;
- Violating program regulations on the use, presentation, acquisition, receipt or possession of medical assistance or the medical card; or
- Not reporting the receipt of a medical card or medical service that the individual knows the individual was not eligible to receive;
- Posing as someone else;
- Not reporting a required change within 10 days after the change occurs, and the individual knew the reporting requirements, and the intent was to obtain benefits they were not entitled to receive;
- Intentionally submitting a signed application or eligibility review containing false or misleading statements in an attempt to obtain medical assistance, even if the individual received no assistance.

The State will inform individuals of the reporting requirements at application, upon Medicaid approval, and at recertification.

The determination of an IPV is different from a determination of fraud. Fraud is a conviction made by the District Court on Intentional Program Violations of specified severity that the agency refers for criminal prosecution. For the purposes of medical assistance eligibility and public assistance, the definition of fraud is found in Title 76 Chapter 8 Section 1205 of the Utah Code Annotated. The agency makes fraud referrals when evidence clearly shows an intent to fraud and the situation meets one of the following additional criteria:

1. The combined overpayment amount exceeds $5,000 and the duration of the overpayment is at least twelve months, or
2. In addition to any application and review forms, the defendant must have knowingly provided false or forged documents, worked or received government benefits using a false ID or social security number, or overtly taken an action for the purpose of perpetrating the fraud, or
3. It is the second occurrence of a fraud situation for that defendant, or
4. It is a Check Fraud case that includes multiple checks/warrants or collusion.

If the evidence supports pursuing adjudication through the criminal process, the agency refers the case to a criminal specialist for review. If the specialist agrees with the referral, the specialist prepares the case for review by the assigned attorney in the Attorney General's (AG) Office. The AG's Office will either accept or reject the case. If the AG's Office accepts the case, they will file the case in court. If rejected, it is classified as a suspected IPV.

Process to Determine IPV Lock-Out

If the agency suspects a Medicaid overpayment, the overpayment is referred to a DWS Benefit Accuracy Analyst (BAA). The BAA reviews the available evidence to determine if the individual committed an IPV. The agency must have clear and convincing evidence that the individual knowingly, willingly, or recklessly provided false or misleading information with an intent to receive benefits to which he or she was not eligible to receive.

- Evidence may include applications or review forms, incomplete or inaccurate verification forms, income or tax records showing a history of unreported income, proof an individual posed as someone else or allowed someone else to use the individual's medical card, etc.
- Evidence may include case notes of conversations with the individual that show the agency asked specific questions, and later the agency shows such responses from the individual are erroneous.

If enough evidence exists to substantiate the overpayment calculation, and the classification of the cause, the BAA ensures the amount of the overpayment is correct, and the classification is correct and makes a referral for adjudication. If evidence is not sufficient to support the overpayment referral calculation, the BAA requests an investigation to gather additional evidence. After a thorough investigation, if the State suspects a Medicaid overpayment occurred, and the cause of the overpayment is classified as a suspected IPV, the agency sends the individual a written notice, which includes, but is not limited to, the following:

1. The overpayment amount
2. The classification as a suspected IPV
3. Appeal rights and time frames
4. Who to contact if they disagree with the suspected IPV

The individual is allowed 30 days from the date the written notice is issued to appeal the overpayment and suspected IPV. If the individual does not respond within 30 days, an adjudicator reviews the overpayment and suspected IPV. If the adjudicator upholds the overpayment and suspected IPV, the adjudicator issues the order of default to the individual. The lock-out becomes effective as described in the "Lock-Out Period" section below. The order of default will include, but is not limited to, the following information:

1. Overpayment amount and time period of the overpayment

2. Evidence used in the decision
3. The date the disqualification will begin and end
4. Additional appeal rights to have the order set aside.

Lock-Out Period

The period of ineligibility begins the month following the month the adjudicator issues the final IPV lock-out order, allowing for proper advance notice. The lock-out remains in place for six-months from that date. As part of the appeal rights, the individual can request to receive continued benefits while they are appealing the IPV decision. If the IPV decision is upheld, and the individual requested continued benefits, an overpayment will be assessed for the months the individual continued to receive Medicaid.

The individual has 30 days after DWS issues the hearing decision to request a Superior Agency Review of the overpayment and IPV. The UDOH conducts the Superior Agency Review.

Exemptions from IPV Lock-Out:

The State allows the following exemptions from an IPV lock-out:

1. If the individual becomes eligible for another Medicaid program, the lock-out will end as of the first of the month the individual becomes eligible for that program. (Example: an individual becomes pregnant or moves to Disabled Medicaid).
2. The individual may request an undue hardship if a medical practitioner determines lack of medical care places the individual's life in jeopardy or in danger of permanent disability.
    a. The agency will notify the individual of the option to contact the State Medicaid agency to claim undue hardship.
    b. The State Medicaid agency must receive verification of the reason the undue hardship exists.
    c. The State Medicaid agency will make the determination of whether to grant a hardship exemption.
    d. If a hardship exemption is granted, the State Medicaid agency will notify DWS to not apply the lock-out.

Enrollment Limit and IPV Lock-Out

Individuals who have served a lock-out period, and later reapply may not re-enroll in Adult Expansion if enrollment is closed for that program. The individual will have to wait for an open enrollment period to become eligible again for Adult Expansion. However, they may apply and have eligibility determined for other Medicaid programs for which they may be eligible.

Impact to Beneficiaries and how this Modifies Medicaid Programs

The implementation of this proposal may cause approximately 500 individuals per year to lose eligibility for six-months as a result of committing an IPV. The State anticipates this may be a deterrent to individuals committing an IPV. Currently, the State does not impose a lock-out as a result of committing an IPV for any Medicaid program. This would allow the State to implement a new policy for a specific Medicaid population.

The State believes that imposing a lock-out period for individuals who knowingly withhold or intentionally report inaccurate household information, will ensure that limited state resources are used for individuals who truly meet the eligibility requirements of the Adult Expansion demonstration program. Accurate eligibility information is imperative to the integrity of the Medicaid program and is key to maintaining the fiscal sustainability of the program overall. Although this proposal may have an impact on coverage levels if an

individual chooses to commit an IPV, the demonstration as a whole will allow the State to provide greater access to low-income individuals who are eligible, thus improving the sustainability of the safety net.

3. Housing Related Services and Supports

Background Information

Individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma encounter a variety of health and social challenges. Challenges include such things as acute and chronic medical and behavioral health conditions, criminal justice system involvement, and extended periods of unemployment and poverty. Individuals having these experiences often lack health insurance and may have limited access to health care. These challenges pose significant barriers to achieving housing stability, pursuing mental health or substance use disorder recovery, improving health outcomes, and reducing health care costs. To address barriers that influence individuals' health, the State seeks expenditure authority under this demonstration application to provide an array of evidence-based services and supports to the Adult Expansion Population.

As directed by Senate Bill 96 (2019), the State, in collaboration with stakeholders, is developing a Utah-specific solution to provide evidence-based services and supports to improve health outcomes of identified populations. Because food insecurity, transportation insecurity, interpersonal violence or trauma pose potential barriers to housing and health, housing supports also include evidence-based services to address these barriers. Through this waiver, the State requests authority to provide housing supports across the Adult Expansion Population. The State also requests authority to target services to targeted populations through its administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated, rather than waiver amendment. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the targeted services and/or targeted populations.

For initial implementation, the State intends the Targeted Adult Population to be one of the groups that will receive these evidence-based services and supports. In addition, The State's efforts to reduce barriers that impact individuals' health will initially focus on providing housing related services and supports to eligible populations.

Housing Related Services and Supports (HRSS) will be available to identified populations, but participation is voluntary. Individuals' ongoing need for HRSS will be verified every six months.

Housing Related Services and Supports Definitions

The State intends to offer the following HRSS:

1. ***Tenancy Support Services*** – are services provided directly to eligible members that include:

    a. Conducting a tenant screening and housing assessment to identify the member's preferences (e.g., housing type, location, living alone or with someone else, identifying a roommate, accommodations needed, etc.) and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers;

    b. In collaboration with the eligible member, developing an individualized housing support plan based on the housing assessment that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes the participant's approach to meeting the

goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal;

c. Participating in person centered planning meetings to assist the member to develop a housing support plan

    i. Assisting the member to review, update and modify his or her housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers;

d. Assisting with the housing application process, and selection process, including filling out housing applications and obtaining and submitting appropriate documentation;

e. Assisting the member to complete reasonable accommodation requests as needed to obtain housing;

f. Assisting with the housing search process;

g. Identifying available resources to cover expenses such as rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses;

h. Ensuring that the living environment is safe and ready for move-in;

i. Assisting in, arranging for and supporting the details of the move;

j. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized;

k. Connecting the member to education and training on tenants' and landlords' role, rights, and responsibilities;

l. Assisting in reducing risk of eviction by providing services that help the member improve conflict resolution skills, coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; communicate with landlords and neighbors to reduce the risk of eviction; address biopsychosocial behaviors that put housing at risk; and provide ongoing support with activities related to household management;

m. Assistance with housing voucher or subsidy applications and recertification processes.

Because individuals with Serious Mental Illness who receive Targeted Case Management services under Utah's Medicaid State Plan currently have access to the component parts of Tenancy Support Services, these individuals will not be eligible to receive the Tenancy Support Services offered through this demonstration.

2. ***Community Transition Services*** – are services provided to assist an eligible member to secure, establish, and maintain a safe and healthy living environment. Service includes:

    a. One-time purchase of essential household items and services needed to establish basic living arrangements in a community setting, to include basic furnishings, kitchen, bathroom and cleaning equipment and goods;

b. One-time payment of a security deposit and the first and last month's rent, when a member moves to a new residence. The State will impose a maximum of two such payments per member during the pilot period. The State seeks authority to cover the first and last month's rent because expecting both the first, and last month's rent is a ubiquitous requirement in Utah's extremely competitive housing market. The services would also include payment of one-time, non-refundable fees to submit rental applications, establish utility services and other services essential to the operation of the residence.

This service is furnished only to the extent it is determined reasonable and necessary as clearly identified through a member's housing support plan, when the member is unable to meet such expenses, and funding for such items is not available through any other funding source.

Because this service, and its component parts, are not otherwise available through Medicaid State Plan services, the State seeks authority to offer "Community Transition Services" to all individuals identified in this section.

3. ***Supportive Living/Housing Services*** – Supportive living and housing services link decent, safe, affordable, community-based housing with flexible, voluntary support services designed to help the individual or family stay housed.

Supportive Living/Housing Services do not include room and board costs.

Supportive Living/Housing Services may include a wide variety of coordinated services needed by individuals, including:

a. Health and Medical Services—Routine medical care, medication management, health and wellness education, nutritional counseling, home health aides and personal care services;

b. Mental Health Services—screening, assessments, counseling, psychiatric services, clubhouses, peer services, and assertive community treatment;

c. Substance Abuse Services—relapse prevention, counseling, intensive outpatient services, medication assisted treatment, detoxification, residential services and formal and informal (AA/NA) recovery support services;

d. Independent Living Services—Financial management services, entitlement assistance, training in cooking and meal preparation, and mediation training;

e. General Supportive Services—Services such as case management, community support, meals, peer support, crisis intervention, representative payee supports and non-medical transportation.

Current Medicaid members with serious mental illness may receive Supportive Living/Housing Services (or its component parts) through Utah's Prepaid Mental Health Plans. Adult Expansion members with Serious Mental Illness may also receive the component parts of Supportive Living/Housing Services through the Prepaid Mental Health Plans.

Eligibility for Housing Related Services and Supports

1. The following table details the eligibility criteria for HRSS.

Eligibility Criteria for Housing Related Services and Supports		
Eligible Population	Age	Needs-Based Criteria (Must meet one of the following items)
Adults	19-64	1. Living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter continuously for at least 12- months or on at least 4 separate occasions in the last 3 years; and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability; 2. Currently living in supportive housing, but who has previously met the definition of chronically homeless defined in Item 1.; 3. Is an individual who has successfully completed a substance use disorder treatment program while incarcerated in jail or prison, including Tribal jails; 4. Is an individual discharged from the Utah State Hospital who was admitted to the hospital due to an alleged criminal offense; 5. Is an individual involved in a Drug Court or Mental Health Court, including Tribal courts. 6. Is an individual receiving General Assistance from the Utah Department of Workforce Services, who has been diagnosed with a substance use or mental health disorder; or 7. Is an individual discharged from the State Hospital who was civilly committed.

Table 2

2. The following table identifies populations eligible for individual HRSS

Populations Eligible for Individual Housing Related Services and Supports		
Tenancy Support Services	**Community Transition Services**	**Supportive Living/Supportive Housing Services**
All individuals must meet at least one of the needs-based criteria identified in Table 2	All individuals must meet at least one of the needs-based criteria identified in Table 2	All individuals must meet at least one of the needs-based criteria identified in Table2

Individuals who do not have a Serious Mental Illness diagnosis ● Individuals with Serious Mental Illness currently have access to Tenancy Support Services (or component parts) through *Targeted Case Management for Individuals with Serious Mental Illness* Services available through the Medicaid State Plan		Individuals who do not have a Serious Mental Illness diagnosis ● Individuals with Serious Mental Illness currently have access to Supported Living /Supportive Housing Services (or component parts) through 1915(b) authority through Utah's Prepaid Mental Health Plans

Table 3

3. If the State identifies additional populations to be added through the administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated, specific eligibility criteria for a new population will be included within that administrative rule.

Impact to Beneficiaries and how this Modifies Medicaid Programs

As a growing body of evidence shows, social determinants, such as housing instability, play a significant role in individual health outcomes. *"A Primer on Using Medicaid for People Experiencing Chronic Homelessness and Tenants in Permanent Supportive Housing[2]"* published by the U.S. Department of Health & Human Services states the following:

> "***Ample evidence documents the potential for people with complex health and behavioral health conditions who have been homeless to achieve housing stability, pursue recovery, manage chronic health conditions, and stay out of hospitals, if they receive appropriate health care, other services and supports, and care coordination."***

An excerpt from the ***National Academies of Sciences, Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness[3]*** describes:

> ***"A pilot study conducted in Portland, Oregon, examined the effects of single-site supportive housing on health care costs, health care utilization, and health outcomes for 98 "highly medically vulnerable" individuals experiencing homelessness (Wright et al., 2016, p. 21).***

[2] US Health and Human Services Primer on Using Medicaid for People Experiencing Chronic Homelessness https://aspe.hhs.gov/system/files/pdf/77121/PSHprimer.pdf

[3] National Academies of Sciences, Engineering, and Medicine. 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25133.

This study, using retrospective survey responses and Medicaid administrative claims data, showed that placing individuals experiencing homelessness and high medical costs into supportive housing significantly reduced Medicaid expenditures for inpatient hospital and emergency department services for physical health issues, with an average annual reduction of $8,724 in the year after moving in (Syrop, 2016). The self-reported data also showed a reduction in hospital stays and emergency department visits, indicating a shift toward using primary care services rather than acute care services. Although these results are promising, the absence of a comparison group and the use of retrospective self-reported data limit interpretations of this study."

One of the key distinctions of Tenancy Support Services and Supportive Living/Supportive Housing services proposed in this section is to provide services, or component parts, to vulnerable and complex populations beyond only those with serious mental illness, who already have access to these services.

The State intends to further demonstrate that health care costs and utilization can be reduced when individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma receive needed evidence-based services and supports.

The State believes coverage of Housing Related Services and Supports is consistent with the overall goals of the Medicaid program and recent guidance provided by CMS, through the June 26, 2015, CMCS Informational Bulletin titled, "*Coverage of Housing-Related Activities and Services for Individuals with Disabilities." The document states in part, "This Informational Bulletin is intended to assist states in designing Medicaid benefits, and to clarify the circumstances under which Medicaid reimburses for certain housing-related activities with the goal of promoting community integration for individuals with disabilities, older adults needing long term services and supports (LTSS), and those experiencing chronic homelessness."*

The Informational Bulletin identifies 1115 Research and Demonstration Programs as a potential authority through which housing related services may be provided, including the following: *"Some section 1115 demonstrations include housing-related services consistent with the statutory authorities described in this bulletin. For example, states can provide services to individuals already in the community, by helping the individual problem solve, advocate with landlords, access community resources to assist with back rent, and assist individuals to complete forms for subsidized housing. For people leaving institutions, states assist with locating housing, completing forms for subsidies, moving, and household set ups."*

The State will use the CMS guidance to design housing related services and supports to increase individuals' ability to attain and retain safe, affordable housing, which will reduce barriers that impact individuals' health and wellness.

The State intends to further demonstrate that health care costs and utilization can be reduced when individuals experiencing homelessness, housing, food, or transportation insecurity, or interpersonal violence and trauma receive needed evidence-based services and supports.

Estimated Enrollment for Housing Related Supports and Services

The State estimates the following annual enrollment for each service:

- Tenancy Support Services: 5,000 individuals
- Community Transition Services: 5,000 individuals

- Supportive Living/Housing Services: 1,000 individuals

4. Up to 12-Months Continuous Eligibility

Under the State's 1115 PCN Demonstration Waiver, the Targeted Adult Population is currently authorized to receive continuous eligibility for a period of 12 months. Income and other changes during this continuous eligibility period do not affect the individual's eligibility with the exception of the following:

- Turns age 65;
- Moving out of state;
- Death;
- Fails to apply for other benefits;
- Becomes institutionalized;
- Determined eligible for another Medicaid eligibility category;
- Fraud; or
- Client request

The State requests to continue providing 12-months of continuous eligibility to the Targeted Adult Population under this new demonstration application. The State estimates that approximately 240 individuals per year will continue to receive Medicaid after having increased their household income over five percent FPL, with a five percent FPL disregard.

Also with this application, the State proposes to allow up to 12-months of continuous eligibility for the Adult Expansion Population. This specific request applies to the individuals in the Adult Expansion Population who are not identified as Targeted Adults. With some exceptions, changes that occur during the certification period will not affect eligibility during the period of continuous eligibility. These exceptions include, but may not be limited to:

- Turns age 65;
- Moves out of state;
- Fails to apply for other benefits;
- Becomes institutionalized;
- Is determined eligible for another Medicaid program;
- Failure to comply with the community engagement requirement during the three-month participation period;
- Closure due to lock-out for committing an intentional program violation;
- Fraud;
- Failure to enroll in employer-sponsored insurance.

When an individual's household income exceeds 95 percent of FPL, with a five percent FPL disregard, they may continue to receive up to 12-months continuous eligibility. The State requests the ability to limit the continuous eligibility provision for the Adult Expansion Population based on income or targeted populations as defined by the State in administrative rule. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to the number of continuous months, the income level, and/or targeted populations.

It is anticipated that the State would initially implement 6-month continuous eligibility, without a maximum income, across the Adult Expansion Population that is not identified as Targeted Adults.

Individuals who become eligible for another Medicaid program while enrolled in this demonstration will move to that program. For example, if an individual becomes pregnant, the individual will move to the Pregnant Woman program once the Medicaid program is made aware of that pregnancy.

In addition, if future waiver amendments to this demonstration cause an individual to become ineligible, members currently enrolled through this Demonstration will retain their existing eligibility period.

Impact to Beneficiaries and how this Modifies Medicaid Programs

The State estimates approximately 1,400-1,600 individuals per year will be eligible to receive up to 12-months continuous eligibility after having increased their household income over 95 percent FPL, with a five percent FPL disregard. This will allow eligible individuals to continue to receive Medicaid while increasing their household income.

Continuous eligibility is currently authorized under the State's 1115 PCN Demonstration waiver for the Targeted Adult population. This is a new request for the Adult Expansion population.

5. Not Allow Presumptive Eligibility Determined by a Hospital

The State proposes to not allow presumptive eligibility determined by a hospital as a qualified entity, for the Adult Expansion Population. Currently, the State does not allow presumptive eligibility determinations for the Targeted Adult Population. This will allow the State to complete a full determination of eligibility before enrolling the individual, thereby improving program integrity and better assuring that each individual has met the requirements of the program before paying for their medical care. Coverage will no longer be based solely on a limited review of information by hospitals.

Impact to Beneficiaries and how this Modifies Medicaid Programs

Presumptive eligibility determined by a hospital is currently allowed for the Adult Expansion population, but is not allowed for the Targeted Adult Population. The requested change will align the policy for both populations. The State anticipates that by no longer allowing hospitals to make presumptive eligibility determinations, approximately 300-400 individuals per month will no longer receive eligibility through presumptive eligibility. However, the State believes there will be no impact to individuals, as these individuals may still apply and have a full determination of eligibility completed for up to three months prior to the month of initial application.

6. Per Capita Cap Funding Mechanism

Information regarding this proposal can be found in "Section VII. Demonstration Financing and Budget Neutrality" below.

Section III. Demonstration Hypotheses and Evaluation

The State intends to contract with an independent evaluator to develop a plan for evaluating the hypotheses indicated below. The State, in consultation with the evaluator, will identify validated performance measures that assess the impact of the Demonstration on beneficiaries. In addition, the State intends to work with the

evaluator to identify meaningful comparison groups in designing the evaluation plan. It is the intent of the State to follow all CMS evaluation design guidance in working with the State's independent evaluator to draft an evaluation plan.

The evaluation budget will be included with the evaluation plan.

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

The State intends to test the following hypotheses contained in table 4 below, during the Demonstration period:

Table 4 - Waiver Hypotheses

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
Adult Expansion			
The Demonstration will improve access to medical assistance in Utah.	• Number of adults ages 19-64 in Utah without health coverage	Utah Behavioral Risk Factor Surveillance System (BRFSS)	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will improve the health and well-being of enrolled individuals by increasing access to primary care and improving appropriate utilization of emergency department (ED) services by Adult Expansion members.	• Review of claims for Primary Care • Review of claims for ED visits	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will reduce uncompensated care provided by Utah hospitals.	• Amount of statewide hospital-reported uncompensated care	Hospital Costs Report	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will assist previously uninsured individuals in	• Number of enrolled members with employer-	Enrollment data	Independent evaluator will design quantitative and qualitative

purchasing employer sponsored insurance to help reduce the number of uninsured adults.	sponsored insurance		measures to include quasi-experimental comparisons
Community Engagement			
The community engagement requirement will encourage skills development through an evaluation of job search readiness and the completion of employment related training workshops. In addition, by increasing the individual's job skills and encouraging job search activities, the community engagement requirement will promote gainful employment.	● Number of trainings completed/ ended ● Number of job searches ● Number of job registrations ● Amount of earned income	eREP & UWORKS system data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Community engagement requirements that promote engagement with the employment process will improve the health outcomes of Medicaid beneficiaries subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	● Number of prescriptions ● Number of non-emergent ED visits ● Number of cancer screenings ● Number of well-care visits	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after	Reported enrollment in commercial coverage, including ESI and Marketplace plans, within 1 year of disenrollment from Medicaid	Beneficiary Surveys	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.			
Up to 12-Months Continuous Eligibility			
The Demonstration will not discourage increases to household earned income.	Percentage of adults increasing earned income compared to a comparison group	eREP Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Per Capita Cap Funding			
Medicaid expenditures under this demonstration will grow at a slower rate than the national average of Medicaid Adult Expansion per enrollee spending which will demonstrate program sustainability.	Demonstration growth rate compared to Medicaid national growth rate in equivalent basis years of expansion (e.g. year one, year two, etc.)	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The Demonstration will not negatively impact an individual's health.	• Number of prescriptions • Number of non-emergent ED visits • Number of cancer screenings • Number of well-care visits	Claims/encounter data CMS Adult Core Measures	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Lock-Out for Intentional Program Violation			
The Demonstration will discourage individuals from committing an IPV by disqualifying individuals who commit an IPV.	Percentage of IPVs compared to a comparison group	Enrollment and IPV Lock-Out Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

Housing Supports			
The demonstration will increase continuity of treatment.	Medication Assisted Treatment Pharmacotherapy	Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will improve participant health outcomes and quality of life.	Access to screening services and primary care visits	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The demonstration will reduce non-housing Medicaid costs.	Comparison of Medicaid reimbursement with a comparison group	Medicaid Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

In addition to the data outlined above, the State will also gather HEDIS and CAHPS data to evaluate the overall well-being of this population group.

Section IV. Demonstration Benefits and Cost Sharing Requirements

Individuals eligible under this demonstration will receive benefits as listed in table 5 below. The exception to this are housing related supports and services that will be available to specific waiver populations, as outlined in the "Housing Related Supports and Services" section above.

Table 5- Eligibility Group and Benefit Package

Eligibility Group	Benefit Package
Adults with Dependent Children	• Non-Traditional Benefits (see description below) • Up to 12-months continuous eligibility
Adults without Dependent Children	• State Plan Benefits • Up to 12-months continuous eligibility

ESI Eligible Adults with Dependent Children	● Premium Reimbursement with Non-Traditional Benefit Wrap-around ● Up to 12-months continuous eligibility
ESI Eligible Adults without Dependent Children	● Premium Reimbursement with State Plan Benefit Wrap-around ● Up to 12-months continuous eligibility
Targeted Adults	● State Plan Benefits, and state plan dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms & Conditions of the 1115 PCN Demonstration Waiver) ● 12-months continuous eligibility
Clinically Managed Residential Withdrawal Pilot	● Assessment of substance use disorder and treatment needs ● Observation of the beneficiary's course of withdrawal ● Medication services ● Psychoeducation services ● Discharge services to prepare for reentry into the community
Substance Use Disorder Treatment	● Early intervention (Screening, Brief Intervention and Referral to Treatment) ● Outpatient therapy ● Intensive outpatient program ● Partial hospitalization treatment ● Residential treatment ● Withdrawal management ● Medication-assisted treatment (MAT) ● Peer support ● Crisis intervention ● Residential crisis stabilization

Non-Traditional Benefit Package

Adults with dependent children will receive the State's non-traditional benefit package, authorized under the State's 1115 PCN Demonstration Waiver. This benefit package contains most of the services covered under Utah's Medicaid state plan according to the limitations specified in the state plan. This benefit package is reduced from that available under the state plan as detailed in the table 6 below.

Table 6- Benefits Different from State Plan

Service	Special Limitations for the Non-traditional Benefit
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.

Cost Sharing

Cost Sharing for Individuals without ESI: Cost sharing requirements provided under the State Plan will apply to Demonstration individuals who do not have ESI.

Cost Sharing for ESI: For ESI eligible individuals, the State will pay cost sharing imposed by the ESI up to the State Plan levels. ESI eligible individuals will have the same cost sharing that they would have under the State Plan. The State will pay such cost sharing directly to providers, provided that such providers are enrolled in the Medicaid program.

Cost Sharing for Certain American Indian/Alaskan Native Eligibles: American Indian/Alaskan Native individuals 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.

Section V. Delivery System

Services for Demonstration individuals will be provided initially through FFS. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

By January 2020, the State intends to transition populations covered by this application into managed care. In Utah's four largest counties, individuals in the Adult Expansion program will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity.

Employer Sponsored Insurance- Individuals with Access to ESI

Demonstration individuals who receive ESI reimbursement will receive services through the delivery systems provided by their respective qualified plan for ESI. Wrap-around benefits provided by Medicaid will be delivered through FFS.

Proposed Managed Care Flexibility

In Utah, approximately 83 percent of all Medicaid members are enrolled in an Accountable Care Organization (ACO) for their physical health benefits. Under federal regulation, these ACOs are comprehensive full risk managed care organizations (MCO) and are subject to extensive federal regulations at 42 CFR 438. Utah Medicaid ACOs must be licensed in the state of Utah and are also regulated by the Department of Insurance pursuant to Title 31A Chapter 8 UCA.

In addition, more than 90 percent of all Medicaid Members are enrolled in Prepaid Mental Health Plans (PMHP) for behavioral health services. PMHPs are administered by county mental health and substance abuse

authorities that are statutorily required to provide these services to the residents of their counties. Both ACOs and PMHPs were created under 1915(b) authority.

ACOs were implemented on January 1, 2013 in the four Wasatch Front counties. In July 2015 the ACO delivery system was extended to nine additional counties. ACOs are available in all other counties on a voluntary basis.

While containing cost is one measure of the effectiveness of the Utah Medicaid ACOs, containing costs cannot come at the risk of access to or quality of services. It also should not come at the unfair expense of other stakeholders. The use of managed care as a delivery system should also encourage improvements in the delivery of healthcare. To that end, from the onset of the ACO model, the Department's contract with each ACO includes specific requirements to comply with the reporting of HEDIS (Healthcare Effectiveness Data and Information Set) measures and to participate in CAHPS (Consumer Assessment of Healthcare Providers and Systems.)

Utah intends to use managed care as the primary service delivery system for populations covered under this waiver. As part of this amendment request, Utah is asking for greater flexibility and authority to use alternative approaches to come into compliance with 42 CFR 438 in the following areas. This will allow the State to administer its managed care delivery system upon approval of this waiver without delays related to additional federal approvals.

Demonstration of Actuarial Soundness of Rates

The State is requesting authority to demonstrate actuarial soundness of managed care rates for groups covered by this waiver without prospective CMS review ordinarily required under 42 CFR 438.7(a). The State will submit a rate certification to CMS but will have authority to implement the rates and draw down federal funds prior to CMS review and final approval of the proposed rates for the populations covered under this waiver.

The State is working with its contracted actuary, Milliman, Inc. to determine actuarially sound rates for three specific populations within the waiver expansion group. The State has sufficient historical claims data for parents with dependent children. In addition, the State has more than a year of historical claims experience to establish rates for the Targeted Adult Medicaid group. For adults without dependent children, Milliman, Inc. has recommended that the state segment this group into at least two age bands 19-33 and 34-64. The actuary will use the Adults with Dependent Children, the Targeted Adult Medicaid group and expansion experience from other states to inform the creation of a rate for Adults Without Children. In addition, initially the rates will include a risk corridor based on a medical loss ratio specified in the plan contract.

The State intends to submit plan contracts and rates to CMS as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, the State is requesting authority to make such changes effective the month following the month in which the State is notified of the change by CMS. The State is requesting that FMAP be available for any expenditures related to managed care rates paid to contractors from the date of waiver approval.

The State will submit subsequent modifications to rates to CMS prior to the intended effective date. The State is requesting authority to apply the same authority to subsequent contract amendments.

Flexibility in Managed Care Contract Review

The State is requesting authority to have more flexibility in the administration of our managed care contracts for the populations covered under this waiver. The State will submit its initial contract to CMS for review and approval as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by the Center for Medicaid and CHIP Services (CMCS) and the Office of the Actuary.

If any changes are required to either contract language or rates, the State is requesting authority to make such changes effective the month following the month in which the State is notified of the change by CMS. The State is requesting that FMAP be available for any expenditures related to contracts from the date of waiver approval.

The State will submit subsequent contract amendments to CMS prior to the intended effective date. The State is requesting authority to apply the same authority to subsequent contract amendments.

Demonstration of Directed Payment Compliance

The State is requesting authority to implement directed payments which are included in the contracts and rates pertaining to the population groups covered under this waiver consistent with the requirements of 42 CFR 438.6(c) prior to formal approval from CMS. The State intends to submit any new or updated Directed Payment 438.6(c) templates as soon as October 1, 2019. However, due to the length of the federal contract and rate review process, the State is requesting authority to implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary. If any changes are required to either contract language or rates, such changes will go into effect the month following the month in which the State is notified of the change. The State is requesting that FMAP be available for any directed payments made to providers from the date of waiver approval.

Access to Care and Availability of Services

The State is requesting authority to adopt an approach to network adequacy, access to care, and availability of services. The State is currently incorporating standards into its current managed care contracts based on time and distance as well as provider type, to determine the sufficiency of a plan's network. As part of the initial readiness review of managed care contracts covering the populations under this waiver, the State will validate the adequacy of each plan's network based on established standards. The State will conduct an annual review of these standards for each plan.

In addition, the State has a Constituent Services/Access to Care Monitoring tool. This tool is used to capture all constituent complaints, including access to care complaints. The State monitors access to care on an ongoing basis. The State will also rely on direct measures of access such as consumer and secret shopper surveys to demonstrate satisfactory access. Utah managed care plans are required to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for all Medicaid eligible populations.

Section VI. Enrollment in Demonstration

Individuals Currently Eligible for Medicaid

Individuals currently eligible for Adult Expansion under Utah's 1115 PCN Demonstration waiver at the time this demonstration is implemented will be moved to this new demonstration group.

Eligible individuals will be notified of any benefit changes or new program requirements.

When the State elects to enroll the Adult Expansion group in managed care, enrollment in managed care plans for the Demonstration group will occur as it does for those covered under the State plan. Individuals eligible for the Demonstration who reside in one of the thirteen managed care counties will be notified of the requirement to choose a managed care plan. If they do not choose one, one will be assigned. Eligibles not enrolled in an integrated plan will also be enrolled in a prepaid mental health plan.

Individuals Eligible for ESI Reimbursement

As approved in the March 29, 2019 amendment to Utah's 1115 PCN Demonstration waiver, individuals with household income up to 95 percent of the FPL who are determined eligible for the Demonstration and have access to, or are enrolled in, a qualified ESI will receive premium reimbursement for the cost of the eligible individual's premium amount. ESI eligible individuals will be notified of the following:

- Eligibility for ESI reimbursement
- Requirement to purchase their ESI plan, if not already enrolled
- Availability of wrap-around benefits, including cost sharing protections
- Failure to purchase or maintain the ESI plan will result in ineligibility for Medicaid

If an individual voluntarily disenrolls from the ESI coverage, the individual will become ineligible for Medicaid coverage under this Demonstration. If the individual involuntarily disenrolls from the ESI plan, such as when the plan no longer meets the criteria for a qualified health plan, the individual will remain enrolled in the Demonstration and will receive direct Medicaid coverage.

Section VII. Demonstration Financing and Budget Neutrality

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

Table 7 shows the projected demonstration enrollees in each demonstration year (DY). These enrollment projections include all members in the demonstration as identified by the Budget Neutrality attachment. These enrollment projections include members that may be excluded from the per capita cap funding calculations as described in that section.

Enrollment	DY 1	DY 2	DY 3	DY 4	DY 5
Targeted Adults	4,086	4,188	4,293	4,400	4,510
Dental - Targeted Adults	3,000	3,075	3,152	3,231	3,311
Expansion Parents	30,430	31,191	31,971	32,770	33,589
Expansion Adults without Children	46,133	47,287	48,469	49,680	50,922
SUD	503	516	528	542	555
Withdrawal Management	279	286	293	301	308

Table 7

Table 8 shows the projected demonstration expenditures in each demonstration year (DY). These amounts are calculated by applying the estimated per member per month estimates detailed in the following sections to the enrollment figures from Table 7. These amounts also assume the inflation factor applied to DY 2 remains constant for the remaining years of the demonstration. These expenditure projections include all projected expenditures covered by this demonstration as identified by the Budget Neutrality attachment (Demonstration With Waiver). These expenditures include some that may be excluded from the per capita cap funding calculations as described in that section.

Expenditures (Total Fund)	**DY 1**	**DY 2**	**DY 3**	**DY 4**	**DY 5**
Targeted Adults	$68,013,000	$72,641,000	$77,585,000	$82,864,000	$88,503,000
Dental - Targeted Adults	$1,375,000	$1,469,000	$1,569,000	$1,675,000	$1,789,000
Expansion Parents	$245,247,000	$261,936,000	$279,760,000	$298,798,000	$319,131,000
Expansion Adults without Children	$434,558,000	$464,130,000	$495,714,000	$529,447,000	$565,476,000
SUD	$25,611,000	$27,354,000	$29,216,000	$31,204,000	$33,327,000
Withdrawal Management	$2,345,000	$2,504,000	$2,675,000	$2,857,000	$3,051,000
Annual Total	$777,149,000	$830,034,000	$886,519,000	$946,845,000	$1,011,277,000

Table 8

Per Capita Cap Funding Mechanism

The State requests that the increased FFP under 42 U.S.C. Section 1396d(y) be available up to a limit set by a per capita cap methodology for this demonstration. Under this methodology, the State will work with CMS to establish a per enrollee base amount for the first demonstration year with trending for future demonstration years. Separate per capita caps for distinct enrollment groups will account for differences in costs among populations. Expenditure caps will be set annually and reconciled with actual expenditures and enrollment. Per capita caps for the enrollment groups should aggregate into a total per capita cap weighted according to each enrollment group's respective member months.

The State requests that the entire 5-year demonstration period be used for reconciliation. Excess expenditures above the total per capita cap in a particular year may be allowable using room under the total per capita cap in a separate year. Expenditures in excess of the total per capita cap but within budget neutrality will receive the State's traditional FMAP.

Enrollment Groups

The State requests that separate per capita cap amounts be created for enrollment groups in order to account for differences in costs. The proposed enrollment groups have distinct attributes, benefits, and experience with the State's Medicaid program. The State recognizes that the enrollment trends of each group may vary. Therefore, establishing separate caps for each group will reduce the risk of a case mix change between populations. The State proposes three enrollment groups:

- Adults with Dependent Children;
- Adults without Dependent Children; and
- Targeted Adults and members residing in an IMD primarily to receive short-term residential treatment for SUD.

The State requests that individuals with verified membership in a federally recognized tribe be excluded from the per capita cap calculations. Expenditures for these individuals will be 100 percent FMAP when services are

provided through facilities where 100 percent match is allowed. Otherwise costs for these individuals will be at the enhanced FMAP.

The State requests that inpatient stays lasting longer than 24 hours for incarcerated individuals that are otherwise Medicaid eligible under this demonstration be excluded from the per capita cap calculations. Expenditures for these individuals will be at the enhanced FMAP.

The State also requests that non-citizens enrolled under the Emergency Only program pursuant to 42 CFR § 435.139 be excluded from the per capita cap calculations. Expenditures for these individuals will be at the enhanced FMAP.

These members and related expenditures will be included in budget neutrality calculations, but excluded from the per capita caps. Estimated per enrollee costs and enrollment are provided in Table 9.

Exclusion Category	2020 Estimated Member Months	2020 Estimated PMPM
Emergency only program	6,806	$3,973.31
Membership in federally recognized tribe	31,892	$763.53
Inpatient Stays for Incarcerated Individuals	233	$10,758.99

Table 9

Adults with Dependent Children

Adults with Dependent Children, hereinafter referred to as "Parents", are expected to have attributes similar to the State's existing 1115 PCN Demonstration Waiver population, "Current Eligibles". These newly eligible Parents have one or more dependent children, with household incomes between the limit for "Current Eligibles" and 95 percent of the FPL. This population excludes members residing in an IMD primarily to receive short-term residential treatment for SUD (members receiving residential treatment will be included in the Targeted Adult and SUD per capita cap). Parents will receive the State's non-traditional benefit package as described under Section IV.

The State proposes that per enrollee expenditures from the "Current Eligibles" demonstration population be used to set the base per capita cap for newly eligible Parents. The "Current Eligibles" demonstration population was created in 2002 and provides the State with extensive expenditure experience. Medical assistance payments are available from the State's quarterly CMS-64 submissions and distinguishable by Waiver Name. Expenditures reported under the "Current Eligibles" Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included. The base period time frame should include the eight quarters in calendar years 2017 and 2018. This will effectively set the per capita cap based on experience by paid date.

The State proposes modifications to the State-reported pharmacy rebates and supplemental payments for the "Current Eligibles" demonstration in the base period. The State will adjust future CMS-64 reporting under this demonstration to match the proposed allocation methodologies.

Pharmacy rebates received under a Managed Care Organization (MCO) national agreement are reported by the State on CMS forms 64.9 and 64.9-Waiver under line 7A3. The State proposes that the rebates in the base period should be apportioned between Medicaid waivers according to pharmacy encounters received by the State. The proposed method under this per capita cap calculation will vary from the original CMS-64 apportionment between the State's waivers. The original CMS-64 apportionment distributed all pharmacy rebates between the State's waivers according to FFS pharmacy expenditures. This proposed modification to

the apportionment of MCO pharmacy rebates based on MCO pharmacy encounters will provide more accuracy to per enrollee expenditures. The State receives pharmacy encounters from MCO plans and loads these encounters into the Medicaid Data Warehouse. These pharmacy encounters identify the client's Medicaid Eligibility Group and allow for the proposed apportionment identified in Table 10.

Year	Parents MCO Pharmacy Encounters	All MCO Pharmacy Encounters	Parents MCO Pharmacy Percent	MCO Pharmacy Rebates	Apportionment of MCO Rebates to Parents
2017	$18,483,138	$101,391,836	18.2%	($63,335,170)	($11,545,631)
2018	$19,554,324	$104,821,674	18.7%	($75,428,600)	($14,071,091)
Total	**$38,037,462**	**$206,213,510**	**18.4%**	**($138,763,770)**	**($25,616,721)**

Table 10

Supplemental payments should also be included in the base period to reflect the total cost of medical assistance per person. The State proposes allocating certain supplemental payments according to the related fee-for-service expenditures. As an example, if the State made a $5 million inpatient hospital supplemental payment in the base period and 20% of inpatient hospital base payments were paid for a population in this demonstration, then $1 million of the inpatient hospital supplemental payment should be allocated to that population's base period. The State proposes that five supplemental payment types be allocated to the base period expenditures for Parents. These supplemental payments are detailed in Table 11 with Medicaid State Plan reference; the 2017-2018 supplemental expenditure; the related base payments for allocation, Parent percentage of the related expenditure; and the resulting allocation of the supplemental payment.

Supplemental Type	State Plan Reference	2017-18 Supplemental	Related Expenditures	Parents Percentage	Parents Allocation
State Inpatient	4.19-A Section 800	$47,712,351	Inpatient	8.1%	$3,850,255
Private Outpatient	4.19-B (A)(13)	$10,676,520	Outpatient	16.0%	$1,703,999
State Outpatient	4.19-B (A)(11)	$9,278,108	Outpatient	16.0%	$1,480,809
Transitional Outpatient	4.19-B (A)(1)(E)	$2,478,774	Outpatient	16.0%	$395,619
University of Utah Medical Group	4.19-B (D)(7)	$29,153,924	Physician	14.2%	$4,148,813
Total Allocation					**$11,579,495**

Table 11

The State intends to exclude Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and State administration expenses from the per capita cap methodology.

CMS-64 base period expenditures, with the proposed adjustments herein, are divided by the member-months for Parents in order to establish the base period per capita amount. In the base period, the State enrolled 374,629 and 373,185 Parent member-months in 2017 and 2018 respectively. The base period member months are therefore 747,814. The resulting base period per-member-per-month (PMPM) expenditures are detailed in Table 12 with categorization by service type and data source.

Item	Source	Total Computable	Per Member Month (PMPM)
Medicaid MCO	CMS-64; Line 18A	$293,485,860	$392.46
Pharmacy	CMS-64; Line 7	$30,382,505	$40.63
Inpatient	CMS-64; Line 1A	$25,031,181	$33.47
Outpatient	CMS-64; Line 6A, 36	$21,039,624	$28.13
Physician	CMS-64; Line 5A	$14,502,232	$19.39
Behavioral Health	CMS-64; Line 18B1, 18B2, 40	$32,067,163	$42.88
Pharmacy Rebates-FFS	CMS-64; Line 7A1, 7A2	($16,856,536)	($22.54)
Other	CMS-64; All else	$6,529,126	$8.73
Pharmacy Rebates-MCO	Allocation (Table 10)	($25,616,721)	($34.26)
Supplemental Payment	Allocation (Table 11)	$11,579,495	$15.48
Total			**$524.37**

Table 12

In order to account for growth in healthcare expenditures, a growth factor should be applied to base period expenditures in order to set the appropriate per capita cap in demonstration year one. The State proposes this growth factor to be equivalent to the growth factor provided to the State for budget neutrality purposes. CMS has established a growth rate of 5.3% for the "without waiver" PMPM for the comparison population of "Current Eligibles". The State proposes to use this growth rate for per capita expenditures between the base period and demonstration year one. The State proposes that 2.5 years of growth be applied to the base period of 2017-18 in order to establish the demonstration year one per capita cap. This is equivalent to $(1+5.3\%)^{2.5}$ or 13.78%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State's intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL.
- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.
- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 13.

Funding	Effective Date	Parents 2020 PMPM
Private Outpatient UPL	July 1, 2019	$17.76
Housing Supports	Approval of this demonstration	$31.04
Mental Health Crisis Services	April 1, 2019	$4.28
Total Benefit Addition		**$53.08**

Table 13

The calculation of the per capita cap with the methodology described above is shown in Table 14.

Enrollment Group	Base PMPM (2017-18)	Growth Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Parents	$524.37	1.1378	$596.64	$53.08	$649.72

Table 14

Adults without Dependent Children

Adults without Dependent Children will be a new demonstration population with which the State has limited experience. These newly eligible adults do not have dependent children, and have a household income less than 95 percent of the FPL These members and are not enrolled as Targeted Adults or those residing in an IMD primarily for SUD (members in these groups will be included in the Targeted Adult and SUD per capita cap). This population will receive state plan benefits as described under Section IV.

The State is proposing to use a relativity factor applied to the Parents enrollment group in order to establish the per capita cap for Adults without Dependent Children. This relativity factor was developed by the State's independent actuary, Milliman, at the State's request. Milliman relied on the historical Medicaid Expansion experience in other expansion states as well as Utah specific data. Utah specific data includes expenditures from the Primary Care Network (PCN) demonstrations with and without dependent children. The State's experience with the PCN demonstrations is that adults without dependent children have a substantially higher per enrollee cost than parents. This cost relativity, along with other factors developed by Milliman results in a cost relativity factor of 1.17. The State proposes that this factor be applied to the base Parents PMPM to account for cost differences.

The State proposes to use the same growth factor for Parents base period expenditures in order to set the appropriate per capita cap in demonstration year one. As previously described, this is equivalent to $(1+5.3\%)^{2.5}$ or 13.78%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State's intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL.
- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.

- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 15.

Funding	Effective Date	Adults without Dependent Children 2020 PMPM
Private Outpatient UPL	July 1, 2019	$20.79
Housing Supports	Approval of this demonstration	$31.04
Mental Health Crisis Services	April 1, 2019	$5.01
Total Benefit Addition		**$56.84**

Table 15

The calculation of the per capita cap with the methodology described above is shown in Table 16.

Enrollment Group	Base PMPM (2017-18)	Growth Factor	Relativity Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Adults without Dependent Children	$524.37	1.1378	1.17	$698.28	$56.84	$755.12

Table 16

Targeted Adults and Members Residing in an IMD for SUD

Targeted Adults are an existing population under Utah's 1115 PCN Demonstration waiver and became eligible in November 2017. The State will retain this population as a separate demonstration population. This population receives state plan benefits, 12-month continuous eligibility, and dental benefits for individuals receiving Substance Use Disorder Treatment. Substance Use Disorder is also an existing population under Utah's 1115 PCN Demonstration waiver and was also established in November 2017. The State will retain this population as a separate demonstration population under this waiver. These two populations will be reported separately for purposes of budget neutrality, and combined for the purposes of the per capita cap. Hereinafter, this combined per capita cap enrollment group will be called "Targeted Adults and SUD".

The State proposes to use base period expenditures from calendar year 2018 to establish the per capita cap for this enrollment group. This will effectively set the per capita cap based on experience by paid date. Base period expenditures reported under the "Targeted Adults" Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included. Base period expenditures reported under the "SUD" Waiver from both 64.9 Waiver and 64.9P Waiver forms should be included if the adult would otherwise fall under the "Current Eligibles" or "Targeted Adults" demonstration. These populations are the appropriate proxy population relevant to this demonstration and exclude other populations within the state plan. Table 17 details the total computable amounts reported on the CMS-64 under the SUD demonstration for the four quarters in calendar year 2018. The amount attributable to this per capita cap calculation are identified. Pharmacy rebates received under a

Managed Care Organization (MCO) national agreement in the base period will be allocated separately as identified below.

Category	CMS-64 Form; Line	Total Computable	Base Period Allocation
Expenses	64.9 Waiver & 64.9P Waiver; All except 7A1, 7A2, 7A3	$14,909,039	$14,154,783
Pharmacy Rebates-FFS	64.9 Waiver & 64.9P Waiver; 7A1, 7A2	($653,972)	($620,391)
Pharmacy Rebates-MCO	64.9 Waiver & 64.9P Waiver; 7A3	($603,631)	$0
Total			**$13,534,393**

Table 17

The State proposes modifications to the State-reported pharmacy rebates and supplemental payments for the "Targeted Adults" and "Substance Use Disorder" demonstration in the base period. The State will adjust future CMS-64 reporting under this demonstration to match the proposed allocation methodologies.

Pharmacy rebates received under a Managed Care Organization (MCO) national agreement are reported by the State on CMS forms 64.9 and 64.9-Waiver under line 7A3. The State proposes that the rebates in the base period should be apportioned between Medicaid waivers according to pharmacy encounters received by the State. The proposed method under this per capita cap calculation will vary from the original CMS-64 apportionment between the State's waivers. The original CMS-64 apportionment distributed all pharmacy rebates between the State's waivers according to FFS pharmacy expenditures. This proposed modification to the apportionment of MCO pharmacy rebates based on MCO pharmacy encounters will provide more accuracy to per enrollee expenditures. The State receives pharmacy encounters from MCO plans and loads these encounters into the Medicaid Data Warehouse. These pharmacy encounters identify the client's Medicaid Eligibility Group and allow for the proposed apportionment identified in Table 18.

Year	Targeted Adults & SUD MCO Pharmacy Encounters	All MCO Pharmacy Encounters	Targeted Adults & SUD MCO Pharmacy Percent	MCO Pharmacy Rebates	Apportionment of MCO Rebates to Targeted Adults & SUD
2018	$3,473	$104,821,674	0.003%	($75,428,600)	($2,499)

Table 18

Supplemental payments should also be included in the base period to reflect the total cost of medical assistance per person. The State proposes allocating certain supplemental payments according to the related fee-for-service expenditures. The State proposes that five supplemental payment types be allocated to the base period expenditures for Targeted Adults and SUD. These supplemental payments are detailed in Table 19 with Medicaid State Plan reference; the 2018 supplemental expenditure; the related base payments for allocation, Targeted Adults and SUD percentage of the related expenditure; and the resulting allocation of the supplemental payment.

Supplemental Type	State Plan Reference	2018 Supplemental	Related Expenditures	Targeted Adults & SUD Percentage	Targeted Adults & SUD Allocation
State Inpatient	4.19-A Section 800	$24,120,881	Inpatient	6.8%	$1,643,966
Private Outpatient	4.19-B (A)(13)	$9,144,790	Outpatient	4.4%	$398,960
State Outpatient	4.19-B (A)(11)	$3,885,994	Outpatient	4.4%	$169,534
Transitional Outpatient	4.19-B (A)(1)(E)	$1,300,087	Outpatient	4.4%	$56,719
University of Utah Medical Group	4.19-B (D)(7)	$14,684,464	Physician	5.4%	$786,835
Total Allocation					**$3,056,014**

Table 19

The State intends to exclude Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments, and State administration expenses from the per capita cap methodology.

CMS-64 base period expenditures, with the proposed adjustments herein, are divided by the member-months for Targeted Adults and SUD in order to establish the base period per capita amount. In the base period, the State enrolled 3,596 member-months. The resulting base period per-member-per-month (PMPM) expenditures are detailed in Table 20 with categorization by service type and data source.

Item	Source	Total Computable	Per Member Month (PMPM)
Medicaid MCO	CMS-64; Line 18A	$73,025	$2.18
Pharmacy	CMS-64; Line 7	$8,734,987	$261.24
Inpatient	CMS-64; Line 1A	$10,975,106	$328.24
Outpatient	CMS-64; Line 6A, 36	$5,060,723	$151.36
Physician	CMS-64; Line 5A	$2,949,533	$88.21
Behavioral Health	CMS-64; Line 18B1, 18B2, 40	$13,504,701	$403.90
Pharmacy Rebates-FFS	CMS-64; Line 7A1, 7A2	($4,992,609)	($149.32)
Other	CMS-64; All else	$4,409,962	$131.89
Pharmacy Rebates-MCO	Allocation (Table 18)	($2,499)	($0.07)
Supplemental Payment	Allocation (Table 19)	$3,056,014	$91.40
Total			**$1,309.03**

Table 20

In order to account for growth in healthcare expenditures, a growth factor should be applied to base period expenditures in order to set the appropriate per capita cap in demonstration year one. The State proposes this growth factor to be equivalent to the growth factor provided to the State for budget neutrality purposes. CMS has established a growth rate of 5.3% for the “without waiver” PMPM for the comparison population of “Targeted Adults” and “SUD”. The State proposes to use this growth rate for per capita expenditures between the base period and demonstration year one. The State proposes that 2 years of growth be applied to the base period of 2018 in order to establish the demonstration year one per capita cap. This is equivalent to $(1+5.3\%)^2$

or 10.88%. The growth rate for subsequent years beyond demonstration year one will be proposed separately, as described below.

The State requests that certain newly approved and pending benefit changes be added to the per capita cap for demonstration year one. These additions represent recently approved 1115 PCN Demonstration waiver and State Plan Amendment changes with a fiscal impact not represented in the base period, as well as pending 1115 PCN Demonstration waiver requests. New additions are as follows:

- Private Outpatient Upper Payment Limit (UPL) - As enacted by the Utah State Legislature 2019 General Session, House Bill 37 (Reauthorization of Hospital Provider Assessment Act) represents the State's intention to submit a forthcoming State Plan Amendment for a Private Outpatient UPL.
- Housing Supports - As specified within this Demonstration application, the State requests federal expenditure authority to provide housing related services and supports.
- Targeted Adult Dental - Effective with the February 1, 2019 CMS approval of Amendment #15 of this demonstration waiver, the State is beginning to deliver dental services for Targeted Adults.
- Clinically Managed Residential Withdrawal Pilot - Effective with the March 29, 2019 CMS approval of Amendment #16 of this demonstration waiver, the State is beginning to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries.
- Improved Payment Structure for Mental Health Crisis Services - As detailed by the State Plan Amendment submitted under transmittal number (TN) 18-0010 and authorized by CMS on January 9, 2019, the State is implementing a bundled payment for rehabilitative mental health and substance use disorder (SUD) services including Assertive Community Treatment (ACT) teams, Mobile Crisis Outreach Teams (MCOT), and SUD residential treatment programs with 16 or fewer beds.

The expected per-member-per-month (PMPM) expenditures for these new benefit changes are shown below in Table 21.

Funding	**Effective Date**	**Targeted Adults & SUD 2020 PMPM**
Private Outpatient UPL	July 1, 2019	$27.00
Housing Supports	Approval of this demonstration	$208.85
Targeted Adult Dental	February 1, 2019	$24.97
Clinically Managed Residential Withdrawal Pilot	May 1, 2019	$42.59
Mental Health Crisis Services	April 1, 2019	$6.61
Total Benefit Addition		**$310.02**

Table 21

The calculation of the per capita cap with the methodology described above is shown in Table 22.

Enrollment Group	Base PMPM (2018)	Growth Factor	Adjusted Base PMPM	Benefit Additions	Year 1 (2020) Per Capita PMPM
Targeted Adults and SUD	$1,309.03	1.1088	$1,451.46	$310.02	$1,761.48

Table 22

Growth Rate

In order to account for the rising costs of healthcare, per capita caps should grow at a rate reflective of this population's characteristics. According to the Office of the Actuary's 2017 Actuarial Report, the Medical consumer price index is projected to grow at a rate of 4.2% in fiscal year 2021. The State believes that this projection is the most credible estimate for the growth of expenditures. The State proposes to use 4.2% as the growth rate for per capita caps from demonstration year one to demonstration year two.

The State proposes to use future Office of the Actuary projections of the Medical consumer price index as the per capita cap growth rate for subsequent demonstration years. Upon the release of the 2018 Actuarial Report on the Financial Outlook for Medicaid, the State proposes to use the report's projected Fiscal Year 2022 Medical consumer price index as the growth rate of per capita caps for demonstration year three. The State proposes to continue this process for per capita cap growth rates in subsequent demonstration years.

Method for Applying Cap and Reconciling Expenditures

The State will work with CMS regularly through the operation of this demonstration to reconcile and account for expenditures related to this demonstration. The State understands that accurate CMS-64 reporting will be vital to this goal. The State has certified and will continue to certify that quarterly CMS-64 expenditure reports provide an accurate accounting of Medicaid expenditures. The State will provide increased detail of expenditures reported under this demonstration in order to satisfy the requirements of the per capita caps. Increased detail may include, but is not limited to, the following:

- Detailed enrollment counts.
- Detailed summarization of pharmacy encounters received through a Managed Care Organization and used for the purposes of allocating pharmacy rebates received through a Managed Care Organization.
- Detailed accounting of supplemental payments with related expenditures used for allocation to enrollment groups under this demonstration.
- Detailed reporting of enrollees under this demonstration with claiming under a separate demonstration authority (e.g. Clinically Managed Residential Withdrawal Pilot or SUD).

The State will provide CMS with a review performed by its independent actuary, Milliman, of the reasonableness of this increased detail.

While the State endeavors to estimate per enrollee expenditures under this demonstration as accurately as possible, there is a level of uncertainty for future years. The State requests that the following event automatically triggers a re-basing of per capita caps for any applicable enrollment group after demonstration year two:

- Actual per enrollee expenditures in the first two demonstration years are at least 5 percent below or above the established per capita cap amounts.

This re-basing of per capita caps may not be necessary for all enrollment groups, but it should apply to whichever groups trigger the re-basing event. Under these circumstances, the per capita caps should be based on the average of the eight quarters in demonstration years one and two. The growth rate approved under this demonstration for per capita caps should be applied to this eight-quarter average in order to set demonstration year three per capita caps. This re-basing formula is as follows:

$(\text{Average PMPM}) * (1 + \text{Growth Rate})^{1.5}$

After demonstration year 3 per capita caps are re-based, they should continue to grow in subsequent years at the growth rate approved under this demonstration.

Special Circumstances

The State requests that CMS consider unforeseen special circumstances beyond the State's control in the establishment of per capita caps. Special circumstances may include the following:

- Public health emergency or natural disaster
- Major economic event
- New federal mandate, including changes to pharmacy rebate methodology
- Any subsequent waivers approved by CMS that impact the populations under this waiver.

In the event of a public health emergency, natural disaster, or major economic event, the State will engage its independent Actuary to estimate the impact to medical assistance expenditures and newly eligible members. The independent Actuary will estimate the impact already experienced by the State and the ongoing impact on future demonstration years. With sufficient documentation under these special circumstances, the State may request that a certain percentage or amount of medical assistance expenditures be excluded from per capita cap calculations. These excluded medical assistance expenditures should receive the enhanced FMAP.

In the event of a new federal mandate, including changes to pharmacy rebate methodology, the State will engage its independent Actuary to provide estimates for the effect on members covered in this demonstration. If the new federal mandate results in retroactive changes to medical assistance expenditures or rebates, the State will estimate the impact to medical assistance expenditures. If the new federal mandate results in prospective changes to medical assistance expenditures or rebates, the State may negotiate with CMS a change to the Special Terms and Conditions under this demonstration. The changes may include one or more of the following options:

- Creation of a new demonstration enrollment group;
- Modification to the per capita cap growth rate;
- Exclusion of certain medical assistance expenditures from the per capita cap; or
- Re-basing of the per capita caps.

Under each of these special circumstances, the State will provide CMS with a review by its independent Actuary.

Section VIII. Proposed Waivers and Expenditure Authorities

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

Waiver Authority	Reason and Use of Waiver
Section 1902(a)(10) and (a)(52)- Eligibility	To the extent necessary to enable the State to prohibit re-enrollment and deny eligibility for the Adult Expansion Medicaid demonstration group for a period of six months for individuals who commit an intentional program violation.
Section 1902(a)(10)(B)- Comparability	To enable the State to provide additional benefits to Adult Expansion eligibles compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide housing supports and services.
Section 1902(a)(1)- Statewide Operation	To the extent necessary to enable the State to implement housing supports in geographically limited areas of the state.
Section 1902(a)(10)(A)(i)(VIII)- 133 Percent Income Level	To enable the State to apply a lower income level to receive the full FMAP allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Medicaid Populations who have an income level of 95 percent FPL.
Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	Effective no sooner than January 1, 2020, to the extent necessary to enable the state to suspend eligibility for, and not make medical assistance available to beneficiaries subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs. Effective no sooner than January 1, 2020, to the extent necessary to enable the state to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.
Section 1906(i)(26)- Compliance with ABP Requirements	In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that the conditions for FFP in section 1903(i)(26) are not satisfied.

Table 23

Expenditures

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

Housing Services and Supports: Expenditures to provide housing services and supports that would not otherwise be matchable under Section 1903.

Section IX. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration application, and notice of the public hearing will be advertised in the newspapers of widest circulation and sent to an electronic mailing list. In addition, public notice will be posted on the State's Medicaid website. The public comment period will be held May 31, 2019 through June 30, 2019.

Two public hearings to take public comment on this request will be held. The first public hearing will be held on June 6, 2019 from 2:00 p.m. to 4:00 p.m., during a special session of the Medical Care Advisory Committee (MCAC) meeting, at the Cannon Health Building located at 288 N 1460 W, Salt Lake City, UT. The second public hearing will be held on June 17, 2019 from 4:00 p.m. to 6:00 p.m., at the Multi-Agency State Office Building, located at 195 N 1950 W, Salt Lake City, UT. Telephonic conferencing is available for both public hearings.

Tribal Consultation

In accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF has notified the UDOH Indian Health Liaison of the waiver application. As a result of this notification, DMHF will begin the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on June 7, 2019 to present this demonstration application. Per UDOH Tribal Consultation Policy, the consultation process will include, but is not limited to:

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

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

Section X. Demonstration Administration

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Per Capita Cap 1115 Waiver

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

ELIGIBILITY GROUP	TREND RATE 1	TREND RATE 2	DEMONSTRATION YEARS (DY) DY01 (FFY20)	DY02 (FFY21)	DY03 (FFY22)	DY04 (FFY23)	DY05 (FFY24)	TOTAL WOW
Targeted Adults Medicaid (TAM)								
Pop Type:	**Expansion**		*Started 11/1/17, suspended in previous 1115 waiver and transferred to the new 1115 waiver 10/1/19*					
Eligible Member Months	2.5%	2.5%	49,028	50,254	51,510	52,798	54,118	
PMPM Cost	5.3%	5.3%	$ 1,387.23	$ 1,460.75	$ 1,538.17	$ 1,619.70	$ 1,705.54	
Total Expenditure			$ 68,013,112	$ 73,408,253	$ 79,231,362	$ 85,516,390	$ 92,299,978	$ 398,469,095
Dental - TAM								
Pop Type:	**Expansion**		*Started 3/1/19, suspended in previous 1115 waiver and transferred to the new 1115 Waiver 10/1/19*					
Eligible Member Months	2.5%	2.5%	36,000	36,900	37,823	38,768	39,737	
PMPM Cost	5.3%	5.3%	$38.20	$40.22	$42.35	$44.60	$46.96	
Total Expenditure			$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 1,728,998	$ 1,866,151	$ 8,056,376
Expansion Parents								
Pop Type:	**Expansion**							
Eligible Member Months	2.5%	2.5%	365,164	374,293	383,650	393,241	403,072	
PMPM Cost	5.3%	5.3%	$ 671.61	$ 707.20	$ 744.68	$ 784.15	$ 825.71	
Total Expenditure			$ 245,246,656	$ 264,700,847	$ 285,698,242	$ 308,361,255	$ 332,822,011	$ 1,436,829,011
Expansion Adults w/out Dependent Children								
Pop Type:	**Expansion**							
Eligible Member Months	2.5%	2.5%	553,599	567,439	581,625	596,166	611,070	
PMPM Cost	5.3%	5.3%	$ 784.97	$ 826.57	$ 870.38	$ 916.51	$ 965.09	
Total Expenditure			$ 434,557,732	$ 469,029,024	$ 506,234,751	$ 546,391,823	$ 589,734,354	$ 2,545,947,684
Substance Use Disorder (SUD)								
Pop Type:	**Expansion**							
Eligible Member Months	2.5%	2.5%	6,036	6,186	6,341	6,500	6,662	
PMPM Cost	5.3%	5.3%	$ 4,243.43	$ 4,468.33	$ 4,705.15	$ 4,954.53	$ 5,217.12	
Total Expenditure			$ 25,611,365	$ 27,642,987	$ 29,835,767	$ 32,202,489	$ 34,756,951	$ 150,049,558
Withdrawal Management								
Pop Type:	**Expansion**							
Eligible Member Months	2.5%	2.5%	$ 3,350	3,434	3,520	3,608	3,698	
PMPM Cost	5.3%	5.3%	$ 700.00	$ 737.10	$ 776.17	$ 817.30	$ 860.62	
Total Expenditure			$ 2,345,000	$ 2,531,017	$ 2,731,790	$ 2,948,489	$ 3,182,378	$ 13,738,675

Program transferred from current PCN 1115 Demonstration Waiver effective 10/1/19

Note: Member months and PMPMs are based on state fiscal year and have not been adjusted to reflect starting on federal fiscal year

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

ELIGIBILITY GROUP		DEMO TREND RATE	DY01 (FFY20)	DY02 (FFY21)	DY03 (FFY22)	DY04 (FFY23)	DY05 (FFY24)	TOTAL WW
Targeted Adults Medicaid (TAM)								
Pop Type:	**Expansion**		*Started 11/1/17, suspended in previous 1115 waiver and transferred to the new 1115 waiver 10/1/19*					
Eligible Member Months		2.5%	49,028	50,254	51,510	52,798	54,118	
PMPM Cost		4.2%	$ 1,387.23	$ 1,445.49	$ 1,506.20	$ 1,569.46	$ 1,635.38	
Total Expenditure			$ 68,013,112	$ 72,641,405	$ 77,584,652	$ 82,864,288	$ 88,503,203	$ 389,606,660
Dental - TAM								
Pop Type:	**Expansion**		*Started 3/1/19, suspended in previous 1115 waiver and transferred to the new 1115 Waiver 10/1/19*					
Eligible Member Months		2.5%	36,000	36,900	37,823	38,768	39,737	
PMPM Cost		4.2%	$ 38.20	$ 39.80	$ 41.47	$ 43.22	$ 45.03	
Total Expenditure			$ 1,375,111	$ 1,468,687	$ 1,568,631	$ 1,675,377	$ 1,789,386	$ 7,877,193
Expansion Parents								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	365,164	374,293	383,650	393,241	403,072	
PMPM Cost		4.2%	$ 671.61	$ 699.82	$ 729.21	$ 759.83	$ 791.75	
Total Expenditure			$ 245,246,656	$ 261,935,691	$ 279,760,415	$ 298,798,111	$ 319,131,323	$ 1,404,872,196
Expansion Adults w/out Dependent Children								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	553,599	567,439	581,625	596,166	611,070	
PMPM Cost		4.2%	$ 784.97	$ 817.94	$ 852.29	$ 888.09	$ 925.39	
Total Expenditure			$ 434,557,732	$ 464,129,385	$ 495,713,390	$ 529,446,686	$ 565,475,533	$ 2,489,322,727
Substance Use Disorder (SUD)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	6,036	6,186	6,341	6,500	6,662	
PMPM Cost		4.2%	$ 4,243.43	$ 4,421.65	$ 4,607.36	$ 4,800.87	$ 5,002.51	
Total Expenditure			$ 25,611,365	$ 27,354,218	$ 29,215,673	$ 31,203,800	$ 33,327,218	$ 146,712,274
Withdrawal Management								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	$ 3,350	3,434	3,520	3,608	3,698	
PMPM Cost		4.2%	$ 700.00	$ 729.40	$ 760.03	$ 791.96	$ 825.22	
Total Expenditure			$ 2,345,000	$ 2,504,577	$ 2,675,014	$ 2,857,048	$ 3,051,471	$ 13,433,110

(Orange shading) Program transferred from current PCN 1115 Demonstration Waiver effective 10/1/19

Note: Member months and PMPMs are based on state fiscal year and have not been adjusted to reflect starting on federal fiscal year

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WOW
Current Eligibles						*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*				
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	0	377,866	0.0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	5.3%	0	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults with Children						*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**									
Eligible Member Months	5.9%	0	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	5.3%	0	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure					$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children										
Pop Type:	**Hypothetical**									
Eligible Member Months	34.9%	0	6,067	34.9%	8,182	11,034	14,881	20,068	27,064	
PMPM Cost	5.3%	0	$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.51	$ 194.29	
Total Expenditure					$ 1,292,995	$ 1,836,150	$ 2,607,473	$ 3,702,809	$ 5,258,269	$ 14,697,695
Dental - Targeted Adults	Suspend, then new subgroup in new waiver									
Pop Type:	**Expansion**					*Started 3/1/19*	*Porcelain crowns anticipated start date of 7/1/19*			
Eligible Member Months		0			-	12,000	9,000	-	-	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$38.20	$40.22	$42.35	
Total Expenditure					$ -	$ 400,000	$ 343,778	$ -	$ -	$ 743,778
System of Care										
Pop Type:	**Hypothetical**					*Start 6/1/19*				
Eligible Member Months		0			-	120	1,440	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	$ -	$ 2,100.00	$2,211.30	$2,328.50	$2,451.91	
Total Expenditure					$ -	$ 252,000	$ 3,184,272	$ 3,353,038	$ 3,530,749	$ 10,320,060
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure					$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged										
Pop Type:	**Hypothetical**						*Anticipated start date of 7/1/19*			
Eligible Member Months	2.5%	0					108,000	110,700	113,468	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 3,321,000	$ 3,584,438	$ 3,868,774	$ 10,774,212
Former Foster										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure					$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WOW
Substance Use Disorder (SUD)										
Pop Type:	**Hypothetical**						Expansion SUD population transfers to new 1115 waiver 10/1/19			
Eligible Member Months	6.9%	18	36,913	6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18	$ 3,163.77	5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Starts 5/1/19*	Expansion Withdrawal Management population transfers to new 1115 waiver 10/1/19			
Eligible Member Months	0.0%	0		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 1,106,543	$ 1,161,870	$ 1,219,963	$ 3,957,113

Legend	
Green	Assumes start date of 5/1/19 (2 months of SFY19)
Yellow	Assumes start date of 7/1/2019 (SFY20); includes costs for porcelain crowns
Blue	Assumes start date of 10/1/19 for new 1115 waiver

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*				
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.06	$ 1,166.79	$ 1,228.63	
Total Expenditure			$ 377,612,297	$ 383,419,793	$ 355,641,069	$ 372,829,701	$ 390,798,329	$ 1,880,301,189
Demo Pop I - PCN Childless Adults				*PCN ends 3/31/19*				
Pop Type:	**Medicaid**							
Eligible Member Months	70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost	$ 48.97	5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure			$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	159	4.9%	167	175	184	193	202	
PMPM Cost	$ 68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 84.16	$ 88.62	
Total Expenditure			$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Targeted Adults								
Pop Type:	**Expansion**		*Started 11/1/17, suspended in this 1115 waiver and transferred to the new 1115 waiver 10/1/19*					
Eligible Member Months		0%	78,000	78,000	78,000	78,000	78,000	
PMPM Cost		5.3%	$ 979.53	$ 1,031.45	$ 1,086.11	$ 1,143.68	$ 1,204.29	
Total Expenditure			$ 76,403,340	$ 80,452,717	$ 84,716,711	$ 89,206,697	$ 93,934,652	$ 424,714,116
Dental - Targeted Adults								
Pop Type:	**Expansion**			*Started 3/1/19*	*Porcelain crowns anticipated start date of 7/1/19*			
Eligible Member Months			-	12,000	9,000	-	-	
PMPM Cost		5.3%	$ -	$ 33.33	$ 38.20	$ 40.22	$ 42.35	
Total Expenditure			$ -	$ 400,000	$ 343,778	$ -	$ -	$ 743,778
System of Care								
Pop Type:	**Hypothetical**			*Start 6/1/19*				
Eligible Member Months			-	120	1,440	1,440	1,440	
PMPM Cost		5.3%	$ -	$ 2,100.00	$ 2,211.30	$ 2,328.50	$ 2,451.91	
Total Expenditure			$ -	$ 252,000	$ 3,184,272	$ 3,353,038	$ 3,530,749	$ 10,320,060
Demo Pop I - PCN Adults w/Children				*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**							
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$ 46.18	5.3%	$ 48.63	$ 51.20	$ 53.92	$ 56.77	$ 59.78	
Total Expenditure			$ 5,399,479	$ 4,516,681	$ -	$ -	$ -	$ 9,916,160
Demo Pop III/V - UPP Adults with Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,067	34.9%	$ 8,181.96	$ 11,034.19	$ 14,880.70	$ 20,068.12	$ 27,063.86	
PMPM Cost	$ 150.08	5.3%	$ 158.04	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure			$ 1,293,049	$ 1,836,227	$ 2,607,582	$ 3,702,963	$ 5,258,489	$ 14,698,309

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure			$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 7/1/19*			
Eligible Member Months		0%	-	-	108,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 3,321,000	$ 3,584,438	$ 3,868,774	$ 10,774,212
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**				Expansion SUD population transfers to new 1115 waiver 10/1/19			
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Starts 5/1/19*	Expansion Withdrawal Management population transfers to new 1115 waiver 10/1/19			
Eligible Member Months		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 1,106,543	$ 1,161,870	$ 1,219,963	$ 3,957,113

[Green] Assumes start date of 5/1/19 (2 months of SFY19)

[Yellow] Assumes start date of 7/1/2019 (SFY20); includes costs for porcelain crowns

[Light blue] Assumes start date of 10/1/19 for new 1115 waiver

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.