STATE OF UTAH

SPENCER J. COX
GOVERNOR

OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

DEIDRE M. HENDERSON
LIEUTENANT GOVERNOR

June 30, 2021

The Honorable Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue S. W.
Washington, D.C. 20101

Re: Utah's 1115 Primary Care Network (PCN) Demonstration Waiver Extension Request

Dear Secretary Becerra:

On behalf of the residents of the State of Utah, I am pleased to submit the enclosed application to renew Utah's 1115 Primary Care Network (PCN) Demonstration Waiver. Utah's existing Demonstration project is currently approved through June 30, 2022 Our application is seeking a renewal period from July 1, 2022 through June 30, 2027.

Over the period of this demonstration, the waiver continues to allow Utah to provide high quality, cost effective health care services by expanding the programs and benefits authorized under this waiver. Utah's demonstration waiver currently authorizes programs and benefits for approximately 225,000 Medicaid members.

This 1115 Waiver renewal requests authority to continue to operate the provisions currently approved, with additional approval of four new amendments including an increased reimbursement for Utah's Premium Partnership (UPP) Program, coverage for In Vitro Fertilization and Genetic Testing for qualified conditions, Medicaid coverage for Justice Involved Populations, and Housing Related Supports and Services. Utah is also requesting to change the name of our state's waiver and is requesting technical changes, technical changes to the Special Terms and Conditions (STCs) for Intensive Stabilization Services (ISS), technical changes to the American Recovery and Reinvestment Act (ARRA) references, and authority to combine Demonstration Populations III, V, VI and Current Eligible CHIP Children.

While Utah has achieved many successes under our current 1115 PCN Waiver, the continuation of this waiver is critical to our ongoing efforts to improve the health and wellbeing of our most vulnerable Utahns.

I look forward to our continued collaboration to ensure access to quality healthcare for Utah's most needy citizens. We appreciate your consideration of this proposal.

Sincerely,

Spencer J. Cox
Governor of Utah

Utah 1115 Demonstration Waiver

Renewal Request
(2022-2027)

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

Contents

State of Utah
Section 1115 Demonstration Waiver Renewal

Section I. Summary

The Utah Department of Health is requesting a five-year renewal of Utah's demonstration waiver under Section 1115 of the Social Security Act. Utah's existing demonstration waiver is currently approved through June 30, 2022. With this application, Utah is seeking a renewal period from July 1, 2022 through June 30, 2027. This 1115 waiver renewal requests authority to continue to operate as currently approved, with minimal changes.

Utah's 1115 demonstration waiver currently authorizes programs and benefits for approximately 220,000 individuals per month. These programs and benefits are outlined below:

- **Primary Care Network (PCN) Program**- Provides a limited package of preventive and primary care benefits to adults age 19-64 (suspended March 31, 2019 due to the implementation of Adult Expansion Medicaid on April 1, 2019).
- **Current Eligibles/ Non-Traditional Medicaid**- Provides a slightly reduced benefit package for adults receiving Parent/ Caretaker Relative (PCR) Medicaid.
- **Utah's Premium Partnership Program (UPP)**-Provides premium assistance to pay the eligible individual's or family's share of monthly premium costs of employer sponsored insurance or COBRA.
- **Targeted Adult Medicaid**- Provides state plan Medicaid benefits to a targeted group of adults without dependent children.
- **Former Foster Care Youth from Another State**- Provides state plan Medicaid benefits to former foster care youth from another state up to age 26.
- **Dental Benefits for Individuals with Blindness or Disabilities**- Provides state plan dental benefits to individuals age 18 and older, with blindness or disabilities.
- **Substance Use Disorder (SUD) Residential Treatment**- Coverage of SUD Residential Treatment in an Institution for Mental Disease (IMD) for all Medicaid eligible individuals.
- **Targeted Adult Dental Benefits**- Provides state plan dental benefits for Targeted Adult Medicaid eligible individuals who are actively receiving SUD treatment.
- **Adult Expansion**- Provides Medicaid benefits to adults age 19-64 who have household income up to 133 percent of the federal poverty level (FPL).
    - Adult Expansion members are required to participate in community engagement activities (if they do not meet an exemption or have good cause), and are required to enroll in employer sponsored insurance (ESI), if it is available to the eligible individual.
- **Community Engagement-** Requires Adult Expansion beneficiaries who do not meet an exemption or good cause reason to participate in qualifying activities in order to be eligible for Medicaid. Individuals who do not participate in the community engagement requirement will lose eligibility for Adult Expansion Medicaid. (Note-The community engagement requirement was suspended as of April 1, 2020 due to the COVID-19 public health emergency.)

- **Clinically Managed Residential Withdrawal Pilot-** Provides expenditure authority to provide clinically managed residential withdrawal services to Medicaid individuals, age 18 and older, who reside in Salt Lake County.
- **Dental Benefits for Aged Individuals**-Provides state plan dental benefits to Medicaid individuals age 65 and older.
- **Utah Medicaid Integrated Care (UMIC)**- Allows the state to operate an integrated managed care pilot combining physical health and behavioral health services in five Utah counties for the Adult Expansion Population (not including the Targeted Adult Population).
- **Intensive Stabilization Services (ISS)**- Allows the state to provide intensive stabilization services to Medicaid eligible children/youth under age 21 in state custody, or at risk of state custody, who are experiencing significant emotional and/or behavioral challenges.
- **Serious Mental Illness (SMI)Services in an IMD**- Provides access to services for individuals diagnosed with a serious mental illness residing in an IMD treatment setting.

In addition to the provisions currently approved, Utah is asking for approval of the following pending amendments as part of the renewal of this waiver:

- UPP Premium Reimbursement Increase Amendment
- In Vitro Fertilization and Genetic Testing for Qualified Conditions
- Medicaid Coverage for Justice Involved Populations
- Housing Related Supports and Services (Fallback Plan Amendment)

In addition to the renewal of current waiver and expenditure authorities, the state is requesting the following changes:

- A name change of the state's 1115 waiver
- Technical changes to the Special Terms and Conditions (STCs) for ISS
- Combining Demonstration Populations III, V, VI and Current Eligible CHIP Children (referred to as the UPP program)
- Technical changes to references to the American Recovery and Reinvestment Act (ARRA).

Section II. Historical Background

Utah's 1115 Primary Care Network (PCN) Demonstration Waiver is a statewide waiver that was originally approved in February 2002, and implemented July 1, 2002. Initially, Utah received approval to provide state plan eligibles (referred to as Current Eligibles), a reduced benefit package and increased cost-sharing. Savings from this state plan population were used to fund the PCN program, which provided a limited package of preventive and primary care services to uninsured adults aged 19 to 64 with family incomes up to 150 percent of the Federal Poverty Level (FPL). In addition, it provided full Medicaid benefits to high-risk pregnant women, whose resources made them ineligible under the state plan. Over the 19 years of this demonstration, the waiver approval has continued to allow the state to provide high quality, cost effective health care services by expanding the programs and benefits authorized under this waiver. Below is the history of amendments to Utah's 1115 Demonstration Waiver.

- Utah's 1115 PCN Demonstration Waiver was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- Amendment #1 - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that become pregnant received the full Medicaid state plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform with changes to the benefits available under the state plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the state plan. (Approved on August 20, 2002, effective on July 1, 2002)
- Amendment #2 - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the state subsidized the employee's portion of the premium for up to 5 years. The employer sponsored insurance must have provided coverage equal to or greater than the limited Medicaid package. The subsidy was phased down over 5 years, to provide a span of time over which employees' wages could increase to the point of unsubsidized participation in the employer sponsored plan. With this amendment, the state was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance individuals, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the state reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003).
- Amendment #3 - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004).
- Amendment #4 - This amendment changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the Current Eligibles ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the state provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005).
- Amendment #5 - This amendment implemented the adult dental benefit for the Current Eligibles population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005).
- Amendment #6 - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #7 - This amendment implemented an increase in the prescription copayments for the Current Eligibles population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #8 - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #9 - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this

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

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

- Amendment #10 – This amendment enables the state to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of employer-based group health coverage at group rates. COBRA coverage becomes available following the loss of ESI due to specified qualifying events, such as an end of employment (voluntary or involuntary); divorce or legal separation; death of employee; entitlement to Medicare; reduction in hours of employment; and loss of dependent-child status. Through this amendment, Utah is able to provide premium assistance to programmatically- eligible adults and children (as differentiated from individuals who are COBRA-eligible but not otherwise eligible for the Utah COBRA premium assistance program) toward the purchase of COBRA coverage, in a manner similar to the provision of premium assistance for the purchase ESI coverage. (Medicare-eligible individuals who are also COBRA-eligible would be ineligible for the Utah COBRA Premium Assistance Program (CPAP) based on age or the State's standard processes of cross-matching with SSI/SSDI eligibility files).

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

The ARRA COBRA subsidy could last for up to nine months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ended, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP continued to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage.

The Utah CPAP program provided premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualified for the ARRA COBRA subsidy. Individuals and families who are COBRA-eligible but uninsured may also apply for enrollment in the Utah CPAP. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the state under the STCs. The amendment was approved by CMS on December 18, 2009.

- Amendment #11 - This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150 percent of the FPL to 200 percent of the FPL. This amendment was approved by CMS on September 28, 2012.
- Amendment #12 – On June 29, 2017, CMS approved an amendment which allows the state to provide state plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.
- Amendment #13 – On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, Targeted Adults, under which eligible individuals receive state plan services. This new population is made of adults without dependent children, aged 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the state has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.
- Amendment #14 – This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this waiver. The state withdrew this amendment.
- Amendment #15 – In February 2019, the state received the authority to provide comprehensive dental benefits to Targeted Adults who are receiving SUD treatment. In addition, the state received approval to provide state plan Medicaid coverage to Former Foster Care Youth who were ever enrolled in Medicaid in another state.
- Amendment #16 – In March 2019, the state received authority to provide full state plan benefits to adults without children who have incomes up to 95 percent of the FPL and the Current Eligibles benefit package to adults with children who have incomes up to 95 percent of the FPL (together, these categories are known as the Adult Expansion Population) effective April 1, 2019. If the state determines that the state needs to close enrollment in this Medicaid eligibility group (MEG) due to budgetary restrictions, coverage will be closed and no applicants will be able to enroll in this MEG until enrollment re-opens. individuals in this category who have access to ESI coverage are required to enroll in that coverage to maintain Medicaid eligibility,

and receive wraparound coverage. In addition, non-exempt Adult Expansion Population individuals are required to complete community engagement requirements (or demonstrate good cause for failing to do so) each benefit year to be eligible for continued coverage. Lastly, this approval allowed the state to provide clinically managed residential withdrawal services to adult individuals who reside in Salt Lake County.

- Amendment #17 – In November 2019, the state received the authority to provide intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS includes state plan and home community-based services, and are provided during the first eight -weeks of the intensive program on a fee-for-service (FFS) basis using a daily bundled rate. The state uses this authority to demonstrate that providing these services will reduce Emergency Room (ER) utilization, psychiatric hospitalizations, and residential treatment services and length of stay as well as positively impact the child/youth's physical health in terms of comprehensive care.
- Amendment #18 – In December 2019, the state received the authority to expand the Adult Expansion Population to include adults, ages 19 through 64, with incomes up to and including 133 percent of the FPL, subject to previously approved community engagement requirements. In addition, the approval provided the state authority to provide dental benefits to Medicaid eligible individuals age 65 and older, as well as porcelain or porcelain-to-metal crowns and to Targeted Adults who receive treatment for SUD. This approval also revised and expanded the definition for the Targeted Adults eligibility criteria. Lastly, with this approval, the state received the ability to enroll demonstration populations in managed care plans; create and operate an integrated managed care model, called Utah Medicaid Integrated Care (UMIC), to combine the delivery of physical health and behavioral health services in five Utah counties for the Adult Expansion Population on individuals. Adult Expansion individuals in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP) for their behavioral health services. Adult Expansion individuals in the remaining 16 counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services. ACOs and PMHPs also deliver services to Current Eligibles.
- Amendment #19- In December 2020, the state received authority to maintain and enhance access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment to Medicaid individuals with SMI and/or SUD. This demonstration will provide the state with authority to provide high quality, clinically appropriate treatment to individuals with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including withdrawal management services. With this approval, the state also received authority to change how dental benefits are provided to blind or disabled members and to add porcelain and porcelain-to-metal crowns as a benefit to this population.

Extensions

- Section 1115(e) Extension - On June 23, 2006, the State of Utah formally requested an extension of their 1115 PCN demonstration waiver under the authority of section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.
- Section 1115(f) Extension – On March 1, 2010, the State of Utah formally requested an extension of the PCN demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.
- Temporary Extension – The December 24, 2013 amendment and temporary extension, changed the STCs such that beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and state plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.
- Temporary Extension – The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively 100 percent of the FPL because of the 5 percent income disregard) in order to ensure that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).
- Temporary Extension – On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.
- Temporary Extension – On December 16, 2016, the demonstration was temporarily extended through December 31, 2017.

Section III. Current Demonstration Goals, Objectives and Evaluation

Since the initial approval in 2002, Utah has received CMS authority to implement many additional programs and benefits through its 1115 demonstration waiver. With these additions, Utah's primary objectives have remained consistent. Utah's demonstration strives to do the following:

- Provide health care coverage for low-income Utahns that would not otherwise have access to, or be able to afford, health care coverage
- Improve participant health outcomes and quality of life
- Lower the uninsured rate of low income Utahns
- Provide continuity of coverage for individuals
- Increase access to primary care
- Improve appropriate utilization of emergency department visits
- Reduce uncompensated care provided by Utah hospitals
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs.

With the addition of the SUD and SMI IMD treatment approvals, the state has expanded its objectives to include the following for individuals with a substance use disorder or serious mental illness:

- Improve access to services across the continuum of care
- Provide for better care coordination for individuals transitioning to community-based care

- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate
- Reduce the overdose death rate
- Improve access to care for physical health conditions for these individuals.

Demonstration Evaluation

To determine if Utah's 1115 waiver is meeting its intended goals and objectives, the state has contracted with two independent evaluators to conduct an evaluation of the demonstration. These evaluators are; the University of Utah Social Research Institute (SRI) and Public Consulting Group, Inc. (PCG). Each evaluator is responsible for conducting an evaluation of specific demonstration populations. The University of Utah SRI is responsible to conduct an evaluation of the following waiver populations and components;

- Current Eligibles
- Demonstration Population I (PCN)
- Demonstration Populations III, V, VI, Current Eligible CHIP Children (UPP)
- Targeted Adults
- Targeted Adult Dental
- Intensive Stabilization Services
- Dental Benefits for Aged Members
- Dental Benefits for Individuals with Blindness or Disabilities
- SUD treatment in an IMD
- SMI treatment in an IMD

PCG is responsible to conduct an evaluation of the following waiver populations and components;

- Adult Expansion, including the ESI component
- Community Engagement
- Utah Medicaid Integrated Care (UMIC)

The evaluations have been designed by each independent evaluator to meet the STCs of Utah's 1115 demonstration. The evaluations will test the specific hypotheses and performance measures as identified by the evaluation designs for the demonstration populations.

Evaluation Designs and Interim Evaluation Reports

The state and the University of Utah SRI coordinated with CMS in the development and approval of the evaluation designs for the demonstration populations identified above. The University of Utah SRI completed the required interim evaluation report, which can be found in Attachment 1. As required by the waiver STCs, the summative evaluation report will be submitted to CMS within 18 months of the end of the demonstration period (no later than December 2023).

The state recently contracted with PCG to draft the evaluation design for UMIC. PCG has completed the draft design, which has been submitted to CMS for approval. Once the evaluation design has been approved, PCG will conduct the evaluation and an interim report will be submitted to CMS. Also, as required by the waiver STCs, the summative evaluation report will be submitted to CMS within 18 months of the end of the demonstration period (no later than December 2023).

As mentioned above, because the state recently contracted with PCG to conduct the evaluations for Adult Expansion, ESI, community engagement and UMIC, PCG is still in the process of conducting the evaluation and drafting the interim report for these components. The state intends to submit the interim report for Adult Expansion and ESI in the summer of 2021. The evaluation of the community engagement requirement will not be conducted due to suspension of the requirement on April 1, 2020.

SUD Evaluation Design Changes

Based on the recommendation of the independent evaluation contractor, we seek to revise the SUD evaluation design, originally approved on October 16, 2019. As indicated in the attached Utah 1115 Demonstration Waiver Interim Evaluation Report "the original DiD evaluation design integrity was compromised by the early expansion of IMD's into geographical locations designed to be part of the study control sites". Although SUD findings lacked statistical significance for the five primary research hypotheses, most of the outcome measures were trending positively in the hypothesized direction, suggesting additional time for policy and program implementation may be required to detect the impact of the demonstration on the outcomes. A revised research design will be a key component to accurately measuring hypothesized outcomes. UDOH proposes submitting a revised SUD evaluation design to CMS within 60 days of the 1115 waiver renewal request.

External Quality Review

Part of the overall quality strategy mandated by Section 1932(c)(2) of the Social Security Act and 42 CFR §438.350-370 requires states to include annual independent external quality reviews (EQRs) in each managed care contract. This approach requires an independent External Quality Review Organization (EQRO) to validate performance measures, conduct compliance reviews and otherwise evaluate the performance of Medicaid managed care plans. Utah contracts with HSAG as its EQRO vendor. A summary of activities performed by the Utah EQRO along with their key findings are contained in Attachment 2.

Section IV. Current Program Features to Continue under Demonstration Renewal

With this renewal, the state is requesting to continue all currently approved demonstration populations and components, with the exception of clinically managed residential withdrawal services. This service will be added as a state plan service effective April 1, 2021, and will be phased-out of the 1115 demonstration.

A description of the currently approved demonstration populations is detailed below.

- **Current Eligibles**- includes the following individuals, whose eligibility is derived from the state plan, but whose coverage is affected by the demonstration: 1) adults age 19 and above who are eligible through section 1925 and 1931 of the Act, including those eligible through any liberalized section 1931 criteria already in the state plan; 2) adults age 19 through 64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum.
- **Demonstration Population I (PCN)**- includes individuals age 19 through 64 with incomes at or below 95 percent of the FPL (effectively 100 percent of the FPL considering a disregard of 5 percent of income), who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, do not qualify for Medicare or Veterans benefits, and do not

have other health insurance. PCN was suspended as of March 31, 2019 due to the implementation of Adult Expansion. The state requests continued approval of this demonstration population, although the state will leave this program suspended as long as Adult Expansion is operating.

- **Demonstration Population III**- includes working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes up to and including 200 percent of the FPL, who are U.S. citizens/ qualified non- citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an Utah's Premium Partnership for Health Insurance (UPP)-approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.
- **Demonstration Population V**- includes adults age 19 through 64 with countable gross family income up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).
- **Current Eligible CHIP Children**- includes children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage.
- **Demonstration Population VI**- includes children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child.
- **Targeted Adults**- includes adults, ages 19 through 64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:
    - Be chronically homeless, defined as:
        1. An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        2. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        3. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter;

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

- Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
    1. An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails;
    2. An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;
    3. An individual on probation or parole with serious mental illness and/or serious substance use disorder;
    4. An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
    5. Individuals involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.
- Needing substance use or mental health treatment, defined as:
    1. An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or
    2. An individual recently discharged from the Utah State Hospital who was civilly committed.

- **Former Foster Care Youth from Another State**- consists of individuals under age 26, who were in foster care under the responsibility of a state other than Utah, or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.
- **Adult Expansion Population**- consists of adults, age 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, individuals in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state. Individuals are also required to participate in the community engagement requirement, if they do not meet an exemption or good cause exception.
- **Intensive Stabilization Services (ISS) Population**- consists of children/youth under age 21, whose eligibility is derived from the state plan, and are experiencing significant emotional and/or behavioral challenges while in state custody or are at risk of being placed in state custody.
- **Substance Use Disorder Services in an IMD**- provides authority for Medicaid recipients to receive opioid use disorder (OUD)/substance use disorder (SUD) treatment services provided in a residential or inpatient treatment setting that qualifies as an IMD.
- **Targeted Adult Dental Benefits**- includes individuals who are eligible for the Targeted Adult Medicaid program and are receiving SUD treatment, to receive state plan dental benefits, as well as porcelain or porcelain-to metal crowns.

- **Dental Benefits for Aged Individuals**- includes individuals who are age 65 and older, and are eligible for Medicaid, who are eligible to enroll in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.320 and 435.330. They receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.
- **Dental Benefits for Individuals with Blindness or Disabilities**- includes individuals who are blind or disabled, 18 and older, who are enrolled in the state plan under Section 1902(a)(10)(C) of the Act and 42 CFR 435.322, 435.324 and 435.330. They receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.
- **Serious Mental Illness Services in an IMD-** Provides authority for Medicaid recipients, age 21 through 64, to receive SMI services in IMD treatment settings.

Benefits and Delivery System

The state intends to continue to provide benefits as outlined below.

Table 1: Demonstration Benefits and Delivery System

Demonstration Populations	Benefits	Delivery System
Demonstration Population I- PCN (currently suspended)	• Limited benefit package of primary and preventative care service. • Services include primary care physician, lab, radiology, durable medical equipment, emergency room services, pharmacy (four per month), dental, and vision. • Inpatient hospital, specialty care, and mental health services are among the services that are not covered.	Benefits are delivered through Fee For Service (FFS).
Current Eligibles	• Individuals enrolled in this eligibility category receive most of the benefits covered under Utah's state plan according to limitations specified in the state plan, except as outlined in Table 2 below. • Current Eligibles also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services (mental health services in residential treatment settings).	Benefits are delivered through ACOs and PMHPs for required counties. Voluntary counties may choose to receive benefits through managed care or FFS.
Demonstration Populations III, V, VI and Current Eligible CHIP	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the	Benefits are delivered by their respective qualified plan for ESI or COBRA.

Children (UPP)	employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	
Dental for Blind and Disabled Adults	Individuals that are enrolled in this eligibility category will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	Benefits are delivered through a FFS model by contracting with the University of Utah School of Dentistry, and their associated network of providers.
Targeted Adults	Individuals enrolled in this eligibility category will receive full Medicaid state plan benefits.	Benefits are delivered through FFS Benefits may be delivered through a managed care delivery system in the future.
Dental for Targeted Adults	Individuals that are enrolled in this eligibility category who are receiving SUD treatment will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	Benefits are delivered through a FFS model by contracting with the University of Utah School of Dentistry, and their associated network of providers.
Dental for Aged Adults	Individuals that are enrolled in this eligibility category will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services, and if needed, porcelain or porcelain-to-metal crowns.	Benefits are delivered through a FFS model by contracting with the University of Utah School of Dentistry, and their associated network of providers.
Adult Expansion Population	● Expansion adults without dependent children will receive state plan benefits ● Expansion adults with dependent children will receive most of the benefits covered under Utah's state plan according to limitations specified in the state plan, except as outlined in Table 2 below. ● Expansion adults also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services (mental health	● Benefits are provided through UMIC in five counties. ● Adult Expansion individuals in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP)

	services in residential treatment settings).	for their behavioral health services. Adult Expansion individuals in the remaining 16 counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services.
Adult Expansion- ESI	Individuals in this eligibility group will be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified ESI plan.	• Individuals will receive services through the delivery systems provided by their respective qualified plan. • Wrap-around benefits will be provided through a FFS delivery system.
Intensive Stabilization Services	Individuals eligible for this category will receive state plan and home community-based services.	Benefits are managed through DHS and are delivered FFS using a daily bundled rate.
Former Foster Care Youth from Another State	Individuals enrolled in this eligibility category will receive full Medicaid state plan benefits.	Benefits are delivered through the individual's applicable delivery system (ACO, PMHP, UMIC, or FFS).
SUD IMD	Individuals will receive state plan services, including SUD treatment services provided in residential treatment settings that qualify as an IMD.	Benefits are delivered through the individual's applicable delivery system (PMHP, UMIC, or FFS).
SMI IMD	Individuals will receive state plan services, including mental health treatment services provided in residential and inpatient treatment settings that qualify as an IMD.	Benefits are delivered through the individual's applicable delivery system (PMHP, UMIC, or FFS).

Cost Sharing

Cost sharing requirements for individuals under this demonstration are as defined in the Medicaid state plan, with two exceptions:

- Individuals receiving premium assistance under the UPP program (Demonstration populations III, V, VI and current eligible CHIP children) will have cost sharing requirements set by their qualified ESI or COBRA plan.
- American Indian/Alaska Natives enrolled in the demonstration are exempt from cost sharing requirements under section 5006 of the American Recovery Reinvestment Act of 2009.

Benefit Differences for Current Eligibles and Adult Expansion Members with Dependent Children

The table below identifies benefits for Current Eligibles and members of the Adult Expansion population who are custodial parents/caretaker relatives, that are different from state plan covered services and limitations.

Table 2: Benefit Differences from State Plan for Current Eligibles and Adult Expansion with Children

Service	Special Limitations for Current Eligibles and Adult Expansion Population Parents
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 PT 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.

Community Engagement

Utah's 1115 demonstration waiver currently authorizes a community engagement requirement for individuals in the Adult Expansion population who do not qualify for an exemption, or meet a good cause reason. The state implemented this requirement on January 1, 2020. However, due to the COVID-19 public health emergency, the requirement was suspended as of April 1, 2020. The state requests continued approval of this requirement with this renewal, with no changes to the current approval.

Individuals who meet an exemption below are not required to participate in the community engagement requirement during the 12-month benefit period for which they qualify for an exemption.

Exempt Populations

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 Department of Workforce Services (DWS);
8. Participating regularly in a SUD 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 training 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. Individuals in compliance with or who are exempt from Supplemental Nutrition Assistance Program (SNAP) and/or Temporary Assistance for Needy Families (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.

Good Cause

The state will consider an individual to be compliant with the community engagement requirement if they demonstrate good cause for failing to meet the required community engagement activities within the three-month period. Individuals may report a good cause exception up to 10 days prior to termination. Good cause exceptions include, but are not limited to, the following verified circumstances:

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 has no access to internet or transportation to a place where the requirements can be completed, such as a job center or library, to complete the requirements;
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 (including considerations related to, for example, the individual's ability to obtain transportation to the employment site); 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 the individual demonstrates are likely to be futile; or
7. The individual is the primary caretaker of a child age 6 or older and was unable to meet the requirement due to childcare responsibilities.

Qualifying Activities

Individuals who are not exempt and who are not eligible for good cause must participate in the community engagement requirement by completing all of the following activities through the Department of Workforce Services:

1. Registering for work through the state system;
2. Completing an assessment of employment training needs;
3. Applying for employment, either directly or through the state's automated employment application submission process, with at least 48 applications; and
4. Completing the job training modules as determined to be relevant to the individual through the assessment of employment training needs.

Requirements and Reporting

Individuals who are not exempt and who do not qualify for a good cause exception must participate in the qualifying activities within the three-month period starting on the first of the first month after notification that the individual must meet the community engagement requirement. Once the individual has met the community engagement requirement by completing the required activities, the individual will remain eligible for the remainder of the 12-month eligibility period. The individual must complete the community engagement requirement or qualify for an exemption or demonstrate good cause during the applicable three-month period for each 12-month eligibility period to continue to be eligible for Medicaid.

Non-Compliance

Individuals who fail to comply within the three-month compliance period will be disenrolled as of the last day of the month in which the individual receives notification of the non-compliance, unless the individual requests and demonstrates good cause within the three months that the individual is required to complete the community engagement activities, or if the individual appeals the termination prior to its effective date.

Re-enrollment Following Non-Compliance

Following disenrollment, individuals will be able to re-apply for coverage after completing all required activities and would be re-enrolled effective the first day of the month in which the individual reapplies. However, if the individual reports having met the requirements within one month of disenrollment, the individual will not have to submit a new application. If the individual meets the qualifications for an exemption, 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 or, if eligible in a group other than the Adult Expansion Population, consistent with the individual's new eligibility category.

An individual who has been disenrolled for non-compliance and is subsequently re-enrolled after completing all the required activities or qualifying for an exemption, will begin a new 12-month eligibility period, with an effective date to the first of the month of application, and will be considered to have met the community engagement requirement or to be exempt for that 12-month period

Employer Sponsored Insurance (ESI)

Utah's demonstration authorizes an ESI requirement for all Adult Expansion Medicaid members. Individuals with access to ESI must meet the ESI requirement to maintain their Medicaid coverage. The state requests to continue approval of this requirement with no changes, as indicated below.

Exempt Populations

Adults enrolled in the Targeted Adult Medicaid program, members of federally recognized tribes, and those determined to be medically frail are not subject to the ESI requirement.

Requirement

Adult Expansion members may be required to enroll in their qualified ESI plan. The state notifies members if they are required to enroll in ESI. Once enrolled, Medicaid reimburses the member's full portion of their monthly premium. Medicaid members who receive an ESI reimbursement also receive Medicaid coverage. Wrap-around benefits are provided through a FFS delivery system.

Non-Compliance

If the member fails to enroll in their ESI plan, they lose eligibility for Adult Expansion Medicaid until one of the following occur:

- The member enrolls in the ESI plan, or
- The member loses access to the ESI plan (i.e. loss of job), or
- They apply 12 months after losing eligibility.

Monitoring

Access to and enrollment in a qualified ESI plan and the member's premium amount will be verified at initial application, every three months, and at annual recertification.

Utah Medicaid Integrated Care (UMIC)

The state currently has approval to mandatorily enroll the Adult Expansion Population into UMIC managed care organizations (MCO) for delivery of their physical and behavioral health services in the five urban counties in the state (Davis, Salt Lake, Utah, Washington, and Weber). The state also mandatorily enrolls members of the Adult Expansion Population in an ACO and a PMHP or FFS, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC. The state requests to continue this approval with this renewal.

Section V. Proposed Changes to Current Demonstration

The state requests the following changes to the current demonstration for the identified waiver populations or components.

Name of Waiver

The waiver was originally approved to provide benefits for individuals eligible for the PCN program. As indicated in the Historical Background section above, Utah's 1115 demonstration has expanded significantly over the 19 years of the demonstration to include many different programs and benefits. Due to the expansion of the purpose and goals of this waiver, the state requests to change the name of the waiver to "Utah's Medicaid Reform 1115 Demonstration Waiver", to provide a more comprehensive representation of the waiver.

Intensive Stabilization Services (ISS)

The state implemented ISS on July 1, 2020. These services are provided to Medicaid eligible children and youth who are experiencing significant emotional and/or behavioral challenges based on medical necessity, acuity, and need. The ISS includes state plan and home community-based services provided during the first eight weeks of the intensive program. With this renewal the state requests to make the following changes to ISS:

1. The current approval states that ISS services will be provided and billed during the first eight weeks of the program. Since implementation, it has been determined that these services may be needed for a longer period of time. The state requests approval to provide these services during the entire period of the intensive program, rather than during the first eight weeks.
2. The state requests to make a technical correction to references to "Stabilization and Mobile Response team(s) (SMR)" in the waiver STCs. The state requests to change this reference to

"intensive stabilization services (ISS) team(s)". In addition, the state also requests any references to "care manager" be changed to "ISS staff".

3. The state requests to remove "Psychotherapy with Evaluation and Management (E/M) Services" from the ISS table of services (2c). This service will not be provided as part of ISS, as the staff providing ISS do not have the licensure required to provide it.
4. The state requests a technical correction to STC #82 by removing the term "contracted" from the sentence stating "The ISS *contracted* providers are all Medicaid enrolled providers".

Utah's Premium Partnership for Health Insurance (UPP)- Demonstration Populations III, V, VI, and Current Eligible CHIP Children

The state is requesting the following changes to the waiver STCs related to the UPP populations.

1. Combining the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population. The state is requesting this change to simplify reporting, because the overall group population has remained relatively small, and because the state considers these to be one population for administration purposes.
2. Through the American Recovery and Reinvestment Act (ARRA,) individuals and families affected by involuntary job loss occurring September 1, 2008 through May 31, 2010 were eligible to receive a COBRA subsidy of 65 percent of the cost of COBRA coverage and could last up to 9 months. Once the ARRA subsidy ended, or for those not eligible for the ARRA COBRA subsidy, the state continued to provide a monthly premium payment for up to 18 months to offset the cost of COBRA coverage. Since this program has sunsetted, the state is requesting to remove ARRA language from the STC's, except as needed for historical reference.

Pending Waiver Amendments

At this time, the state has several waiver amendment requests pending a decision from CMS. These amendments can be found in Attachment 3, and on the state's 1115 waiver website at https://medicaid.utah.gov/1115-waiver. The state requests that these amendments be considered in addition to the waiver renewal, with the hope of gaining approval for these amendments prior to the approval of the full waiver renewal. A brief overview of the amendments is contained below.

UPP Premium Reimbursement Increase Amendment

On February 19, 2021 the state submitted an amendment as a result of House Bill 6003 "Premium Subsidy Amendments" which passed during the 2020 Sixth Special Session of the Utah State Legislature. This amendment requests authority to allow the state to increase the maximum reimbursement allowable under Utah's Premium Partnership for Health Insurance Program (UPP), from $150 per enrollee per month, to a higher amount, through the state administrative rulemaking process, rather than by waiver amendment.

In Vitro Fertilization and Genetic Testing for Qualified Conditions

On December 30, 2020, the state submitted an amendment as a result of the 2020 General Session of the Utah State Legislature, House Bill 214 "Insurance Coverage Modifications'' which passed, and was signed into law by Governor Herbert. This legislation required the Utah Department of Health, Division of Medicaid and Health Financing (DMHF) to seek 1115 waiver approval from the Centers for Medicare and Medicaid Services (CMS) to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have specific qualified conditions.

Medicaid Coverage for Justice Involved Populations

On June 29, 2020, the state submitted an amendment as a result of the 2020 General Session of the Utah Legislative Session, House Bill 38 "Substance Use and Health Care Amendments", which passed and was signed into law. 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 provide Medicaid coverage for qualified justice-involved individuals. These individuals must have a chronic physical or behavioral health condition, a mental illness as defined by Section 62A-15-602 of Utah State Code, or an opioid use disorder. If approved, Medicaid coverage will be provided in the 30-day period immediately prior to release of the incarcerated individual from a correctional facility.

Housing Related Services and Supports

As part of the Fallback waiver amendment submitted to CMS on November 1, 2019, the state requested federal expenditure authority to provide housing related services and supports (HRSS) for groups within Medicaid Expansion. Approval of this request will allow the state to help Individuals address barriers that influence their health and well-being. These barriers include but are not limited to; 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.

Other Amendments

At this time the state is not requesting action on the following waiver amendments as part of the waiver renewal. However, the state is not withdrawing these amendment requests at this time;

- Fallback Plan
- Per Capita Cap

Section VI. Goals, Objectives, and Evaluation of Proposed Demonstration Renewal

Utah proposes the following research hypotheses and design approach for Utah's Demonstration renewal. The hypotheses below are consistent with those already approved in the evaluation designs. The state is not requesting any changes at this time.

Table 3: Demonstration Objectives and Proposed Hypotheses		
Objectives	**Proposed Hypotheses**	**Potential Approaches/Data Sources**
Current Eligibles		
Not negatively impact the health and well-being of the	The demonstration will not negatively impact the overall	Utah All Payer Claims Database Utah Medicaid claims

demonstration population by offering a slightly reduced benefit package.	well-being, in relation to health status, of Current Eligibles who experience reduced benefits and increased cost sharing.	Medicaid data warehouse
Demonstration Populations III, V and VI - UPP		
Increase the number of individuals with access to employer-sponsored health insurance in obtaining that coverage.	The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance.	Utah All Payer Claims Database Utah Medicaid claims Medicaid data warehouse
Targeted Adults		
Reduce the number of uninsured, while improving access to primary care and improving the overall health of the population.	The demonstration will reduce the number of uninsured Utahns.	Medicaid data warehouse HEDIS Adult Core Set
	The demonstration will improve access to primary care, while also improving the overall health status of the target population.	Utah Medicaid claims BRFSS insurance questions HEDIS Adult Core Set
	The demonstration will reduce the number of non-emergent Emergency Room visits for the chronically homeless population.	Utah Medicaid claims Medicaid data from other states HEDIS Adult Core Set
	The demonstration will reduce uncompensated care provided by Utah hospitals.	Hospital costs reports
Dental for Blind and Disabled Members		
Improve preventive dental services and reduce emergency dental procedure costs.	The demonstration will reduce the number of individuals who have an emergency dental procedure performed, while increasing the number of members who receive preventive dental services.	Medicaid claims data
Targeted Adult Medicaid Dental		

Improve the SUD treatment completion rate among demonstration participants, while providing much needed dental care.	The demonstration will improve SUD treatment completion.	Medicaid claims data
Adult Expansion		
Improve the health of Utahns, increase access to primary care, improve appropriate utilization of emergency department visits, and reduce uncompensated care provided by Utah hospitals.	The demonstration will improve the health and well-being of individuals in Utah.	Behavioral Risk Factor Surveillance System (BRFSS) Medicaid claims data Utah All Payer Claims Database
	The demonstration will increase access to primary care and improve appropriate utilization of emergency department (ED) services by Adult Expansion members.	Medicaid claims data Utah All Payer Claims Database
	The demonstration will reduce uncompensated care provided by Utah hospitals.	Comparison to other states based on Center for Budget & Policy Priority definition: any services for which a provider is not reimbursed
	The demonstration will assist previously uninsured individuals in purchasing employer sponsored insurance to help reduce the number of uninsured adults.	Medicaid claims data State administrative data
Community Engagement		
To increase employment which will contribute to increased health and well-being.	The demonstration will improve employment levels of individuals.	State administrative data eREP & UWorks data State individual survey
	The demonstration will increase the average income of individuals.	State individual survey

	The demonstration will increase the likelihood that Medicaid individuals will transition to commercial insurance.	State individual survey
	The demonstration will improve the health outcomes of current and former Medicaid individuals.	State individual survey State administrative data
	There are common barriers to compliance with community engagement requirements.	State individual survey
	Individuals subject to the requirements understand how to be compliant.	State individual survey State administrative data
Utah Medicaid Integrated Care		
By integrating the services delivery system for the Adult Expansion group, the State expects to see better health outcomes, better compliance with treatment, and an overall improvement in the quality of life of the individuals.	The demonstration will show that an integrated care delivery model results in better health outcomes for Medicaid individuals.	Beneficiary Surveys BRFSS Medicaid administrative data
	The demonstration will show that the Adult Expansion population has better health outcomes when enrolled in managed care.	Beneficiary Surveys BRFSS Medicaid administrative data
Substance Use Disorder Services in an IMD		
Increased rates of identification, initiation and engagement in SUD treatment.	The demonstration will increase the percentage of members who are referred and engage in SUD treatment.	NQF Measures Individual Survey Adult SUD consumer Satisfaction Survey
Increased adherence to and retention in SUD treatment	The demonstration will increase the percentage of members who adhere to SUD treatment.	NQF Measures Medicaid claims
Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization	The demonstration will decrease the rate of emergency department and inpatient visits within the individual population	Medicaid claims

is preventable or medically inappropriate through improved access to other continuum of care services.	for SUD.	
Improved access to care for comorbid physical health conditions commonly associated with SUD among members.	The demonstration will increase the percentage of members with SUD who experience care for comorbid conditions.	Medicaid claims
Reduce the rate of overdose deaths, particularly those due to opioids.	The demonstration will decrease the rate of overdose deaths due to opioids.	Vital Statistics
Intensive Stabilization Services (ISS)		
To keep children and youth at risk in the community from being placed in state custody, while helping children who are in state custody to return to their families or become independent more quickly.	The demonstration will reduce the number of emergency room visits, psychiatric hospitalizations, and residential treatment services and length of stay.	Medicaid claims APCD
	The demonstration will increase the number of Early Periodic, Screening, Diagnosis and Treatment (EPSDT) visits and improve access to other services, such as dental care.	Medicaid claims APCD YRBS
Dental for Aged Individuals		
To increase the utilization of preventive dental services and improve the quality of life for the demonstration population.	Aged individuals will have increased utilization of preventive dental services.	Medicaid claims Utah All Payer Claims Database
	Aged individuals will have decreased utilization of emergency dental services.	Medicaid claims Utah All Payer Claims Database
	Aged individuals receiving comprehensive dental care will experience increased quality of life.	Aged Dental Survey, with Oral Health Impact Profile -14, quality of life

Serious Mental Illness Services in an IMD		
Reduced utilization of emergency departments (EDs) among Medicaid individuals with SMI/SED while awaiting mental health treatment in specialized settings.	The SMI demonstrations will result in reductions in utilization and length of stay in EDs among Medicaid individuals with SMI while awaiting mental health treatment.	Medicaid claims data
Reduced preventable readmissions to acute care hospitals and residential settings among Medicaid individuals with SMI/SED.	The SMI demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	Medicaid claims data
Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.	The SMI demonstration will result in improved availability of crisis stabilization services throughout the state.	Medicaid claims data Monitoring reports Environmental scan
Improved access to community-based services to address the chronic mental health care needs of individuals with SMI/SED, including through increased integration of primary and behavioral health care.	Access of individuals with SMI to community-based services to address their chronic mental health care needs will improve under the demonstration, including through increased integration of primary and behavioral health care.	Medicaid claims data Monitoring reports Environmental scan Interviews
Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	The SMI demonstration will result in improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	Medicaid claims data Monitoring reports

Section VII. Requested Waiver and Expenditure Authorities

The following table summarizes the current demonstration waiver and expenditure authorities, and whether Utah is requesting to continue these authorities with this renewal request.

Table 4: Requested Waiver Authorities			
Waiver Authority	**Reason and Use of Waiver**	**Demonstration Populations Applicable To**	**Status under Renewal**
Section 1902(a)(34)-Retroactive Eligibility	To permit the state to not provide retroactive eligibility for individuals under this demonstration.	Demonstration Populations I and III	Continue
Section 1902(a)(14)-Cost Sharing Requirements	To permit individuals affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing requirements (including the out-of-pocket maximum) as set by the individual's qualified ESI plan.	Demonstration Populations III, V and VI	Continue
Section 1902(a)(43)-Early Periodic Screening, Diagnosis and Treatment (EPSDT)	To enable the state not to cover certain services required to treat a condition identified during an EPSDT screening.	19 and 20-year olds who are not in the Adult Expansion Population (not including blind and disabled enrollees who receive dental through this demonstration)	Continue
Section 1902(a)(23)(A)-Freedom of Choice	To enable the state to restrict freedom of choice of providers for individuals under this demonstration.	Title XIX Populations affected by this demonstration	Continue
Section 1902(a)(4) insofar as it incorporates 42 CFR 431.54- Methods of Administration	To the extent necessary to relieve the state of the responsibility to assure non-emergency medical transportation to and from providers for individuals with dependent children enrolled in the Adult Expansion Population, except that this requirement nevertheless shall apply with respect to those eligible for EPSDT services.	Adult Expansion with Dependent Children	Continue
Section 1902(a)(10)(B)-	To enable the state to vary the amount, duration, and	-Individuals affected by this demonstration with the	Continue

Amount, Duration, and Scope of Services and Comparability	scope of services offered to individuals by demonstration group.	exception of Former Foster Care Youth from Another State -Targeted Adults -Blind, Disabled and Aged expenditure populations -Adult Expansion population -Intensive Stabilization Services Population	
Section 1902(a)(8) and (a)(10- Eligibility and Provision of Medical Assistance	To the extent necessary to enable Utah to require community engagement as a condition of eligibility for individuals in the Adult Expansion Population as described in these STCs. To the extent necessary to enable Utah to terminate eligibility for, and not make medical assistance available to, individuals in the Adult Expansion Population who fail to comply with the community engagement requirement unless the individual is exempted, or demonstrates good cause, as described in the STCs.	Adult Expansion Population	Continue
Section 902(a)(10(A)(i)(VIII) insofar as it incorporates section 1902(k) and sections 1902(k) and 1903(i)(26) insofar as they incorporate section 1937 and CFR 440.390 - Compliance with ABP Requirements	In order to permit federal financial participation (FFP) to be provided in expenditures to the extent that non-emergency medical transportation (NEMT) is not covered for certain individuals for whom its assurance would otherwise be required.	Adult Expansion Population	Continue
Section 1902(a)(1)- Statewideness/ Uniformity	To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX populations affected by this demonstration.	Title XIX Populations affected by this demonstration	Continue

Section 1902(a)(15) and Section 1902(bb)- Federally Qualified Health Centers Payments	To permit the state to pay for Federally Qualified Health Center services provided to Demonstration Population I individuals on a basis other than a prospective payment system.	Demonstration Population I	Continue

Expenditure Authorities

Table 5: Requested Expenditure Authorities		
Demonstration Population	**Reason and Use of Expenditure Authority**	**Status Under Renewal**
Current Eligibles	Expenditures for optional services not covered under Utah's state plan or beyond the state plan's service limitations and for cost-effective alternative services, to the extent those services are provided in compliance with the federal managed care regulations at 42 CFR 438 et seq.	Continue
Demonstration Population I	Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 95 percent of the federal poverty level (FPL) (effectively 100 percent with the five percent income disregard) who are not otherwise eligible for Medicaid, as described in the waiver STCs. This expenditure authority will end effective April 1, 2019.	Continue
Demonstration Population III	Expenditures for premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' employer sponsored insurance (ESI) plan, who are not otherwise eligible for Medicaid, as described in the STCs.	Continue
Demonstration Population V	Expenditures for premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs.	Continue

Individuals who are Blind or Disabled	Expenditures for dental benefits for individuals who are blind or disabled and who are eligible for Medicaid.	Continue
Individuals who are Aged	Expenditures for dental benefits for individuals who are age 65 and older, and are eligible for Medicaid.	Continue
Former Foster Care Youth from Another State	Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.	Continue
Targeted Adults	Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment.	Continue
Substance Use Disorder	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).	Continue
Adult Expansion	Expenditures to provide coverage to adults, ages 19 through 64, who are not Current Eligibles, and have household income at or below 133 percent of the FPL, as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents will receive state plan coverage, while members of the Adult Expansion Population who are custodial parents/caretaker relatives will receive the Current Eligibles benefit package,	Continue
Mandatory Employer Sponsored Insurance	Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population individuals who are enrolled in ESI plans.	Continue
Intensive Stabilization Services Program	Expenditures to provide an assessment and service package including state plan behavioral services and home and community-based respite and non-medical transportation services reimbursed using a daily bundled rate during the first eight weeks of the 16-week intensive stabilization program for Medicaid eligible children/youth in state custody or at risk of being placed in state custody experiencing significant emotional and/or behavioral challenges.	Continue

Residential and Inpatient Treatment for Individuals with Serious Mental Illness	Expenditures for services furnished to eligible individuals ages 21 through 64 who receive treatment for a SMI and who are short-term residents in facilities that meet the definition of an IMD.	Continue
COBRA Children-Demonstration Population VI	Expenditures to provide premium assistance and benefits specified in the STCs, to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such expenditures are authorized without regard to the funding limitation under section 2105(c)(2) of the Act. Moreover, the Title XXI requirements listed below do not apply to the benefits for this population.	Continue
Title XXI Requirements Not Applicable to CHIP Expenditure Authorities for Demonstration Population VI		
Section 2102 General Requirements, and Eligibility Screening Requirements	The state child health plan does not have to reflect the demonstration population. Eligibility screening is not required to exclude eligibility for individuals enrolled in continuation coverage pursuant to COBRA.	Continue
Section 2013 and 2110-Restrictions on Coverage and Eligibility to Targeted Low-Income Children	Coverage and eligibility are not restricted to targeted low-income children, to the extent that it includes individuals enrolled under continuation coverage pursuant to COBRA.	Continue
Section 2105(c)(1)-Qualified Employer Sponsored Coverage	To permit the state to offer a premium assistance subsidy that does not meet the requirements of section 2105(c).	Continue
Section 2102- Cost Sharing Exemption for American Indian/Alaska Native (AI/AN) Children	To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.	Continue
Section 2103(e) Cost Sharing	To the extent necessary to permit all CHIP populations affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing imposed by employer sponsored insurance plans.	Continue
Section 2103 Benefit Package Requirements	To permit the state to offer a benefit package for all CHIP populations affected by this demonstration that is limited to premium assistance.	Continue

Section VIII. Budget Neutrality

Utah's 1115 demonstration must be "budget neutral" to the Federal government, which means that during the course of the demonstration, Federal Medicaid expenditures will not be more than Federal spending without the demonstration. Information regarding budget neutrality for this demonstration can be found in Attachment 4.

Section IX. Compliance with Public Notice and Tribal Consultation

Public Notice Process

The state certifies that public notice of the state's request for this demonstration renewal, and notice of Public Hearing was advertised in the newspapers of widest circulation, and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the state's Medicaid website at https://medicaid.utah.gov/1115-waiver.

The state certifies that two public hearings to take public comment on this request were held. The first public hearing was held on May 20, 2021 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing was held on May 24, 2021 from 4:30 p.m. to 5:30 p.m. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings were held via video and teleconferencing. Public notice documents can be found in Attachment 5.

Public Comment

The public comment period was held May 5, 2021 through June 11, 2021. The state received public comment from 16 individuals and agencies. This includes comments provided during both public hearings, email and online portal comments, and mailed comments. The state reviewed and considered all public comments received. The state's responses to public comments can be found in Attachment 6.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a) (73) of the Social Security Act, the state ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver renewal. As a result of this notification, DMHF began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on May 14, 2021 to present this demonstration renewal request. No comments or feedback were provided prior to this renewal request being submitted to CMS. The UIHAB meeting agenda can be found in Attachment 7.

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

Name and Title: Emma Chacon, Interim Medicaid Director, Utah Department of Health
Telephone Number: (801) 448-1543
Email Address: echacon@utah.gov

ATTACHMENT 1

Interim Evaluation Report

Utah 1115 Demonstration Waiver Interim Evaluation Report

Prepared by:

Jorge Arciniegas, B.A.

Rodney Hopkins, M.S.

Larissa Shuppy, MStat.

Kristen West, MPA

Jaewhan Kim, Ph.D.*

Norm Waitzman, Ph.D.**

* Jaewhan Kim is with the University of Utah, School of Medicine

** Norm Waitzman is with the University of Utah, Economics Department

Table of Contents

Executive Summary

This report constitutes an interim evaluation of six demonstrations under Utah's 1115 Waiver. These include: Current Eligibles (CE), Targeted Adults (TA), Utah Premium Partnership (UPP), Blind and Disabled Dental (BDD), and Substance Use Disorder (SUD). A sixth demonstration, the Primary Care Network (PCN) was suspended at the end of March 2019, so there are no new data to provide in this evaluation. This report covers several hypotheses on health care utilization and outcomes broadly associated with 1) increased cost sharing (CE); 2) increased dental coverage for blind, disabled (BDD) and targeted adults (TA); 3) until its suspension, establishment of the primary care network (PCN); 4) enhanced coverage of the population experiencing homelessness (TA); 5) incentives to enroll in employer-provided insurance (UPP); and 6) an array of substance use disorder services to eligible populations. This report consists of a variety of analyses related to specific hypotheses associated with implementation through November 2020. In some cases, data were neither available nor robust enough to conduct multivariate analyses at the time of reporting. This interim evaluation is issued in accordance with special terms and conditions (STCs) reporting requirements. This report includes data analysis performed by the independent contractor from Utah Medicaid claims and other data, a beneficiary survey conducted by subcontract, and a review of monitoring metrics submitted by the Utah Department of Health (UDOH). With regard to the CE, TA, BDD, and UPP demonstrations, findings indicate:

1. These preliminary findings do not yet demonstrate statistically significant improvements in access and utilization of appropriate health care and associated health outcomes. Additionally, there is not a reduction in costs reflected among the demonstration populations that is attributable to the incentivized preventive and primary care in lieu of more expensive care such as that provided in the emergency room. The COVID-19 pandemic likely was responsible for some of these trends in 2020.

2. Preliminary results affirming certain hypotheses, however, were noted in the last report. CE enrollees, for example, had an increase in hypertension prescriptions per member diagnosed with hypertension over the time frame analyzed (Table 10) through 2019. Increased access to preventive care, in other words, may have contributed to an increase in quality management that resulted in greater prescribing of hypertensive medications for those diagnosed with hypertension. During that same time frame, there was reduced non-emergent use of the ED over the period assessed for CE enrollees (Table 16) that drove the reduction in overall ED among that population. It is unclear what drove such apparent improvements. Given the longer duration of the CE demonstration, this may suggest that it will take some time for reduction in non-emergent use to arise among more recent programs. It would reinforce that enhanced access to care may result early on in increased ED utilization, both emergent and non-emergent, but over time, as preventive and continuous ambulatory care is improved and incentivized, such enrollees may exhibit reductions in ED use. Of course, more definitive assessments of outcomes await further experience with the program and more data.

3. Substantial and increased enrollment in several of the demonstrations in 2019 also suggest that the programs are meeting significant need. This is evident among the TA demonstration, where enrollment nearly doubled. Smoking cessation program utilization increased, as did antidepressant prescriptions and primary care visitations. These results all align with the intent of the demonstration, and better assessment of such access and utilization on health outcomes and cost await longer term data analysis. However, aggregate costs declined precipitously associated with healthcare use in 2020, almost back to 2018 levels, despite the only modest decrease in enrollees. Such dramatic decline in healthcare use was likely due in significant part to the COVID 19 pandemic.

4. Among the BDD program, there also appeared to be a substantial increase in utilization of preventive dental services in 2019 that swamped a far more modest increase in emergency dental services. Whether emergency dental utilization subsides with longer exposure to such enhanced access awaits further analysis of additional data.

5. The Utah Premium Partnership (UPP) is one program where enrollment has decreased. Access to employer-provided health insurance for this low-income population is likely not substantial, and it is also possible that the incentives in the program for employers to offer such insurance, such as attracting a more skilled and stable workforce in the presence of benefits such as employer-provided insurance is not significant enough to achieve broader success. The impact of COVID-19 on employment has also likely contributed to enrollment decline in the program in 2020.

With respect to implementation of the SUD waiver demonstration to date, despite a lack of statistically significant outcomes for each of the five established research hypotheses there are notable findings as follows:

1. Although lacking statistical significance thus far for the five primary research hypotheses, most of the outcome measures are trending positively in the hypothesized direction, suggesting that additional time for policy and program implementation may be required to detect the impact of the demonstration on the outcomes. Key to this will be the need to change the research design from a DiD analysis to a longitudinal time series design.

2. The beneficiary survey which will serve as a baseline, appears to indicate patient experiences have been quite favorable. For example, the vast majority of beneficiaries responding to the survey recognize there are specific mental health and substance use disorder services available in their communities, if needed. Of those respondents indicating they or a household member needed these services 61% agreed they were able to obtain care “as soon as needed”. When asked to rate counseling or treatment received, the average rating was 6.43/10 and for those receiving services, 62% found the counseling or treatment to be helpful.

3. The supplemental monitoring metrics based on data compiled and analyzed by UDOH were largely trending positively in the direction desired, indicating UDOH is likely on-track to achieve

nearly all of their identified goals. For example, of the individual monitoring metrics, 70% were rated as "low risk" of not being achieved by the end of waiver demonstration period.

4. Further, Utah has experienced a rapid expansion of new SUD services to many beneficiaries with significant needs. There has also been extensive planning and training instituted from the beginning of the waiver to strengthen and build a strong statewide capacity to offer SUD service access in a quality manner.

5. Moving forward it appears additional time implementing the SUD treatment interventions associated with the waiver demonstration will be needed in order to determine if the hypothesized outcomes can be achieved. This notion is true for any new intervention. High fidelity implementation of SUD treatment in multiple locations is a challenge. However, with consistent efforts and uniform and regular progress monitoring, continuous improvement can be made.

6. Another key next step to detecting significant change in waiver outcomes will be the re-design of the evaluation design. Since the original DiD evaluation design integrity was compromised by the relatively early expansion of IMD's into geographical locations chosen by the evaluator as study control sites, the design will need to pivot to another type of design, such as a longitudinal time-series approach.

Overall Impacts of COVID-19

A number of broad general impacts related to the COVID-19 pandemic have influenced the 1115 waiver implementation. Specifically, these have included delays in healthcare utilization due to limited or no access to services during the initial adjustments to periods of lockdown. These were seen in the temporary closures of medical, dental, and behavioral healthcare places of service. Similarly, there were operational changes due to safety procedures in hospital emergency departments, urgent care, and other healthcare facilities that delayed or prevented services from being provided. Additionally, in response to the need to shift healthcare resources to address COVID-19 treatment in hospitals, policies were implemented to delay elective surgeries. Finally, the analysis in this report also demonstrated the clear impact of the pandemic on in person preventive care visits among the targeted adult Medicaid (TAM) population. While the number of preventive care visits per enrollee remained stable, the number of those visits delivered through telehealth increased exponentially from 33 in Q4 of 2019 to 2879 by Q2 2020, and from under 1% of total preventive care visits to over 42% of such visits.

General Background Information

The federal government has established section 1115 of the Social Security Act to allow the approval of demonstration projects that are likely to assist in promoting the objectives of Medicaid. In doing so, the Secretary of Health and Human Services authorizes federal financial support for waiver demonstration costs that would not otherwise qualify for federally matchable expenditures.

The two primary purposes of Medicaid funding are to enable each State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. The Utah 1115 waiver demonstration project, with its various amendments seeks to expand the scope of coverage and benefits for certain at-risk beneficiaries. Additionally, these services seek to advance the health and wellness of the individual receiving them, thus contributing to the individual attaining independence. So, in addition to paying for services, the program also advances the health and wellness needs of its beneficiaries based on actions designed at the state level. Section 1115 demonstration projects offer flexibility to a state to propose new reforms and adjust service delivery with the potential of improving medical care and focus on interventions that drive better health outcomes and quality of life improvements, potentially leading to increased financial independence.

i) States were first granted waivers soon after Medicaid was first established in 1965. Most waivers were small in scope until the 1990s, when states began to use them for a wide range of purposes, including to: expand eligibility, simplify the enrollment and renewal process, reform care delivery, implement managed care, provide long-term services and supports, and alter benefits and cost-sharing.

Although Utah has for many years had both the healthiest population and the lowest per-capita health care costs, there remained many who were unable to obtain health care. Given the flexibility offered by an 1115 waiver to design and improve health care service and delivery, the Utah Department of Health (UDOH) sought state-specific policy approaches to better serve needy populations. Specific goals [1] to be addressed by the initial 1115 waiver were to:

1. Improve the health of Utahns by increasing the number of low-income individuals without access to primary care coverage, which will improve the overall well-being of the health status of Demonstration Population I enrollees (PCN enrollees). Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations;

2. Not negatively impact the overall health of Current Eligibles who experience reduced benefits and increased cost sharing.

3. Assist previously uninsured individuals in obtaining employer-sponsored health insurance without causing a decrease in employer's contributions to premiums that is greater than any decrease in contributions to the overall health insurance market.

4. Reduce the number of uninsured Utahns by enrolling eligible adults in the Targeted Adult Medicaid program.

5. Reduce the number of non-emergent Emergency Room visits for the Targeted Adult population.

6. Improve access to primary care, while also improving the health status of the Targeted Adult Population.

7. Provide care that is more extensive to individuals suffering from a substance use disorder, in turn making this population healthier and more likely to remain in recovery.

ii) The Utah 1115 demonstration waiver was first submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002. It was originally scheduled to expire on June 30, 2007, but since then, there have been six extensions and approximately 17 new waiver amendments. A Utah Department of Health summary of these amendments [2] and extensions are as follows:

• Amendment #1 - This amendment made a technical correction ensuring that those ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that become pregnant, get the full Medicaid state plan benefit package. It eliminated or reduced the benefit package for Current Eligibles to conform to changes to the benefits available under the state plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the state plan. (Approved on August 20, 2002, effective on July 1, 2002)

• Amendment #2 - This amendment provided a premium assistance option for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the state subsidizes the employee's portion of the premium for up to 5 years. The employer- sponsored insurance (ESI) must provide coverage equal to or greater than the limited Medicaid package. The subsidy is phased down over 5 years, to provide a span of time over which employees' wages can increase to the point of unsubsidized participation in the ESI. With this amendment, the state was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance beneficiaries, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the state reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003).

• Amendment #3 - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004).

• Amendment #4 - This changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the Current Eligibles ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the state provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005).

- Amendment #5 - This amendment implemented the adult dental benefit for the Current Eligibles population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005).

- Amendment #6 - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006).

- Amendment #7 - This amendment implemented an increase in the prescription co-payments for the Current Eligible population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006).

- Amendment #8 - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006).

- Amendment #9 - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this amendment suspended Amendment #2 - for the initial ESI program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006).

This amendment provides the option of ESI assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least five percent of the household's countable income. The state subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The employer must pay at least half (50 percent) of the employee’s health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP- eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it is $120 per month. If dental benefits are not provided by a child's ESI plan, the state offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the Title XXI out-of-pocket cost sharing limit of five percent.

Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well- baby/well child care services, age appropriate immunizations, physician visits, hospital inpatient, and pharmacy. Families are provided with written information explaining the differences in benefits and cost sharing between direct coverage and the ESI plan so that they can make an informed choice. All children have the choice to opt back into direct CHIP coverage at any time.

- Amendment #10 – This amendment enables the state to provide premium assistance to children and adults for coverage obtained under provisions of the COBRA Act of 1986. COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary

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

During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) will work in tandem with the subsidy provided under ARRA for the purchase of COBRA coverage. Specifically, ARRA provides a federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008, through December 31, 2009, and as extended by Congress. As long as the individual receives the ARRA subsidy, the state would provide the family with premium assistance based on the number of programmatically-eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the state under these STCs. The amendment was approved by CMS on December 18, 2009.

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

- Section 1115(e) Extension - On June 23, 2006, the State of Utah formally requested an extension of their PCN 1115 demonstration waiver under the authority of section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.

- Section 1115(f) Extension – On March 1, 2010, the State of Utah formally requested an extension of the PCN demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.

- Temporary Extension – The December 24, 2013 amendment and temporary extension, changed the STCs so beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and state plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.

- Temporary Extension – The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively

100 percent of the FPL because of the 5 percent income disregard) in order to ensure that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).

- Temporary Extension – On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.

- Temporary Extension – December 16, 2016, the demonstration was temporarily extended on through December 31, 2017.

- Amendment #12 – On June 29, 2017, CMS approved an amendment which allows the state to provide state plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.

- Amendment #13 – On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, Targeted Adults, under which eligible beneficiaries receive state plan services. This new population is made of adults without dependent children, age 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the state has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.

- Amendment #14 -This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this waiver. The state withdrew this amendment.

- Amendment #15 - In February 2019, the state received the authority to provide comprehensive dental benefits to Targeted Adults who are receiving SUD treatment. In addition, the state received approval to provide state plan Medicaid coverage to Former Foster Care Youth who were ever enrolled in Medicaid in another state.

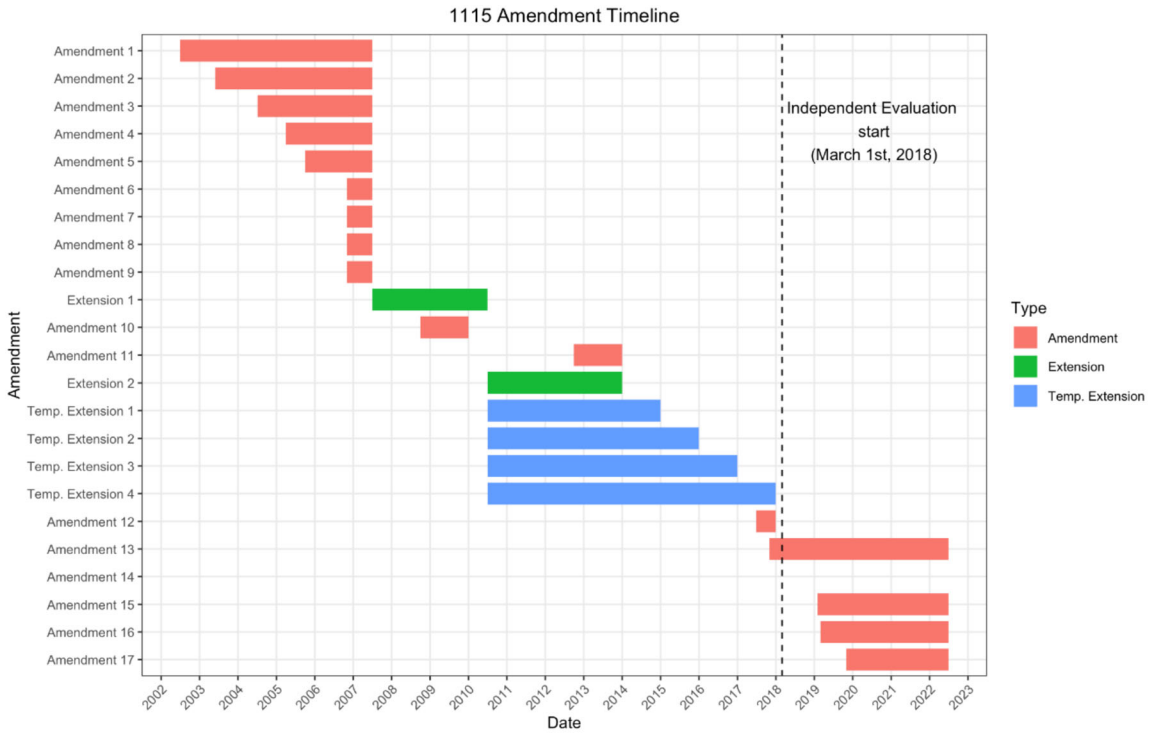
- Amendment #16 – In March 2019, the state received authority to provide full state plan benefits to adults without children who have incomes up to 95 percent of the FPL and the Current Eligible benefit package to adults with children who have incomes up to 95 percent of the FPL (together, these categories are known as the Adult Expansion Population) effective April 1, 2019. If the state determines that the state needs to close enrollment in this Medicaid eligibility group (MEG) due to budgetary restrictions, coverage will be closed and no applicants will be able to enroll in this MEG until enrollment re-opens. Beneficiaries in this category who have access to ESI coverage are required to enroll in that coverage to maintain Medicaid eligibility, and receive wraparound coverage. In addition, non-exempt Adult Expansion Population beneficiaries are required to complete community engagement requirements (or demonstrate good cause for failing to do so) each benefit year to be eligible for continued coverage.

Lastly, this approval allowed the state to provide clinically managed residential withdrawal services to adult beneficiaries who reside in Salt Lake County.

• Amendment #17 – In November 2019, the state received the authority to provide intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS includes state plan and home community-based services and are provided during the first eight -weeks of the intensive program on a FFS basis using a daily bundled rate. The state uses this authority to demonstrate that providing these services will reduce Emergency Room (ER) utilization, psychiatric hospitalizations, and residential treatment services and length of stay as well as positively impact the child/youth's physical health in terms of comprehensive care.

Amendment #18 - On December 16, 2020 the state received approval of the Serious Mental Illness (SMI) waiver plan allowing federal financial participating for beneficiaries to receive mental health treatment in Institutions of Mental Disease (IMD). The specific goal of this approval, which was effective January 1, 2021, is to maintain and enhance access to mental health services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment to Medicaid beneficiaries with serious mental illness (SMI).

Figure 1: 1115 Waiver Timeline.



CMS approved Utah's substance abuse disorder (SUD) evaluation design allowing the State to provide substance use disorder (SUD) residential treatment in an Institution for Mental Disease (IMD) for all

Medicaid eligible individuals. This approval was effective October 16, 2019 and is effective through June 30, 2022. A copy of the approved evaluation design can be found in Attachment C.

iii) The Utah 1115 demonstration waiver has included numerous changes driven primarily by the desire to improve health care access, increase service availability to meet the needs of the various populations, and do so in a fiscally responsible way (e.g. frequently reducing beneficiary co-pays). Consistent with these primary goals, other efforts have been implemented to foster improvements in the health care delivery system. As a result of these frequent and numerous (and on-going) changes in the amendments in Utah, significant challenges to the evaluation have occurred. For example, the initial evaluation design for the 1115 SUD waiver included a DiD approach where substance abuse treatment in implementation counties would be compared to non-implementing comparison counties. However, due to the rapid and unexpected growth of SUD treatment services in newly established IMD's within the comparison counties, the anticipated window of data collection had to be decreased. As a result, the ability to establish an appropriate comparison group was greatly disrupted. This will require a revised analytical design for the SUD waiver moving forward, which has been included as a request in the 1115 Wavier reapplication.

iv) There are multiple population groups impacted by the demonstration.

Under the authority of the 1115 waiver demonstration, expenditures made by the state for the specific population groups identified below are approved through June 30, 2022 and are eligible for matched funding under the state's Medicaid state plan.

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

2. Demonstration Population I. Expenditures to provide health services to non-disabled and non-elderly individuals age 19 through 64 with incomes above the Medicaid standard but at or below 95 percent of the federal poverty level (FPL) (effectively 100 percent with the five percent income disregard) who are not otherwise eligible for Medicaid, as described in the special terms and conditions (STC). This expenditure authority will end effective April 1, 2019.

3. Demonstration Population III. Expenditures for premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' employer sponsored insurance (ESI) plan, who are not otherwise eligible for Medicaid, as described in the STCs.

4. Demonstration Population V. Expenditures for premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid

standard but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs.

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

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

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

8. Targeted Adults. Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs, who are not otherwise eligible for Medicaid. Expenditures to provide dental benefits for individuals in this expenditure population who are receiving substance use disorder (SUD) treatment.

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

10. Adult Expansion Population. As of January 1, 2020, expenditures to provide coverage to adults, ages 19 through 64, who are not Current Eligibles, and have household income at or below 133 percent of the FPL, as described in the STCs. Members of the Adult Expansion Population who are childless/non-custodial parents will receive state plan coverage, while members of the Adult Expansion Population who are custodial parents/caretaker relatives will receive the Current Eligibles benefit package, as specified in the STCs.

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

12. Clinically Managed Residential Withdrawal Pilot. Expenditures to provide clinically managed residential withdrawal services to adult Medicaid beneficiaries, age 18 and older, who reside in Salt Lake County, have a Physician or Licensed Practitioner of the Healing Arts determine the beneficiary demonstrates moderate withdrawal signs and symptoms, have a primary diagnosis of opioid use disorder (OUD) or another SUD, and require round-the- clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery.

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

14. Severe Mentally Ill (SMI) Services in IMD. Beneficiaries will have access to the full range of covered Medicaid services, including SMI treatment services. SMI services will range in intensity from short-term acute care in inpatient settings, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in IMD treatment settings.

Evaluation Questions and Hypotheses

There were several hypotheses to be addressed by each major Waiver component.

Current Eligibles (CE)

For the current eligible population, cost-sharing was increased and benefits were slightly reduced. The associated hypothesis related to that change to be tested was that:

> Hypothesis 1: The decline in benefits and Increase in cost-sharing would not adversely affect the health of enrollees.

This hypothesis is tested by focusing on hypertension in particular. Changes in rates of hypertension diagnosis among the enrollee population and in use of hypertensive medication and number of such prescriptions per month were examined. Overall use of prescriptions were also examined as were the aggregate and per capita amounts of co-pays made.

Primary Care Network (PCN)

The PCN was generated to extend a limited amount of preventive and primary care benefits to uninsured adults age 19-64 years of age up to 95% of the poverty line. The two hypotheses, the first broken into two sub-hypotheses, to be examined associated with the PCN:

> Hypothesis 2a: The PCN will reduce the number of Utahns without coverage for primary care.
>
> Hypothesis 2b: The PCN will increase primary care utilization among the covered population.
>
> Hypothesis 3: The PCN will reduce the number of non-emergent emergency department (ED) visits by PCN members.

Hypothesis 2a was examined with statistics on number of enrollees in the PCN and the percentage of the Utah adult population in poverty without insurance.

Hypothesis 2b was examined based on satisfaction with care in terms of getting timely appointments and how well providers communicate with patients. Rates of hypertension and the extent to which blood pressure was controlled was also examined.

Hypothesis 3 was examined based on measures of ED utilization among the PCN population with additional focus on non-emergent visits.

Several of the hypotheses were tested among two sets of PCN enrollees, those with dependent children (PCN1), and those without dependent children (PCN2).

Given that the PCN was suspended at the end of March 2019, the data provided here cover only through that period, which was provided as well in the previous report.

Utah Premium Partnership (UPP)

UPP was created to incentivize otherwise Medicaid-eligible adults and their children to enroll either in employer-sponsored insurance (ESI) or COBRA when available through premium assistance. The single hypothesis to be examined was:

Hypothesis 4: There would be new take-up of ESI and the cost to the state would be moderate.

This hypothesis would be examined based on the number of new enrollees in UPP, the number denied assistance under UPP, and the percentage and amount of assistance paid by the state.

Targeted Adults (TA)

TA demonstration was designed to assist poor adults who were homeless, involved in the criminal justice system or contending with substance abuse and/or mental illness disorders in obtaining Health care access. There were four hypotheses attendant to the demonstration to be examined:

Hypothesis 5: The demonstration will reduce the number of uninsured in Utah.

Hypothesis 6: The demonstration will increase access to primary health care and improve enrollees' health.

Hypothesis 7: The demonstration would reduce the use of non-emergent ED use.

Hypothesis 8: The demonstration would reduce the amount of uncompensated care at Utah hospitals.

Hypothesis 5 is tested by examining the number of new enrollees in the program and the rate of not being insured among the population in poverty. Hypothesis 6 is tested by examining satisfaction among

enrollees in obtaining appointments for timely care, and in the communication received from providers. Also examined, would be the number of enrollees receiving a smoking or depression diagnosis and cessation treatment or antidepressant medication for those diagnoses, respectively. Also examined would be the amount of preventive care visits received by enrollees.

Hypothesis 7 is tested by examining facets of ED visits: the number of ED visits per enrollees, the number of non-emergent ED visits, and the diagnoses attached to the most commonly experienced ED visits. The cost attendant to ED care is also examined. Hypothesis 8 is tested by examining the total amount of uncompensated care provided by hospitals before and after the demonstration.

Blind and Disabled Dental (BDD)

The BDD demonstration was generated to provide access to dental care for the blind or disabled adult population. There is one hypothesis attendant to the demonstration:

> Hypothesis 9: The demonstration will reduce emergency dental care and increase the amount of preventive dental care.

Hypothesis 9 is tested by examining the percent of dental visits that are classified as emergency visits, and by the number of enrollees that had a preventive dental care visit and the number of such visits per enrollee. Costs of emergency and preventive dental care is also examined.

Substance Use Disorder (SUD)

1. The percentage of members who are referred and engage in treatment for SUDs will increase
2. The percentage of members who adhere to treatment of SUDs will increase
3. The rate of emergency department and inpatient visits will decrease
4. The percentage of members with SUD who experience care for comorbid conditions will increase
5. The demonstration will decrease the rate of overdose deaths due to opioids

Targeted Adult Medicaid (TAM) Dental

6. Individuals receiving comprehensive dental treatment will have a higher rate of SUD treatment completion

Clinically Managed Residential Withdrawal Services

7. The number of individuals receiving emergency department services for substance use disorder will decrease in waiver implementing county
8. Will ED expenditures decrease for substance use disorder services in implementing counties?

9. Will the number of inpatient hospitalization days for SUD services decrease in waiver implementing counties?
10. Will the number of outpatient (OP), intensive outpatient (IOP), or partial hospitalization visits for SUD services increase in Salt Lake County?
11. Additional Research Question: Will the number of beneficiaries who utilize withdrawal management services increase in implementing counties?

Methodology

CMS approved the section 1115 demonstration evaluation design (see Attachment C) on October 16, 2019. The research conducted to evaluate the demonstration in this report complied with the approved evaluation design. The design methodology was based on the hypotheses to be tested, the type of outcome to be evaluated, and on the availability of data to appropriately address the hypotheses. These decisions were made in response to the theoretical relationships identified in the driver diagram included in the evaluation design and which helped identify the short-term, intermediate, and long-term outcomes to be measured. Additionally, the driver diagram considered potential mediating factors that may influence the ability of the waiver strategies to impact outcomes and confounding variables that may bias evaluation results if not controlled for.

The methodology for testing the hypotheses was mainly single year pre- and post- assessment (two- year) of the demonstrations, 2017-2019. Due to limited observations and time frame, this single two-year assessment was restricted to summary statistics and p-value tests for significance from the base (pre-demonstration) year to the two subsequent years. A preponderance of p value tests indicated significant differences on a two-tailed test, but the very large sample sizes assured that this would be the case. The small differences in summary outcomes from pre- and post-intervention were, for the most part, clinically insignificant.

Table 1 below provides a summary of the numbered hypotheses, outcomes, and measures of outcomes and respective data sources, by demonstration. Most data related to diagnoses and reimbursements were taken from Medicaid claims. Other data sources included HEDIS, the Utah Behavioral Risk Factor Surveillance System (BRFSS), enrollee lists provided by UDOH, and CMS published lists of definitions and codes.

Table 1. Demonstration Populations, Outcomes and Measures.

Demonstration Population & Hypothesis	Outcome	Measure
Current Eligibles- Hypothesis 1	Average annual cost share	Total copay amount=medical copay + pharmacy copay PMPM=Total copayment/Total enrollment months (Medicaid Claims)

	Adults with hypertension diagnosis	Essential hypertension (ICD-10 code: I10) from NCQA
	Pharmacy prescriptions per member per month	National drug code (NDC) in the pharmacy claims data was used to identify pharmacy prescriptions. (Medicaid Claims)
	Hypertensive prescriptions	NDC and drug names from HEDIS https://www.ncqa.org/hedis/measures/hedis-2019-ndc-license/hedis-2019-final-ndc-lists/
PCN-Hypothesis 2a	Rate of uninsured adults in poverty in Utah	Adults in Utah under 100% of the poverty line not otherwise covered retrieved from the Utah Behavioral Risk Factor Surveillance System (BRFSS)
PCN-Hypothesis 2b	Hypertension diagnosis	Essential hypertension (ICD-10 code: I10) from NCQA
PCN-Hypothesis 3	Emergency department (ED) visit	Revenue code: 450, 451, 452, 456, 459, 981 Procedure code: 99281~99292 Place of service: 23
	Non-emergent ED visit	Defined from UDOH
UPP-Hypothesis 4	Members receiving assistance obtaining employer-sponsored health insurance	List of enrollees provided from UDOH.
Targeted adults-Hypothesis 5	Members receiving assistance	List of enrollees provided from UDOH.
Targeted adults-Hypothesis 6	Smoking diagnosis	Smoking diagnosis, tobacco screening and cessation -Smoking diagnosis from CMS Chronic Conditions Data Warehouse https://www2.ccwdata.org/web/guest/condition-categories -Tobacco screening and cessation using CPT codes: 99406 and 99407

		-Smoking diagnosis during outpatient visits -Outpatient visit codes from HEDIS Procedure code: 93784 93788 93790 99091 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99241 99242 99243 99244 99245 99347 99348 99349 99350 99381 99382 99383 99384 99385 99386 99387 99391 99392 99393 99394 99395 99396 99397 99401 99402 99403 99404 99411 99412 99429 99455 99456 99483 99341 99342 99343 99344 99345 G0402 G0438 G0439 G0463 T1015 99304 99305 99306 99307 99308 99309 99310 99315 99316 99318 99324 99325 99326 99327 99328 99334 99335 99336 99337 We also used Place of Services to identify outpatient visits: 2, 3, 5, 7, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 33, 49, 50, 71, 72
	Antidepressant medication management	-Major depression diagnosis from CMS Chronic Conditions Data Warehouse https://www2.ccwdata.org/web/guest/condition-categories ICD-10: F3130 F3131 F3132 F3160 F3161 F3162 F3163 F3164 F3175 F3176 F3177 F3178 F3181 F3340 F3341 F3342 F4321 F4323 F314 F315 F3160 F320 F321 F322 F323 F324 F325 F329 F330 F331 F332 F333 F338 F339 F341 -list of antidepressant medications from HEDIS NDC https://catalog.data.gov/dataset/hypertension/resource/6f55a477-90a1-452e-8322-5bb9b5b07574 - Antidepressant medication management from HEDIS https://www.ncqa.org/hedis/measures/antidepressant-medication-management/
	Preventive care visit	Procedure code: 99201 99202 99203 99204 99205 99211 99212 99213 99214 99215 99241 99242 99243 99244 99245 99341 99342 99343 99344 99345 99347 99348 99349 99350 99381 99382 99383 99384 99385 99386 99387 99391 99392 99393 99394 99395 99396

		99397 99401 99402 99403 99404 99411 99412 99429 92002 92004 92012 92014 99304 99305 99306 99307 99308 99309 99310 99315 99316 99318 99324 99325 99326 99327 99328 99334 99335 99336 99337 98966 98967 98968 99441 99442 99443 98969 99444 99483 G0402 G0438 G0439 G0463 T1015 S0620 S0621 Diagnosis code: Z0000 Z0001 Z0271 Z0279 Z0281 Z0282 Z0283 Z0289 Z00121 Z00129 Z003x Z005x Z008x Z020x Z021x Z022x Z023x Z024 Z025x Z026x Z029x Z761x Z762x
	Costs: smoking diagnosis, antidepressant medication, management, and preventive care visit	Reimbursed amounts.
Targeted adults-Hypothesis 7	Non-emergent ED visit	ED visit Revenue code: 450, 451, 452, 456, 459, 981 Procedure code: 99281~99292 Place of service: 23 Non-emergent ED visit: Defined by UDOH
	Cost of ED visits	Reimbursed amounts associated with ED visits.
	Most commonly experienced diagnoses in ED and associated costs	-Primary diagnoses codes only in ED visits -Reimbursed amounts associated with ED visits.
Blind and disabled dental-Hypothesis 9	ED dental services	CPT code: D0140
	ED dental care cost	Reimbursed amounts associated with ED dental visits.
	Utah rate of members with a preventive dental care	Retrieved from the Utah BRFSS.

	Preventive dental care cost	-All visits other than coded emergency dental visits. - Reimbursed amounts associated with preventive dental visits.

The selected SUD design was developed based on established guidance[3] specifically noting "a preferred approach would be to conduct difference-in-differences analysis (DiD) to compare trends for those affected by the SUD demonstration with beneficiaries not affected by the demonstration during the observation period due to the demonstration's geographic focus." Other sources identified in the literature supported both the strength and rigor of the DiD design. Indicating (DiD) have been shown to be good evaluation designs for intervention studies including Medicaid Demonstrations. [4]

In addition to utilizing Medicaid claims data to address the hypotheses in the waiver, the evaluator subcontracted with Qualtrics to purchase a Utah Medicaid panel of beneficiaries. The online survey focused on answering specific questions related to beneficiary access, utilization, and experience with SUD services. Specific survey responses were used to answer research questions related to the primary waiver hypotheses. Survey response data were analyzed with descriptive statistics.

TAM Dental

Due to the changing and unique target population groups included in the demonstration, a quasi-experimental design approach will be implemented in the independent evaluation. A single interrupted time series (SITS) design will be used to evaluate the new dental benefit change for Targeted Adults (TAM) receiving Substance Use Disorder (SUD) services.

Clinically Managed Residential Withdrawal Services

The approved evaluation design specified that the evaluation would use an interrupted time series or a difference in difference approach to the analysis. As the metrics for this component are measured monthly there were sufficient time points before and after the implementation to use a comparative interrupted time series (CITS) approach to compare outcomes in the target group (Salt Lake County) with the comparison group (all other Utah Counties). Difference in difference designs are a simplification of CITS that tests for the pre-post differences in means between the treatment and comparison groups. CITS is a more rigorous design[5] in that the use of multiple time points before and after the intervention allows for analysis of differences from baseline trends in addition to baselines means. Therefore, if there are sufficient time points, a CITS design is preferable to the simpler difference in difference design. CITS is also preferable to a single group interrupted time series design (ITS) in that the addition of a comparison group helps to address common threats to internal validity in ITS designs such as history and selection as long as the threats operate similarly across the two groups. In within study comparisons, CITS designs have been demonstrated to show similar results to randomized control trials[6].

Evaluation Design

The SUD design focused on a difference-in-differences (DiD) approach, a quasi-experimental before after intervention design, to compare the SUD residential treatment service expansion in the target group (Salt Lake and Utah Counties) with the comparison group (Davis, Weber, and Washington counties). Logistic regression was used to compare the differences between the groups before and after service expansion.

The independent evaluator contracted with an experienced national survey vendor to conduct a cross sectional survey of Medicaid beneficiaries in the spring of 2020. This approach will allow group-level outcome comparisons at different times to understand how a demonstration's effects change over time. The survey included standardized questions and composite question scales from the BRFSS, CAHPS® and CAHPS® Experience of Care and Health Outcomes (ECHO) Survey[7], which asks health plan enrollees about their experiences with health care services, including behavioral health care services. The questions have been validated for patients and family members with a wide range of service needs, including those with SUD. Specific ECHO Survey quality measures of patient experience include: getting treatment quickly and overall rating of counseling and treatment. The getting treatment quickly measure is also included in the core CAHPS Health Plan Survey, while the rating of counseling and treatment is a unique question from the ECHO Survey.

SUD Evaluation Period

The time period before the expansion includes the year 2016 and the time period after the expansion includes the year 2018. The year 2017 was excluded from analysis as it was a partial implementation year (the waiver demonstration expansion began in November 2017). Data from 2019 was not used because comparison sites began service expansion beginning that year and no longer qualify as a comparison group. Consequently, for the purpose of this design, there is only one available year of comparison data for the difference-in-differences design. Table 2 shows the number of IMD providers implemented by year in each of the counties included in the study. There were five that started in 2017, three that started in 2018, and five in 2019.

Table 2. Number of New IMD Providers by Year.

	2017	2018	2019
Salt Lake	4	2	0
Utah	1	1	3
Davis	0	0	1
Washington	0	0	1
Weber	0	0	0

The beneficiary survey was designed to be conducted in 2020, 2021, and 2023.

For clinically managed residential withdrawal services, the baseline period before the amendment spans from November 2015 to March 2019 and the time period after the amendment includes the time period

after implementation until June 2020 for the current report. TAM dental was implemented on March 1, 2019, and clinically managed residential withdrawal services was implemented on May 1, 2019.

Target and Comparison Populations

The SUD target population included any Medicaid beneficiary residing in a county that began provision of IMD residential facilities in 2018 (Salt Lake and Utah). The comparison population included any Medicaid beneficiary residing in a county that did not have IMD residential facilities during 2018 (Davis, Weber, and Washington). Table 3 below summarizes the target and comparison populations and those that have been diagnosed with SUD. The comparison sites began provision of IMD residential facilities in 2019 so the analysis can only look at 2018 for comparison.

TAM dental service expansion was implemented uniformly across the state so there are no specific comparison populations available. However, the TAM population receiving SUD treatment with comprehensive dental care will be compared to those receiving SUD treatment without comprehensive dental care. Clinically managed residential withdrawal services were implemented in Salt Lake County, so all other counties serve as a comparison population for the analysis. Medicaid beneficiaries that moved or received services outside of their specified target or comparison counties were removed from the analysis. In addition, Medicaid beneficiaries in the Primary Care Network (PCN) program, or a part of the emergency only population were removed from the analysis due to limitations in their service coverage. Targeted Adult Medicaid beneficiaries were removed because that demonstration did not exist prior to the SUD demonstration. Graphs with and without these groups showed the same distributions which determined that the removal of these groups did not significantly change the characteristics of the population.

Table 3: Summary of Medicaid beneficiaries with a SUD diagnosis.

Counties w/ IMD Expansion	**County Population**	**# of clients w/ SUD**	**Percentage**
Salt Lake	228,222	18,729	8.21%
Utah	111,997	5,239	4.68%
Counties w/ No Expansion			
Davis	51,361	3,005	5.85%
Washington	37,850	1,759	4.65%
Weber	59,886	5,154	8.61%

Evaluation Measures

The measures used in the SUD evaluation included nationally standardized data collection protocols such as Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NFQ #0004) and Continuity of Pharmacotherapy for OUD (NQF #3175). The specific measures and their modifications are listed in Table 4 below.

Table 4: Description of Measures of their Modifications.

Measure Description	Steward	Numerator	Denominator	Modification
Initiation of alcohol and other drug dependence treatment	NQF #0004	Members who began initiation of treatment through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date	Total members diagnosed with a new episode of alcohol or drug dependency during the first 10.5 months of the measurement year	
Engagement in alcohol and other drug dependence treatment	NQF #0004	Members with initiation of treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter	Total members diagnosed with a new episode of alcohol or drug dependency during the first 10.5 months of the measurement year	
Continuity of pharmacotherapy for OUD	NQF #3175	Members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Total members who had a diagnosis of OUD and at least one claim for an OUD medication	**Evaluation period of one year instead of two**
Any SUD Treatment	CMS Metric #6	Members w/ at least one SUD treatment service or pharmacy claim	Total Medicaid members	
Emergency Department Follow-up	NQF #2605	Members w/ a follow-up visit within 7 days and 30 days of emergency department visit	Total members w/ SUD diagnosis and an emergency department visit	
Access to preventive / ambulatory health services (AAP)	NCQA Metric #32	Members w/ at least one ambulatory or preventive care visit	Total members with SUD diagnosis and continual enrollment	
Inpatient stays for SUD per 1,000 Medicaid beneficiaries	CMS Metric #24	Members with inpatient visit for SUD	Total Medicaid members	**Evaluation period of one year instead of monthly**
Days in treatment	None	Total number TAM members in SUD treatment receiving comprehensive dental services	Total number of TAM members in SUD treatment and TAM members receiving any dental services	

Metric #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	CMS	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Beneficiaries enrolled in Medicaid for at least one month during the measurement period	
Mean Emergency Department cost per SUD client	None	Total Cost of SUD related ED visits in the measurement period	Total number of Clients who received SUD emergency services in the measurement period	
Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	CMS	The number of inpatient discharges related to a SUD stay during the measurement period	Beneficiaries enrolled in Medicaid for at least one month during the measurement period	
Metric #8: Outpatient Services	CMS	Number of beneficiaries who used outpatient services for SUD during the measurement period	All Medicaid beneficiaries with SUD diagnosis enrolled for any amount of time during the measurement period	
Metric #11 Withdrawal Services	CMS	The total number of unique beneficiaries with a service or pharmacy claim for withdrawal management services during the measurement period	All Medicaid beneficiaries with SUD diagnosis enrolled for any amount of time during the measurement period	

CMS = Centers for Medicare and Medicaid Services. NQF = National Quality Forum, NCQA = National Committee for Quality Assurance

Due to the nature of the analysis looking at change over time, the same versions of these metrics must be used for every year for the results to be comparable over time. The versions of the metrics were taken from those listed in the 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Version 2. Two of the outcome metrics used did not have standardized national metrics specified. These were emergency department cost per SUD client and TAM (SUD) definition for successful treatment. (TAM and ED cost). The following table outlines which metric measure outcomes related to each research question.

Table 5. Outcome Measures for each SUD Hypothesis.

Hypothesis 1: Percent of members who are referred and engage in treatment for SUDs will increase.	• Initiation and Engagement of Treatment
Hypothesis 2: Percent of members who adhere to treatment of SUDs will increase.	• Continuity of Pharmacotherapy • Any SUD treatment (treatment utilization)

Hypothesis 3: Rate of emergency department and inpatient visits will decrease.	● Follow up after Emergency Department visit of AOD ● Inpatient Stays for SUD
Hypothesis 4: Percent of members with SUD who experience care for comorbid conditions will increase.	● Preventative health care/ambulatory visits
Hypothesis 5: Rate of overdose deaths due to opioids will decrease.	● Deaths due to opioids
Additional research questions.	
The Demonstration will improve SUD treatment completion among the targeted adult Medicaid (TAM) population.	● Number of days in treatment and percent retained in treatment 90 or more days.
Will the number of individuals receiving emergency department services for substance use disorder decrease in waiver implementing counties?	● Metric #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
Will ED expenditures decrease for substance use disorder services in implementing counties?	● Mean Emergency Department cost per SUD client
Will the number of inpatient hospitalization days for SUD services decrease in waiver implementing counties?	● Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
Will the number of outpatient (OP), intensive outpatient (IOP), or partial hospitalization visits for SUD services increase in Salt Lake County?	● Metric #8: Outpatient Services
Will the number of beneficiaries who utilize withdrawal management services increase in implementing counties?	● Metric #11 Withdrawal Services

Specific ECHO Survey quality measures of patient experience included in the beneficiary survey included: recognition of plan coverage for mental health and SUD services, availability of services,

getting treatment quickly, overall rating of counseling and treatment, and patient rating of the helpfulness of the care received. Specific measures from the beneficiary survey are listed in Table 6 below.

Table 6: Description of Beneficiary Survey Measures.

Evaluation Design Hypothesis	Beneficiary Survey Question
Hypothesis 1: Percent of members who are referred and engage in treatment for SUDs will increase.	● Patient experience with care. Q30 – Does your plan cover MH, SUD, counseling, treatment? ● Community knowledge of available treatment and services Q31 – Are there places in your community you can get help? Q32 – Did you or a member of your household need help?
Hypothesis 2: Percent of members who adhere to treatment of SUDs will increase.	● Patient experience with care Q33 – Able to get services as quickly as possible Q34 – Rate the care received Q35 – How helpful was the care received

Data Sources

Quantitative Analysis

Administrative data was provided by UDOH and include Utah Medicaid claims, procedure, drug, and diagnosis and eligibility information for beneficiaries. Data includes pre-demonstration data beginning January 2016 and extends through the current reporting period.

Beneficiary Survey

The beneficiary survey is an online survey consisting of 46 questions administered to a statewide cross-sectional sample of Medicaid beneficiaries. The survey was administered to a purchased panel by Qualtrics Inc., one of the foremost research panel aggregators in the world. This design will compare group-level outcomes at different times to understand how a demonstration's effects change over time. The survey questions are standardized questions and composite question scales from the BRFSS, CAHPS® and CAHPS® Experience of Care and Health Outcomes (ECHO) Survey, which asks health plan enrollees about their experiences with health care services, including behavioral health care services.

Survey data was collected from May 7 to June 2, 2020.

Analytic Methods

The SUD DiD analysis studies the differential effect of a treatment on a target and comparison group[8]. It allows observational data to have the similar statistical power to an experimental study design. A DiD design compared SUD residential expansion counties with SUD residential services in non-expansion counties. The four assumptions of a DiD analysis are equivalency of population characteristics, parallel

trends, spillover effect, and common shock. The first three assumptions were tested using summary statistics and logistic regression models. However, the common shock assumption involves exogenous forces and is difficult to test. In discussion with the UDOH team no concerns about external factors were raised and so it is assumed that no major events unrelated to the Medicaid waiver impacted one group differently than the other.

The covariates included in the DiD model were age, race, gender, Hispanic, and diagnosis of alcohol SUD, opioid SUD, other SUD, and mental health. Means, standard deviations, and standardized mean differences were calculated for each covariate to test for equivalency of population characteristics. The equivalency of population characteristics compared the target and comparison groups for 2016, the target group for 2016 and 2018, and the comparison group for 2016 and 2018. Covariates with a standardized mean difference above 0.1 indicated inclusion in the DiD models.

Parallel trends assume that any trend in the outcome between target and comparison groups are the same prior to intervention. The interaction term between group and time was determined using a logistic regression model. A significant interaction term indicates a trend and the DiD analysis will be bias. The spillover assumption states that the comparison group has no measurable change in outcome at the time of implementation. This was tested using a logistic regression model for the comparison group. Causal effect is established when all DiD design assumptions are met. All metrics met these assumptions and were analyzed using DiD.

Descriptive analysis of beneficiary responses for this baseline survey will focus on patient experience of care and will be analyzed with descriptive measures.

We also used a CITS design to compare the impact of clinically managed residential withdrawal service provision through Medicaid in Salt Lake County to the other non-implementing Utah counties. Logistic regression was used to test for these differences. Population equivalency at baseline and from pre to post intervention was tested for the following characteristics: age, race, gender, Hispanic, and diagnosis of alcohol SUD, opioid SUD, other SUD, mental health and type of Medicaid eligibility. Means, standard deviations, and standardized mean differences were calculated for each covariate to test for equivalency of population characteristics. Covariates with a standardized mean difference above 0.1 indicated inclusion in the models. This testing helped control for selection bias which is a common threat to internal validity in ITS designs.

One month prior to the implementation of clinically managed withdrawal, the Department of Health also implemented its Medicaid adult expansion across the state. As this was implemented statewide it is assumed that it would impact both the target and comparison groups. There are no other known historical factors that impacted one group more than the other.

Methodological Limitations

There are several limitations to the current study. The primary limitation of the methodology for the CE, TA, BDD, and UPP demonstrations is the absence of adjustment for demographic, comorbidities, and

other dimensions of the enrollee population in the descriptive statistics generated. As a result, some parameters that may have been significantly affected by the demonstration may not have been isolated due to the heterogeneous composition of the sample or to changes over time in that composition.

A second limitation is associated with the absence or paucity of time-dependent data, necessitated by the short time frame encompassed in this report. For example, results for treatment for smoking or hypertension may have lags that are beyond the window of the analyses. Such longer-term effects will be more evident as there is reassessment from periods after the first or second year. Furthermore, the restricted one-year periods in the analysis window prior to implementation of the demonstrations didn't permit assessment of variation in length of time for which conditions like smoking, hypertension, depression and substance abuse were present and potentially untreated prior to the demonstration. Such duration of chronic conditions could be significantly associated with the response to any intervention. Finally, health care utilization and costs may actually go up initially for conditions that have been neglected and accumulated due to absence of insurance coverage and medical care. Longer follow up may demonstrate more substantial cost savings as such care is provided and deleterious conditions and habits are addressed.

A third limitation concerns the relatively limited set of measures in certain instances that were assessed to gauge effect. Hypertension, for example, is well established as a condition that responds to good primary care management and hypertensive medication. But there are other conditions that are responsive to good primary care that may be as consequential to health outcomes, if not more so among certain sub-populations. These would include obesity and timely and appropriate prenatal care for pregnant women. For the Blind and Disabled Dental (BDD) program, outcomes to date focus strictly on dental utilization and cost, but dental care is also a gateway to better general health. It may worthwhile to include outcomes on other medical health care utilization, outcomes and costs that may be attributable to dental coverage. For this and several other of the demonstrations, it may be worthwhile to include a broader set of outcomes in future analyses as described above.

A fourth limitation is that some outcome measures, such as patient satisfaction, are subjective by nature. While such outcomes are of importance in and of themselves, supplementation with objective data, for example on appropriate care according to recommended guidelines, may extend the value generated from subjective data.

A fifth limitation relates to "churning" of enrollment in the demonstrations. Some beneficiaries are enrolled for a short time, while others for more prolonged periods. The analyses were oftentimes restricted to eleven or twelve months of continuous enrollment to assess effects. As a result, however, potentially distinct effects for those enrolled for short periods of time were not assessed.

A sixth limitation is the disruptive nature of the pandemic in 2020, which likely altered eligibility in a manner that changed the comparative nature of the sample over time. While some became newly eligible based on weak labor market conditions, others perhaps experienced extended eligibility associated with the same factors. The pandemic also may have delayed care in some instances and altered the venue of

visits from face-to-face to telehealth in certain instances. The impact of such changes in care delivery on quality merit study, are beyond the scope of this evaluation.

Finally, the integrity of empirical evaluation is contingent on quality of data. While the claims data used in much of the evaluation is of high quality, there are potential limitations that are associated with administrative claims data in general. Diagnoses must be filled in comprehensively and accurately by providers, for example. That may vary systematically across providers and result in distortions in assessment. Certain quality controls can be engaged, such as investigating the extent to which a diagnosis is listed in more than one claim, or whether a procedure is consistent with a diagnosis.

Still, such quality control is not failsafe. The merge of Medicaid claims to All Payers Claims Data (APCD) data in Utah makes for a particular strength in Utah for cross-checking and substantiating the integrity of Medicaid data within the APCD relative to Medicaid data alone. Furthermore, the APCD permits a more seamless assessment of beneficiaries that transition between Medicaid and commercial insurance than permitted by Medicaid claims and encounter data alone. This also permits great value in constructing matched controls and in integration of potentially important time-dependent covariates in multivariate analyses. It should be noted that the APCD data contains a large portion of commercial claims, but does not contain claims for insured individuals of Employee Retirement Income Security Act (ERISA) plans nor those who are uninsured.

For the SUD evaluation, many of the metric specifications have changed throughout the years and not all the metrics were designed for the purpose of measuring change over time. For the purpose of this analysis, outcomes for each year were measured using the same version of the metric, even if the measure specifications changed. Two of the metrics needed modifications to work with the evaluation design. Since we were limited to one year of before and after intervention data we had to modify the continuity of pharmacotherapy metric to look at a one-year time period rather than a two-year time period. This resulted in lower numbers of clients meeting the criteria for this metric and may not have allowed enough time to pass to detect a change in the metric. Additionally, we had to modify the metric for inpatient stays for SUD to an annual metric rather than a monthly metric in order to fit with the evaluation design.

Even though there were two available years of data we were only able to look at one year due to losing the comparison population in 2019. This report moved forward with the original design, however, for future reports the design will need to change to a single group longitudinal study in order to look at change in subsequent years of the demonstration. Systematic change can often take time to see results particularly considering that IMD's were not all implemented at once and the number of beds has continued to increase throughout the duration of the demonstration. As such, one year of data may not have been enough time to detect significant changes in the analyses.

One explanation for the lack of significance in the results is possible unknown external factors that were not controlled for in the model. One potentially relevant factor may be implementation factors. When making system wide service changes, implementation factors can also have an influence on outcomes that can make it difficult to pinpoint if the results (or lack of results) may be due to implementation factors versus program factors. For instance, an intervention may indeed be effective, but if it is not implemented

correctly, or if it takes a long time to implement, the results may not show an impact on outcomes or the impact may be delayed. It may be valuable to explore and examine potential process metrics or other potential confounding factors for future analyses if feasible.

Another limitation to being able to measure long term changes in Medicaid beneficiary satisfaction with SUD treatment services is the inability to link annual satisfaction surveys administered to those receiving treatment in publicly funded SUD programs. Utah, like most other states, sets benchmarks in publicly funded SUD treatment programs for consumer satisfaction with treatment services. However, there is great variance in the way local programs implement the Mental Health Statistics Improvement Program (MHSIP) which prevents accurate tracking of responses by the Medicaid eligible population.

For the clinically managed residential withdrawal services there were only limited control variables, which does not ensure the populations were comparable between the target population and the rest of the state. We were not able to match comparison counties, although we did control for variables that were dissimilar between the groups and time points.

Results

Results are reported by hypothesis and reference the tabular results provided by hypothesis.

Current Eligibles (CE)

With respect to **hypothesis 1**, results, drawn from Medicaid claims and encounters, are provided in Tables 7-10. The current eligible population declined slightly from 2017 to 2020 (Table 7), but there is no indication, without further multivariate analysis, whether this decline was attributable to increased cost-sharing. Aggregate co-pays decreased in that same time period, not simply due to the decline in enrollees, and average co-pays decreased over 10% from $5.61 to $5.04 from 2017 to 2020 and a significant decrease to $2.38 in 2020 (Table 8). Such decline merits additional analysis. Hypertensive diagnoses, a proxy for health, and hypertensive medication, a proxy for good health management, held fairly steady throughout the period, with the former a less than 1% and the latter at 21% decline by 2020 (Table 9). Mean prescriptions per member per month remained fairly steady both before and after the copay increase except for an increase during the third and fourth quarters of 2019 (Figure 2).

The percentage of enrollees diagnosed with hypertension with antihypertensive prescriptions actually dipped continuously from 61% in 2017 to 48% in 2020 (Table 9). None of the figures adjusted for severity of hypertension, which would merit future attention. Mean hypertensive pharmacy prescriptions steadily declined about 17% during the period from 2017 to 2019 and then remained at a similar level in 2020, perhaps reflecting changes in the number of pills per prescription (Table 10).

Sample selection criteria for table entries are indicated in notes below tables. Some require enrollment for at least one month (Tables 7 and 8). Hypertension diagnosis and management indicators were limited to those with 11 or 12 months of continuous enrollment (Tables 9 and 10), reflecting HEDIS criteria.

While p values suggest significant changes in several instances, that is attributable to large sample sizes, and the small magnitude of the changes indicate no clinical significance.

Table 7. Total Current Eligible Members by Year.

FY	Unique members	Average monthly enrollment
2017	51343	30716
2018	51238	30852
2019	48990	28905
2020	40633	24010

Note: Includes number of clients enrolled for at least one month within the year and average beneficiaries enrolled per month.

Table 8. Average copayment amount per person per month.

FY	Total copayment	PMPM copayment
2017	$1,988,676	$5.40
2018	$2,075,782	$5.61
2019	$1,749,405	$5.04
2020	$684,639	$2.38

Table 9. Adults with hypertension diagnosis and antihypertensive prescriptions.

FY	% with hypertension diagnosis	% of subjects with antihypertensive prescriptions among subjects with hypertension diagnosis
2017	12.72	60.99
2018	12.75	52.62
2019	12.60	47.78
2020	12.69	48.26

Note: Selects those with 11- or 12-months continuous enrollments (i.e. HEDIS criterion)

% with hypertension diagnosis

2017 vs. 2018: p-value=0.93
2018 vs. 2019: p-value=0.73
2019 vs. 2020: p-value=0.86

% of subjects with antihypertensive prescriptions (among those who had hypertension diagnosis)

2017 vs. 2018: p-value=0.00
2018 vs. 2019: p-value=0.00
2018 vs. 2019: p-value=0.77

Figure 2. Mean Pharmacy Prescriptions Per Member Per Month before and after Copay Increase.

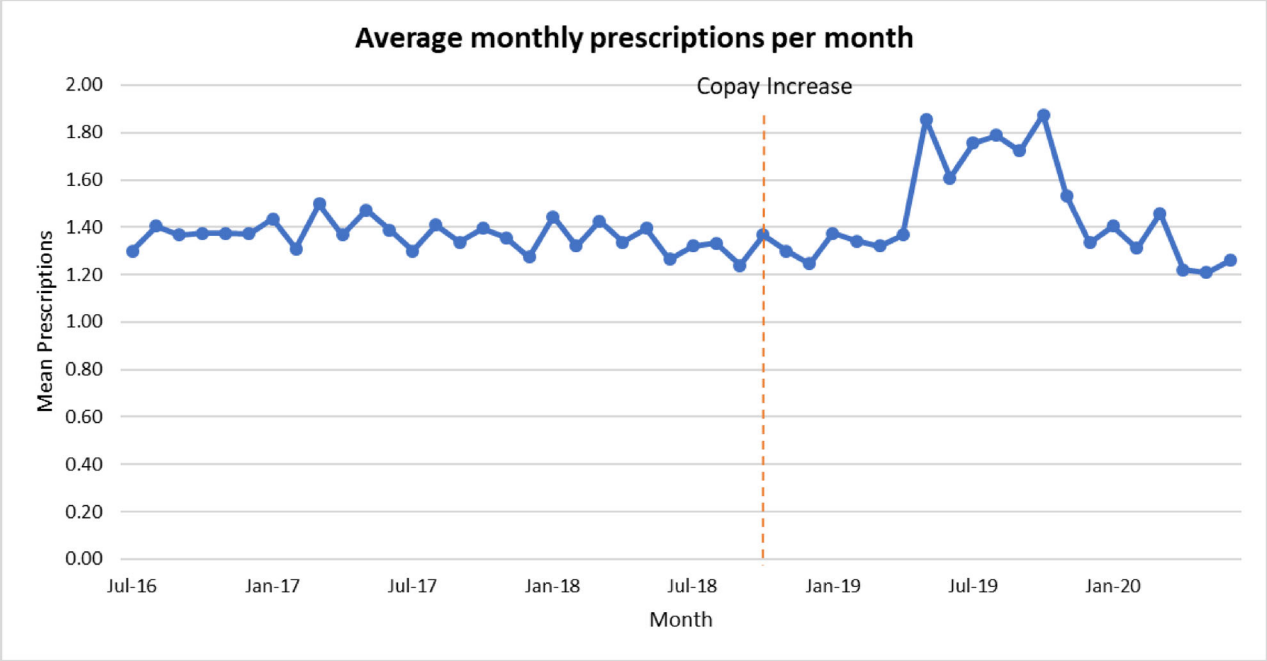


Table 10. Average Monthly Hypertensive Prescriptions.

FY	Mean Prescriptions	Mean drug quantity per prescription	Mean days supplied per prescription
2017	0.47	36.18	30.07
2018	0.39	37.52	30.39
2019	0.32	41.72	33.09
2020	0.31	44.98	36.10

*Note: considers members who had hypertension diagnosis.

Average Monthly Hypertensive Prescriptions

2017 vs. 2018: p-value<0.01
2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Mean drug quantity per prescription

2017 vs. 2018: p-value<0.01
2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Mean days supplied per prescription

2017 vs. 2018: p-value<0.01
2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01
Additional results on CE enrollees are included below in the discussion of enrollees in the PCN use of ED relative to enrollees in the PCN (tables 11, 12, 16 and 17).

Primary Care Network (PCN)

With respect to **hypothesis 2a**, the % of uninsured adults, based on data from the Behavioral Risk Factor Surveillance System (BRFSS) in poverty are provided in Table 11. While means fluctuated slightly over the period from 2016 to 2019, there was no significant change at around 35% for the entire duration. Because the PCN demonstration was suspended in March, 2019, no summary statistics were generated for the program in 2020.

Table 11. Percentage of Uninsured Adults in Poverty in Utah by Year.

Includes Adults in Utah with 0 to 100% Poverty. Numbers retrieved from the Utah Behavioral Risk Factor Surveillance System.

Year	Percent Uninsured	Lower 95% Confidence	Upper 95% Confidence
2016	35.2	30.4	40.4
2017	39.7	34.9	44.7
2018	35.9	31.5	40.6
2019	36.8	32.2	41.7

2016 vs. 2017: p-value=0.33
2017 vs. 2018: p-value=0.40
2018 vs. 2019: p-value=0.84

With respect to **hypothesis 2b**, there is some preliminary indication that there was slight improvement in PCN access to care from 2017 to 2018 as measured by hypertension diagnosis and treatment (Table 12). In that period there was close to a 2-percentage point increase (from 14.9% to 16.8%) in those diagnosed

with hypertension. Despite the small increase in the percent of those diagnosed with hypertension, the percentage of those receiving medication during the period held fairly steady at around 57%.

Table 12. Adults with hypertension diagnosis and antihypertensive prescriptions.

FY	Unique members	% with hypertension diagnosis	% of subjects with antihypertensive prescriptions[+]
2017	24421	14.93	56.56
2018	23844	16.75	57.04
2019	24336	*	*

Note: Selects those with 11- or 12-months continuous enrollments (i.e. HEDIS criterion). No HEDIS data were available for 2019 as of the time of this report.

*In 2019, all subjects had 9 months enrollment as maximum so the numbers were not calculated.

[+] Among those who had hypertension diagnosis

The percent of patients with a hypertension diagnosis increased 14.93% in 2017 to 16.75% in 2018. This increase is statistically significant (p-value >.000). Percent of patients with antihypertensive prescriptions did not change statistically (2017 vs. 2018: p-value=0.67).

In terms of testing ED utilization and under **hypothesis 3** among the PCN population, there was an increase over 2017-2019 (Table 13); when statistics were broken into PCN1 and PCN2 (Tables 14 and 15), it is clear that this increase was primarily due to a change in the PCN composition between PCN1 and PCN2 enrollment rather than changes in ED utilization within those groups. ED utilization was lower among enrollees with children (PCN1) (about 20 visits per 1000 enrollees per month each year, Table 9) than enrollees without children (PCN2), who experienced a slight increase from about 42 to 46 visits per 1000 enrollees per month, Table 10). The overall increase exhibited in Table 8 was therefore attributable to a substantial decline in PCN1, where utilization was lower, and a substantial increase in PCN2, where ED use was significantly higher.

Table 13. Emergency Department Utilization per PCN member.

FY	Total ED visits	ED visits per member per month per 1000
2017	5051	29.25
2018	5664	34.77
2019	5245	37.23

Note: Includes members who had at least 1-month enrollment.

Table 14. Emergency Department Utilization per PCN member (PC1 only).

FY	Total ED visits	ED visits per member per month per 1000
2017	2186	20.88
2018	1381	18.69
2019	1008	20.66

Table 15. Emergency Department Utilization per PCN member (PC2 only).

FY	Total ED visits	ED visits per member per month per 1000
2017	2865	42.11
2018	4283	48.12
2019	4237	46.01

Information on ED claims between the PCN and CE enrollee population are provided in Tables 16 and 17. ED utilization was significantly higher among the CE enrollee population than among the PCN population, but while claims per 1,000 members per month declined for CE enrollees, they increased, as noted above, for PCN enrollees. Thus, the ratio of PCN to CE ED claims increased from .31 to .43 over the period (Table 10, final column).

Table 16. Emergency Department Utilization per Current Eligibles.

FY	Total ED visits	ED visits per member per month per 1000
2017	34909	94.71
2018	32925	88.93
2019	30074	86.70

Note: Includes members who had at least 1-month enrollment.

Table 17. ED utilization per PCN member / Current Eligible (CE) Member Per 1000.

Emergency department claims per person per month per 1000

FY	PCN	CE	PCN/CE
2017	29.25	94.71	0.31
2018	34.77	88.93	0.39
2019	37.23	86.70	0.43

With respect to **Hypothesis 3**, evidence on non-emergent ED utilization for the PCN and CE enrollee population are provided in Tables 18-23.

Non-emergent ED visits per 1,000 enrollees per month increased for the overall PCN population from about 11.8 to 16.0 (Table 13). This increase was generated mainly by an increase among the PC2 population (having an increase from 17.2 to 19.2 in visits per 1,000 enrollees per month, Table 15), although non-emergent ED use among the PC1 enrollee population increased as well (from 8.3 in 2017 to 9.0 in 2019, Table 14). Non-emergent ED utilization was substantially higher among CE enrollees, at more than 3 times that of the PCN2 enrollee population. However, whereas PCN non-emergent ED utilization increased over 2017-2019 among PCN enrollees, it declined among CE enrollees, from about 65.1 to 60.2 per 1,000 enrollees per month from 2017 to 2019 (Table 16). The ratio of non-emergent ED utilization among PCN enrollees to that among CE enrollees therefore increased from about one-fifth (.18) in 2017 to over a quarter (.27) by 2019 (Table 17). Furthermore, average total monthly ED visits that were emergent among PCN enrollees declined from close to 60% to about 57%, reflecting the increase in non-emergent ED visits among that population (Table 18).

Table 18. Average Non-Emergent ED utilization by PCN Members Per Year (PC1+PC2).

FY	Total ED visits	Total non-emergent ED visits	ED visits per member per month per 1000
2017	5051	2037	11.79
2018	5664	2338	14.35
2019	5245	2249	15.96

Table 19. Average Non-Emergent ED utilization by PCN Members Per Year (PC1 only).

FY	Total ED visits	Total non-emergent ED visits	ED visits per member per month per 1000
2017	2186	864	8.25
2018	1381	582	7.88
2019	1008	439	9.00

Table 20. Average Non-Emergent ED utilization by PCN Members Per Year (PC2 only).

FY	Total ED visits	Total non-emergent ED visits	ED visits per member per month per 1000
2017	2865	1173	17.24
2018	4283	1756	19.73
2019	4237	1810	19.66

Table 21. Average Non-Emergent ED utilization by Current Eligibles only Per Year.

FY	Total ED visits	Total non-emergent ED visits	ED visits per member per month per 1000
2017	34909	23981	65.06
2018	32925	23074	62.32
2019	30074	20881	60.20
2020*	*	*	*

* There were no subjects in the PCN in 2020.

Table 22. Non-Emergent ED Claims per person per month (PCN member / Current Eligible (CE) Member Per 1000).

FY	PCN	CE	PCN/CE
2017	11.79	65.06	0.18
2018	14.35	62.32	0.23
2019	15.96	60.20	0.27

Table 23. Percent of Average Monthly ED Visits without Non-Emergent ED Visits (PC1+PC2).

FY	Average Monthly ED visits without non-emergent ED	% of average monthly ED visits without non-emergent ED
2017	421	59.86
2018	472	58.68
2019	583	57.16

% of average monthly ED visits without non-emergent ED visits

2017 vs. 2018: p-value=0.01
2018 vs. 2019: p-value<0.01

Utah Premium Partnership (UPP)

With respect to **hypothesis 4,** preliminary assessment of the success in UPP to enroll individuals in employer-sponsored insurance was assessed based on the number of enrollees and enrollee-months, given

in Table 24. Total enrollment in UPP decreased from 2017 to 2019 from 780 to 615, and was reflected in a corresponding decrease in enrollment months from 6214 to 4848. The average number of enrollment months per enrollee decreased slightly from about 7.97 to 7.88. There was a precipitous decline in enrollment and average number of enrollment months in 2020 as indicated in the table, likely reflecting the impact of the COVID pandemic on employment and employer-provided insurance.

Table 24. Total UPP Members by Year and Month.

FY	Unique Members	Total enrollment months	Average number of enrollment months
2017	780	6214	7.97
2018	726	5716	7.87
2019	615	4848	7.88
2020*	486	3868	7.96

*Note: The 2020 entries are based on data from July 2019 - June 30, 2020

Targeted Adults (TA)

Hypothesis 5 related to the TA program was gauged by the number of enrollees. Table 25 presents information on the increase in enrollment, 2,835 in 2018, more than doubling to 6,786 in 2019, and tripling to 8,517 in 2020. Similarly, the corresponding increase in average monthly members more than doubled from 1,529 in 2018 to 4,064 in 2019, and to 5,042 in 2020.

Table 25. Enrollees in TA.

FY	Unique Enrollees	Average monthly enrollment
2018	2835	1529
2019	6786	4064
2020*	8517	5042

Note: * FY 2018 included 8 months (November 2017 through June 2018), while FY 2019 and FY 2020 considered 12 months.

Hypothesis 6 related to primary care access and improved health status were tested assessing smoking diagnosis and cessation treatment (Table 26), antidepressant medication management (Table 27) and extent of preventive visits (Table 28). Associated costs of these treatments and visits were also assessed (Tables 29-31). The rate of smoking diagnosis and cessation treatment increased from 34% to 42% from 2018 to 2019, then slightly declined to 39% in 2020 (Table 26).

Major depression diagnosis increased markedly, as did the level of anti-depressant management and continuity of such management between 2018 and 2019. Diagnosis of major depression more than tripled

from 374 to 1,211 (Table 27). The number of TA enrollees with antidepressant medication quadrupled from 222 to 829 over the same period. And, management improved for this population despite the increase in numbers. Those with acute phase treatment increased from 56% to 69%, while those with effective continuous treatment increased from about 23% to 39% (Table 26). In 2020, the number of those diagnosed with major depression increased about 25% to 1,512. The percentage that received effective continuation phase treatment in 2020 increased further to 74%, so did the rate of effective continuous treatment to 47%.

Even with the more than doubling in enrollees, the annual rate of those receiving at least one preventive care visit increased from 49% to about 56% (Table 27). That percentage remained relatively stable in 2020 at 57%.

With the increase in numbers receiving smoking diagnostic services noted above, there was a concomitant increase in aggregate costs (Table 28). Total costs for smoking cessation treatment increased from over $66,000 to nearly $373,000. Average cost per TA enrollee of smoking diagnoses and cessation treatment increased from $23.38 to $54.95 per enrollee (Table 28). Despite the decrease in numbers receiving smoking diagnosis services in 2020, aggregate costs doubled from 2019 to 2020. The per member cost consequently increased significantly to $89.08.

Similarly, total anti-depression management cost more than quadrupled over the period from 2018 to 2019, from about $25,600 to nearly $114,700 (Table 29), reflecting a quadrupling of enrollees being treated, but also perhaps so some increase in continuity of care. The increase in per enrollee cost of such treatment was far more modest, from $8.67 to $16.89 (Table 29). Aggregate anti-depression management costs continued to increase to about $172,100 in 2020 along with enrollment. The average cost per member increased to $20.21.

The aggregate costs for preventive care visits also increased significantly with the increase in enrollment between 2018 and 2019, from about $975,300 to nearly $3,099,000 (Table 30). For this service, however, the per enrollee cost slightly, from $344 to $457 (Table 30). The per visit cost decreased slightly from $204 to $176 (Table 31). Aggregate costs moderately increased to nearly $3,751,000 with a slightly decreased average cost per member, at $440 in 2020 (Table 30). Such slowdown in increasing costs in preventive care was likely due in significant part to the COVID 19 pandemic. The decline in average cost per preventive care visit to $163 perhaps also reflected an increase in the composition of lower cost telehealth visits in the overall delivery of preventive visits (Table 31).

There was a clear impact of the COVID pandemic on the delivery of preventive care visits for this population as indicated in the number of telehealth versus in person visits provided in Table 31.1. While the number of preventive care visits per enrollee remained stable, the number of those visits delivered through telehealth increased upward by nearly two orders of magnitude from 33 in Q4 of 2019 to 2879 by Q2 2020, and from under 1% of total preventive care visits to over 42% of such visits (Table 32.1).

*Table 26. Percent of Adults with a Smoking Diagnosis. **

FY	Unique Enrollees	Percent
2018	2835	34.64
2019	6786	41.69
2020	8517	38.64

Note: * Smoking includes diagnosis, screening and cessation drugs.

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Table 27. Annual Rate of Adults with Antidepressant Medication Management.

FY	Number of members with major depression diagnosis	Number of members with antidepressant prescriptions	Effective acute phase treatment* (%)	Effective continuation phase treatment** (%)
2018	374	222	55.86	22.97
2019	1211	829	69.12	39.45
2020	1512	1035	73.53	47.15

Note: *Adults who remained on an antidepressant medication for at least 84 days (12 weeks).

**Adults who remained on an antidepressant medication for at least 180 days (6 months).

Effective acute phase treatment

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value=0.01

Effective continuation phase treatment

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Table 28. Percent of Adults with a Preventive Care Visit.

FY	Unique Members	Percent
2018	2835	49.21
2019	6786	56.22
2020	8517	56.55

2018 vs. 2019: p-value<0.01

2019 vs. 2020: p-value=0.68

Table 29. Average Smoking Diagnosis Cost Per Targeted Adult Member by Year. ***

FY	Unique Members	Total	Average cost per member***
2018	2835	$66,278	$23.38
2019	6786	$372,905	$54.95
2020	8517	$758,665	$89.08

Note: *Includes costs associated with smoking diagnosis, screening and cessation drugs.

**Includes costs associated with outpatient visit and prescriptions.

*** $ in 2019

Table 30. Average Antidepressant Medication Management Cost Per Targeted Adult Member by Year.

FY	Unique Members	Total	Average cost per member*
2018	2835	$24,573	$8.67
2019	6786	$114,638	$16.89
2020	8517	$172,106	$20.21

Note: * $ in 2019

Table 31. Average Preventive Care Visit Cost Per Targeted Adult Member by Year.

FY	Unique Members	Total	Average cost per member*
2018	2835	$975,314	$344
2019	6786	$3,098,718	$457
2020	8517	$3,750,793	$440

Note: * $ in 2019

Table 32. Average Preventive Care Cost Per Visit by Year.

FY	Unique Members	Number of preventive care visits	Average cost per visit*
2018	2835	4792	$204
2019	6786	17574	$176
2020	8517	23022	$163

Note: * $ in 2019

Average cost per visit:

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Table 32.1. Quarterly Total Number of Preventive Care Visits.

Quarter	Unique Members	# of preventive care visits	Average # of preventive care visits per member	Preventive care visits via telehealth	% Preventive care visit via telehealth	# of preventive care visits excluding telehealth	Average # of preventive care visits excluding telehealth
2018 Q1	*1356*	*1754*	*1.29*	*0*	*0.00*	*1754*	*1.29*
2018 Q2	*2372*	*2643*	*1.11*	*3*	*0.11*	*2640*	*1.11*
2018 Q3	*3275*	*3282*	*1.00*	*3*	*0.09*	*3279*	*1.00*
2018 Q4	*4064*	*4098*	*1.01*	*1*	*0.02*	*4097*	*1.01*
2019 Q1	*4341*	*5038*	*1.16*	*32*	*0.64*	*5006*	*1.15*
2019 Q2	*4577*	*5156*	*1.13*	*30*	*0.58*	*5126*	*1.12*
2019 Q3	*4818*	*5168*	*1.07*	*52*	*1.01*	*5116*	*1.06*
2019 Q4	*4769*	*5300*	*1.11*	*33*	*0.62*	*5267*	*1.10*
2020 Q1	*4832*	*5772*	*1.19*	*315*	*5.46*	*5457*	*1.13*
2020 Q2	*5750*	*6782*	*1.18*	*2879*	*42.45*	*3903*	*0.68*

Hypothesis 7 focused on Emergency Department (ED) utilization among chronically homeless enrollees (Tables 33-35). With the increase in enrollees, the number of monthly ED visits increased considerably, from 345 to 631 (Table 33). In both years the proportion of non-emergent visits comprised about three-quarters of those visits. Clearly, improvement can still be made in terms of reducing the number and proportion of non-emergent ED visits. In 2020, ED use fell to close to 488. Non-emergent use as a percentage of the total remained about the same, however, at close to 80% (Table 33).

Concomitant with the increase in enrollees and use of the ED, the aggregate monthly ED cost increased from about $25,900 to about $51,300 in 2018 and 2019, respectively (Table 34). Average monthly costs of ED visits declined to $40,000 in 2020 with a very slight rise unique members. The average real cost of ED visits, however, remained stable, at close to $82 (Table 34).

Table 35 provides the top 5 diagnoses (based on primary diagnosis only) for ED visits in 2018 and 2019 and the associated monthly costs. The top 5 diagnoses are similar by rank between the two years, but not identical. For example, alcohol abuse with intoxication headed the list in 2018, but chest pain led the list in 2019. Costs associated with alcohol abuse with intoxication were highest in 2018 (at close to $7,200), and alcohol abuse with intoxication suicidal ideations were the costliest primary diagnosis in 2019 (about $18,100) as well.

Table 33. Percent of Average Monthly ED Visits without Non-Emergent ED Visits.

FY	Average monthly ED visits	Average monthly non-emergent ED visits	Average monthly emergent ED visits	Percent of average monthly ED visits with emergent ED visits
2018	345	275	70	20.21
2019	631	502	129	20.50
2020	488	384	104	21.25

Percent of average monthly ED visits with emergent ED visits:

2018 vs. 2019: p-value=0.82
2019 vs. 2020: p-value=0.48

Table 34. Average Monthly Cost of ED Visits and Average Cost per ED visit.

FY	Unique Members	Average monthly cost (total)*	Average cost per visit*
2018	1496	$25,892	$81.32
2019	2940	$51,299	$81.33
2020	2964	$40,005	$81.95

Note: Reimbursed amount only

*adjusted to in $ 2019

Average monthly cost:

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Average cost per visit

2018 vs. 2019: p-value=0.89
2019 vs. 2020: p-value=0.56

Table 35. Top 5 Emergency Department Diagnoses for Homeless Members in 2018 and associated costs.

2018			2019			2020		
Top 5 diagnosis	n	Cost*	Top 5 diagnosis	n	Cost*	Top 5 diagnosis	n	Cost*
Alcohol abuse with intoxication, unspecified	132	$10,942	Suicidal ideations	221	$25,431	Suicidal ideations	116	$12,366
Unspecified abdominal pain	121	$9,083	Chest pain, unspecified	179	$8,802	Alcohol abuse with intoxication, unspecified	74	$6,305
Chest pain, unspecified	119	$5,043	Alcohol abuse with intoxication, unspecified	167	$15,037	Other chest pain	71	$6,082
Major depressive disorder, single episode, unspecified	98	$10,219	Unspecified abdominal pain	140	$11,825	Chest pain, unspecified	69	$4,677
Other chest pain	71	$6,181	Other chest pain	133	$11,081	Unspecified abdominal pain	67	$5,816

Note: Reimbursed amount *adjusted to in $ 2019

Alcohol abuse with intoxication, unspecified:

2018 vs. 2019: p-value=0.50
2019 vs. 2020: p-value=0.01

Chest pain, unspecified:

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value<0.01

Unspecified abdominal pain:

2018 vs. 2019: p-value=0.77
2019 vs. 2020: p-value<0.01
P-value is calculated based on the proportional test

Hypothesis 8 related to the cost of inpatient uncompensated care. As Table 36 demonstrates, there was a clear reduction in such uncompensated care, by nearly $2 million, in 2019 and 2020. This coincided however with Medicaid expansion eligibility in the state which also was slated to substantially reduce

uncompensated care. What proportion of the reduction was due to the demonstration would require more detailed analysis of inpatient utilization among those targeted in the demonstration.

Table 36. Uncompensated care in Utah.

Year	Total uncompensated care cost
2018	$200,173,232
2019	$181,861,938
2020	$182,368,112

Blind and Disabled Dental (BDD)

To gauge the effects of the BDD related to **hypothesis 9**, analyses were undertaken on the number of emergency and preventive visits and their associated costs.

Table 37 provides a summary of total dental visits among the approximately 48,000 unique enrollees in the program in 2018, 2019, and 2020. There was a large increase in total visits between the two years, from about 27,350 to close to 34,000. Emergency dental visits increased as well, but not nearly as much as total visits, leaving the percent of emergency dental visits for both years at nearly identical, and just less than 19%. The number of dental visits remained steady in 2020 from the previous year.

Given the substantial increase in total visits, total dental costs also increased, by about $1.1 million in 2019 or $1.2 million in 2020, respectively from $6.5 million in 2018 (Table 38). Emergency dental visits comprised a little over 10% of total costs in each year. Per member per month emergency dental costs increased from $1.38 to $1.76 over the period. Average monthly per member per month dental costs remained fairly stable for preventive care, increasing from about $11.80 to $14.12 (Table 38).

Table 37. Percent of emergency Dental Services.

FY	Unique Members*	Total dental visits	Total emergency dental visits	% of emergency dental visits
2018	48178	27365	5143	18.79
2019	47929	33954	6372	18.77
2020	46808	33238	6485	19.51

Note: *Includes number of clients enrolled for at least one month within the year

% of emergency dental visits

2018 vs. 2019: p-value=0.93
2019 vs. 2020: p-value<0.01

Table 38. Average Monthly Dental Care Cost per Member Per Month.

FY	Total dental care costs	Total emergency dental care costs	Average monthly emergency dental care costs
2018	$6,528,087	$683,259	$1.38
2019	$7,654,055	$790,743	$1.62
2020	$7,736,613	$859,036	$1.76

Note: $ in 2019

Average monthly emergency dental care costs

2018 vs. 2019: p-value=0.14
2019 vs. 2020: p-value=0.40

Table 39. Average Monthly Preventive Dental Care Cost per Member.

FY	Total dental care costs	Total preventive dental care costs	Average monthly preventive dental care costs
2018	$6,528,087	$5,844,827	$11.81
2019	$7,654,055	$6,863,312	$14.05
2020	$7,736,613	$6,877,577	$14.12

Note: $ in 2019

Average monthly preventive dental care costs

2018 vs. 2019: p-value<0.01
2019 vs. 2020: p-value=0.92

Substance Use Disorder (SUD)

SUD measures met the assumptions required and were analyzed with DiD. The results are shown in the tables (as percentages) and figures (displayed as rates) below. However, no measures were found to be significant at the 0.05 level.

Hypothesis 1: Percent of members who are referred and engage in treatment for SUDs will increase.

Table 40. Distribution of Initiation of Alcohol and Other Drug Dependence Treatment.

Year	Initiation of Treatment	Total Eligible Members	Percentage
2016	1,560	4,125	37.9%
2017	1,535	3,963	38.7%
2018	1,661	4,151	40.0%
2019	2,304	5,620	41.0%

Table 41. Distribution of Initiation of Alcohol and Other Drug Dependence Treatment by Group.

Year	Group	Initiation of Treatment	Total Eligible Members	Percentage
2016				
	Target	1,080	2,847	37.9%
	Comparison	480	1,278	37.6%
2017				
	Target	1,097	2,761	39.7%
	Comparison	438	1,202	36.4%
2018				
	Target	1,192	2,971	40.1%
	Comparison	469	1,180	39.8%
2019				
	Target	1,557	3,904	39.9%
	Comparison	747	1,716	43.5%

Tables 40 and 41 above show the percent of initiation of alcohol and other drug dependence treatment increasing each year. However, the target group had an increase in initiation from 2016 to 2018 and a decrease in 2019 while the comparison group had a decrease in initiation in 2017 and an increase for 2018 and 2019. As shown below in Table 42, both target and comparison groups have an increase of 2.19% in initiation of treatment. In 2016 and 2018, the initiation of treatment was higher in the target group compared to the comparison group. Overall, there is a 0% increase in the difference of the differences for initiation in alcohol and drug treatment. This difference was found to not be significant at the 0.05 level. Figure 3 shows the initiation change between groups from the pre-exposure period to the post-exposure period.

Table 42. Difference in Differences of Initiation of Alcohol and Drug Dependence Treatment.

Variable	Target	Comparison	Difference
One-year initiation rate (2016)	37.93%	37.56%	0.38%
One-year initiation rate (2018)	40.12%	39.75%	0.38%
Change in one-year initiation rate	2.19%	2.19%	0%

Figure 3. Difference in Differences of Initiation of Alcohol and Other Drug Dependence Treatment.

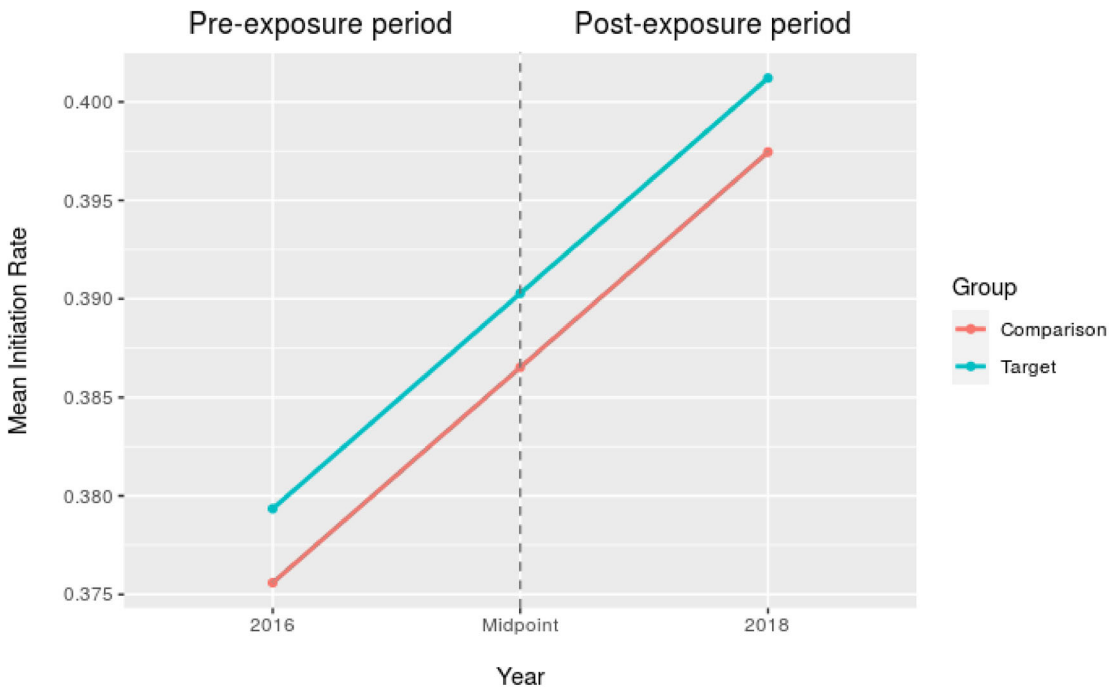


Table 43. Distribution of Engagement of Alcohol and Other Drug Dependence Treatment.

Year	Engagement of Treatment	Total Eligible Members	Percentage
2016	323	4,125	7.83%
2017	292	3,963	7.37%
2018	403	4,151	9.71%
2019	677	5,620	12.05%

Table 44. Distribution of Engagement of Alcohol and Other Drug Dependence Treatment by Group.

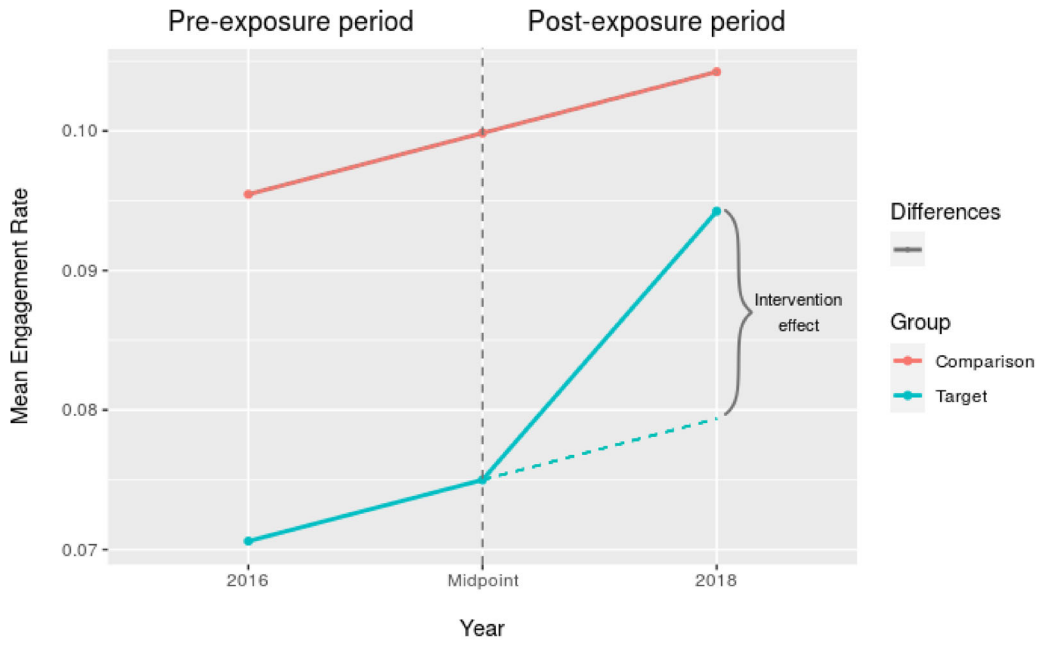
Year	Group	Engagement of Treatment	Total Eligible Members	Percentage
2016				
	Target	201	2,847	7.06%
	Comparison	122	1,278	9.55%
2017				
	Target	207	2,761	7.50%
	Comparison	85	1,202	7.07%
2018				
	Target	280	2,971	9.42%
	Comparison	231	1,761	10.42%
2019				
	Target	446	3,904	11.42%
	Comparison	231	1,716	13.46%

Tables 43 and 44 above show the percent of engagement of alcohol and other drug dependence treatment increasing each year. However, the comparison group had a decrease in engagement in 2017 and an increase for 2018 and 2019. As shown below in Table 45, both target and comparison have an increase in engagement of alcohol and other drug dependence treatment (2.36% and 0.88%, respectively). In 2016 and 2018, the engagement was higher in the comparison group compared to the target group. Overall, there is a 1.49% increase in the difference of the differences for engagement of alcohol and other drug dependence treatment in the target group compared to the comparison group. This difference was found to not be significant at the 0.05 level. Figure 4 shows the engagement change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 45. 5ifference in Differences of Engagement of Alcohol and Other Drug Dependence Treatment.

Variable	Target	Comparison	Difference
One-year engagement rate (2016)	7.06%	9.55%	-2.49%
One-year engagement rate (2018)	9.42%	10.42%	-1%
Change in one-year engagement rate	2.36%	0.88%	1.49%

Figure 4. Difference in Differences of Engagement of Alcohol and Other Drug Dependence Treatment



Hypothesis 2: Percent of members who adhere to treatment of SUDs will increase.

Table 46. Distribution Continuity of Pharmacotherapy for OUD.

Year	Continuous Pharmacotherapy	Eligible members with OUD Diagnosis and at least one OUD medication claim	Percentage
2016	441	724	60.7%
2017	455	757	60.1%
2018	458	885	51.7%
2019	602	1,237	48.7%

Table 47. Distribution Continuity of Pharmacotherapy for OUD by Group.

Year	Group	Continuous Pharmacotherapy	Eligible members with OUD Diagnosis and at least one OUD medication claim	Percentage
2016				
	Target	359	593	60.5%
	Comparison	82	131	62.6%
2017				
	Target	369	601	61.4%
	Comparison	86	156	45.9%
2018				
	Target	369	691	53.4%
	Comparison	89	194	45.9%
2019				
	Target	487	960	50.7%
	Comparison	115	277	41.5%

Tables 46 and 47 above show the percent of continuity of pharmacotherapy decreasing each year. However, the target group had an increase in the continuity of pharmacotherapy in 2017 and a decrease for 2018 and 2019. As shown below in Table 48 below, both target and comparison groups show a decrease in continuity of pharmacotherapy. (-7.24% and –16.72%, respectively). In 2016, the continuity of pharmacotherapy was higher in the comparison group compared to the target group. However, in 2018, the continuity of pharmacotherapy was higher in the target group compared to the comparison group. Overall, there is a 9.48% increase in the difference of the differences for continuity of pharmacotherapy in the target group compared to the comparison group. This difference was found to not be significant at the 0.05 level. Figure 5 below shows the continuity of pharmacotherapy change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 48. Difference in Differences of Continuity of Pharmacotherapy for OUD.

Variable	Target	Comparison	Difference
One-year pharmacotherapy rate (2016)	60.24%	62.6%	-1.95%
One-year pharmacotherapy rate (2018)	53.4%	45.88%	7.52%
Change in one-year pharmacotherapy rate	-7.24%	-16.72%	9.48%

Figure 5. Difference in Differences of Continuity of Pharmacotherapy for OUD

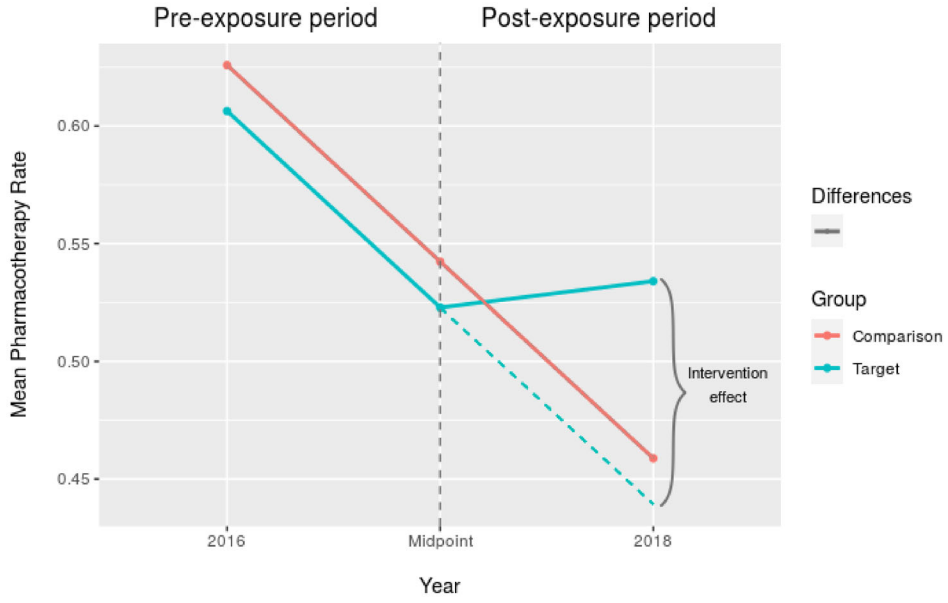


Table 49. Distribution of any SUD treatment service, facility claim, or pharmacy claim.

Year	Any SUD Treatment	Total Eligible Members	Percentage
2016	6,549	260,943	2.51%
2017	6,235	249,423	2.50%
2018	6,061	242,433	2.50%
2019	6,294	242,077	2.60%

Table 50. Distribution of any SUD treatment service, facility claim, or pharmacy claim by group.

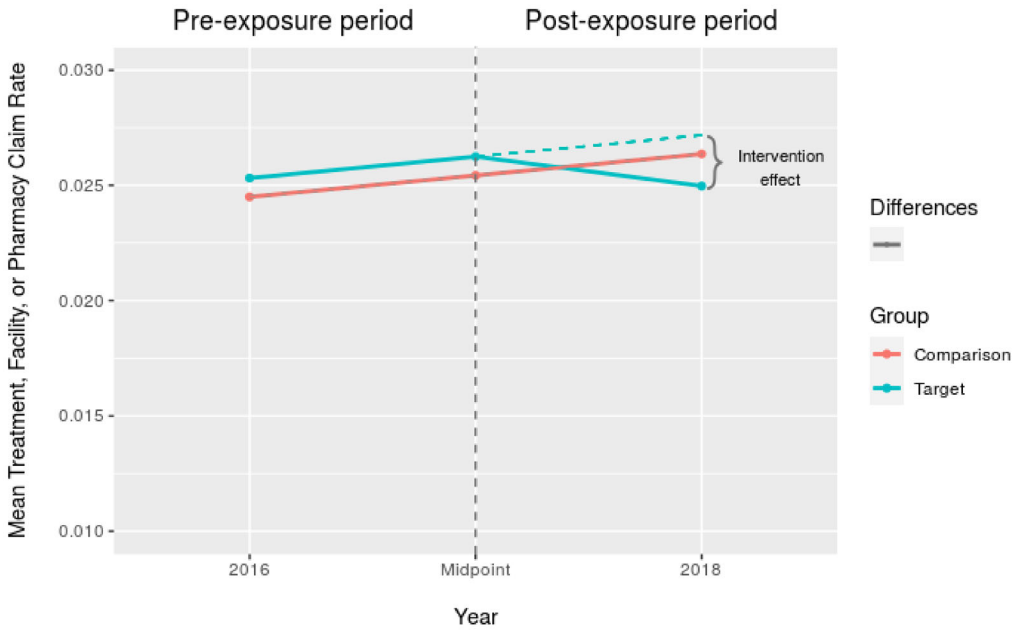
Year	Group	Any SUD Treatment	Total Eligible Members	Percentage
2016				
	Target	4,635	183,208	2.53%
	Comparison	1,905	77,735	2.45%
2017				
	Target	4,286	175,636	2.44%
	Comparison	1,970	73,796	2.67%
2018				
	Target	4,168	170,106	2.45%
	Comparison	1,895	72,327	2.62%
2019				
	Target	4,214	169,901	2.48%
	Comparison	2,071	72,176	2.87%

Tables 49 and 50 above show the percentage of any SUD treatment service, facility claim, or pharmacy claim decreasing in 2017 and increasing in 2019. However, the target group also had an increase in 2018 while the comparison group had an increase in every year except 2018. As shown in Table 51 below, the target group shows a decrease in any SUD treatment service, facility claim, or pharmacy claim (0.08%) and the comparison group shows an increase in any SUD treatment service, facility claim, or pharmacy claim (0.17%). In 2016, the SUD treatment service, facility claim, or pharmacy claims were higher in the target group compared to the comparison group. However, in 2018, the SUD treatment service, facility claim, or pharmacy claims were higher in the comparison group compared to the target group. Overall, there is a 0.25% decrease in the difference of the differences for SUD treatment service, facility claim, or pharmacy claims in the target group compared to the comparison group. This difference was found to not be statistically significant at the 0.05 level. Figure 6 shows the SUD treatment service, facility claim, or pharmacy claim change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 51. Difference in Differences of Receiving any SUD treatment service, facility claim, or pharmacy claim.

Variable	Target	Comparison	Difference
One-year admission rate (2016)	2.53%	2.45%	0.08%
One-year admission rate (2018)	2.45%	2.64%	-0.17%
Change in one-year admission rate	-0.08%	0.17%	-0.25%

Figure 6. Difference in Differences of Receiving any SUD treatment service, facility claim, or pharmacy claim.



Hypothesis 3: Rate of emergency department and inpatient visits will decrease.

Table 52. Distribution of Emergency Department Follow-up within 7 Days.

Year	Follow-up Within 7 Days	Total Eligible Members with an Emergency Department Visit	Percentage
2016	68	514	13.23%
2017	58	469	12.37%
2018	68	552	12.32%
2019	141	980	14.39%

Table 53. Distribution of Emergency Department Follow-up within 7 Days by Group.

Year	Group	Follow-up Within 7 Days	Total Eligible Members with an Emergency Department Visit	Percentage
2016				
	Target	51	367	13.90%
	Comparison	17	147	11.56%
2017				
	Target	45	353	12.75%
	Comparison	13	116	11.21%
2018				
	Target	57	434	13.13%
	Comparison	11	118	9.32%
2019				
	Target	94	729	12.89%
	Comparison	47	251	18.73%

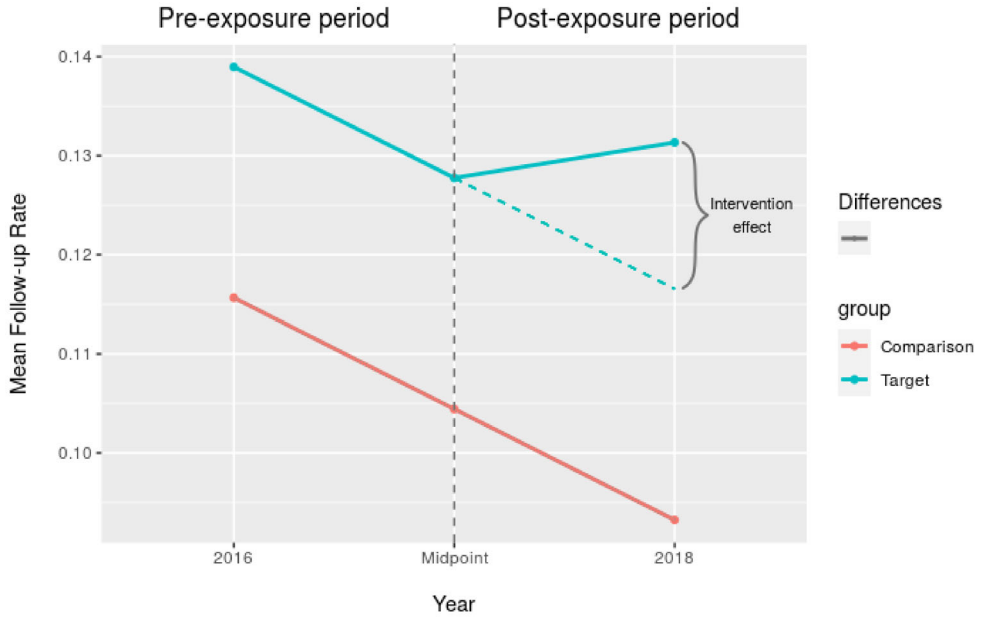
Tables 52 and 53 above show the percent of emergency department follow-up within 7 days decreasing each year except 2019. However, the target group had an increase in the emergency department follow-up in 2018 and a decrease for 2019. As shown below in Table 54 below, both target and comparison groups show a decrease in emergency department follow-up within 7 days (-0.76% and –2.24%, respectively). In

2016 and 2018, the emergency department follow-up within 7 days was higher in the target group compared to the comparison group. Overall, there is a 1.48% increase in the difference of the differences for emergency department follow-up within 7 days in the target group compared to the comparison group. This difference was found to not be statistically significant at the 0.05 level. Figure 7 shows the emergency department follow up within 7 days change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 54. Difference in Differences of Emergency Department Follow-up within 7 Days.

Variable	Target	Comparison	Difference
One-year follow-up rate (2016)	13.9%	11.56%	**2.33%**
One-year follow-up rate (2018)	13.13%	9.32%	**3.81%**
Change in one-year follow-up rate	**-0.76%**	**-2.24%**	**1.48%**

Figure 7. Difference in Differences of Emergency Department Follow-up within 7 Days.



55. Distribution of Emergency Department Follow-up within 30 Days.

Year	Follow-up Within 30 Days	Total Eligible Members with an Emergency Department Visit	Percentage
2016	101	514	19.65%
2017	80	469	17.06%
2018	106	552	19.20%
2019	196	980	20.00%

Table 56. Distribution of Emergency Department Follow-up within 30 Days by Group.

Year	Group	Follow-up Within 30 Days	Total Eligible Members with an Emergency Department Visit	Percentage
2016				
	Target	76	367	20.71%
	Comparison	25	147	17.01%
2017				
	Target	61	353	17.28%
	Comparison	19	116	16.38%
2018				
	Target	86	434	19.82%
	Comparison	20	118	16.95%
2019				
	Target	131	729	17.97%
	Comparison	65	251	25.90%

Tables 55 and 56 above show the percentage of emergency department follow-up for 30 days increasing each year except 2017. However, the target group also had a decrease in the emergency department follow-up in 2019. As shown below in Table 57 below, both target and comparison groups show a decrease in emergency department follow-up within 30 days (-0.89% and –0.06%, respectively). In 2016 and 2018, the emergency department follow-up within 30 days was higher in the target group compared

to the comparison group. Overall, there is a 0.84% decrease in the difference of the differences for emergency department follow-up within 30 days in the target group compared to the comparison group. This difference was found to not be statistically significant at the 0.05 level. Figure 8 shows the emergency department follow up within 30 days change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 57. Difference in Differences of Emergency Department Follow-up within 30 Days.

Variable	Target	Comparison	Difference
One-year follow-up rate (2016)	20.71%	17.01%	3.7%
One-year follow-up rate (2018)	19.82%	16.95%	2.87%
Change in one-year follow-up rate	-0.89%	-0.06%	-0.84%

Figure 8. Difference in Differences of Emergency Department Follow-up within 30 Days.

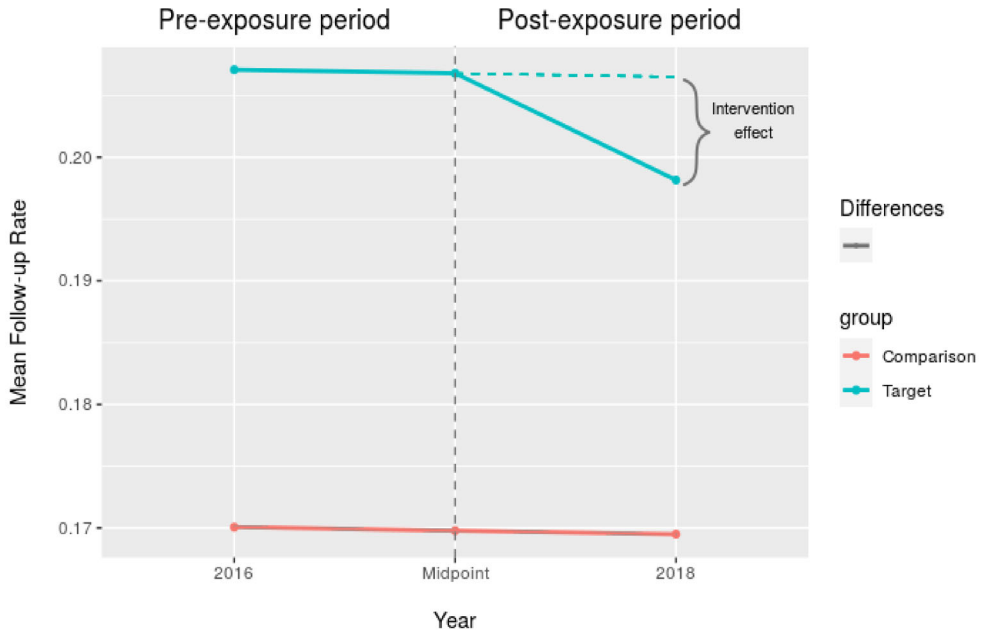


Table 58. Distribution of OUD Inpatient Stays.

Year	SUD Inpatient Admission	Total Eligible Members	Percentage
2016	3,707	260,943	1,42%
2017	3,552	249,423	1.42%
2018	2,383	242,433	1.35%
2019	5,153	242,077	2.13%

Table 59. Distribution of OUD Inpatient Stays by Group

Year		Group	SUD Inpatient Admission	Total Eligible Members	Percentage
2016					
		Target	2,623	183,208	1.43%
		Comparison	1,084	77,735	1.39%
2017					
		Target	2,451	175,636	1.40%
		Comparison	1,101	73,796	1.49%
2018					
		Target	2,286	170,106	1.34%
		Comparison	997	72,327	1.38%
2019					
		Target	3,562	169,901	2.10%
		Comparison	1,591	72,176	2.20%

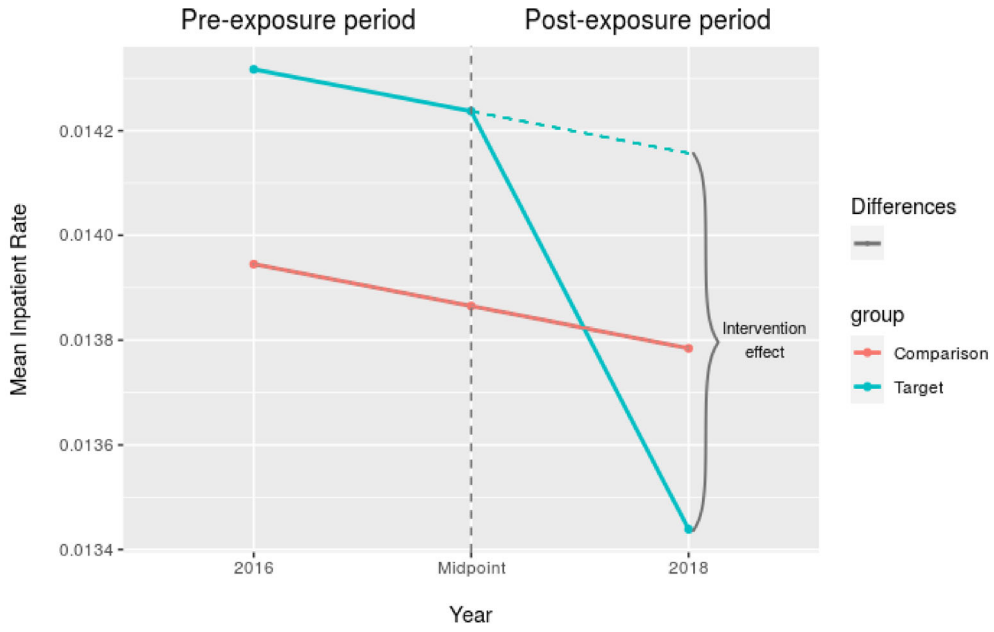
Tables 58 and 59 above show the percentage of inpatient admission for OUD decreasing from 2016 to 2018 and increasing for 2019. However, the target group had a decrease in the inpatient admission for OUD for each year except 2019 while the comparison group also shows an increase in 2017. As shown below in Table 60 below, both target and comparison groups show a decrease in inpatient admissions for OUD (0.09% and 0.02%, respectively). In 2016, inpatient admission for OUD was higher in the target group compared to the comparison group. However, in 2018, the inpatient admission of OUD was higher in the comparison group compared to the target group. Overall, there is a 0.07% decrease in the difference of the differences for inpatient admission of OUD in the target group compared to the comparison group.

This difference was found to not be statistically significant at the 0.05 level. Figure 9 below, shows inpatient admission for OUD change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 60. Difference in Differences of Inpatient Admission of OUD.

Variable	Target	Comparison	Difference
One-year admission rate (2016)	1.43%	1.39%	0.04%
One-year admission rate (2018)	1.34%	1.38%	-0.03%
Change in one-year admission rate	-0.09%	-0.02%	-0.07%

Figure 9. Difference in Differences of Inpatient Admission of OUD.



Hypothesis 4: Percent of members with SUD who experience care for comorbid conditions will increase.

Table 61. Distribution of Access to Preventive/Ambulatory Health Services (AAP).

Year	AAP	Total Eligible Members with SUD and Continual Enrollment	Percentage
2016	6,943	8,146	85.23%
2017	7,027	8,324	85.61%
2018	6,949	7,935	87.57%
2019	10,568	12,972	81.47%

Table 62. Distribution of Access to Preventive/Ambulatory Health Services (AAP) by Group.

Year	Group	AAP	Total Eligible Members with SUD and Continual Enrollment	Percentage
2016				
	Target	4,852	5,719	84.84%
	Comparison	2,091	2,427	86.16%
2017				
	Target	4,818	5,656	85.18%
	Comparison	2,076	2,397	86.61%
2018				
	Target	4,885	5,597	87.28%
	Comparison	2,064	2,338	88.28%
2019				
	Target	7,322	9,074	80.69%
	Comparison	3,246	3,898	83.27%

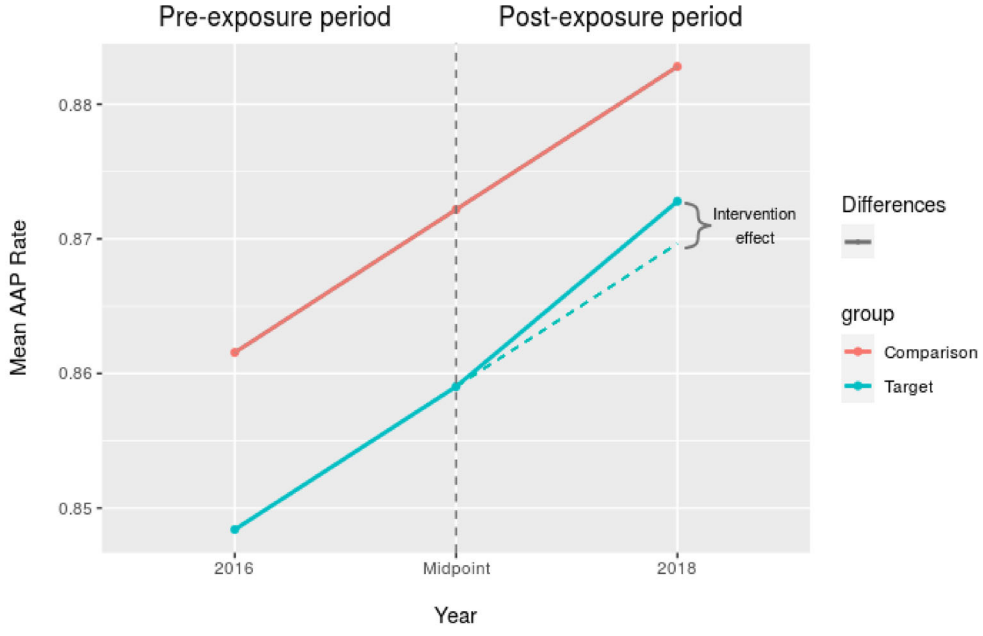
Tables 61 and 62 above show the percentage access to preventive / ambulatory health services (AAP) for OUD increasing for every year except 2019. As shown below in Table 63 below, both target and comparison groups show an increase in AAP (2.44% and 2.12%, respectively). In 2016 and 2018, the AAP was higher in the comparison group compared to the target group. Overall, there is a 0.31% increase

in the difference of the differences for AAP in the target group compared to the comparison group. This difference was found to not be significant at the 0.05 level. Figure 10 below, shows the AAP change between groups from the pre-exposure period to the post-exposure period. In the post-exposure period, the dotted line for the target group represents the expected trend if there was no exposure and the solid lines represent the observed trends for each group.

Table 63. Difference in Differences of Access to Preventive/Ambulatory Health Services.

Variable	Target	Comparison	Difference
One-year access rate (2016)	84.84%	86.16%	-1.32%
One-year access rate (2018)	87.28%	88.28%	-1%
Change in one-year access rate	2.44%	2.12%	0.31%

Figure 10. Difference in Differences of Access to Preventive/Ambulatory Health Services.



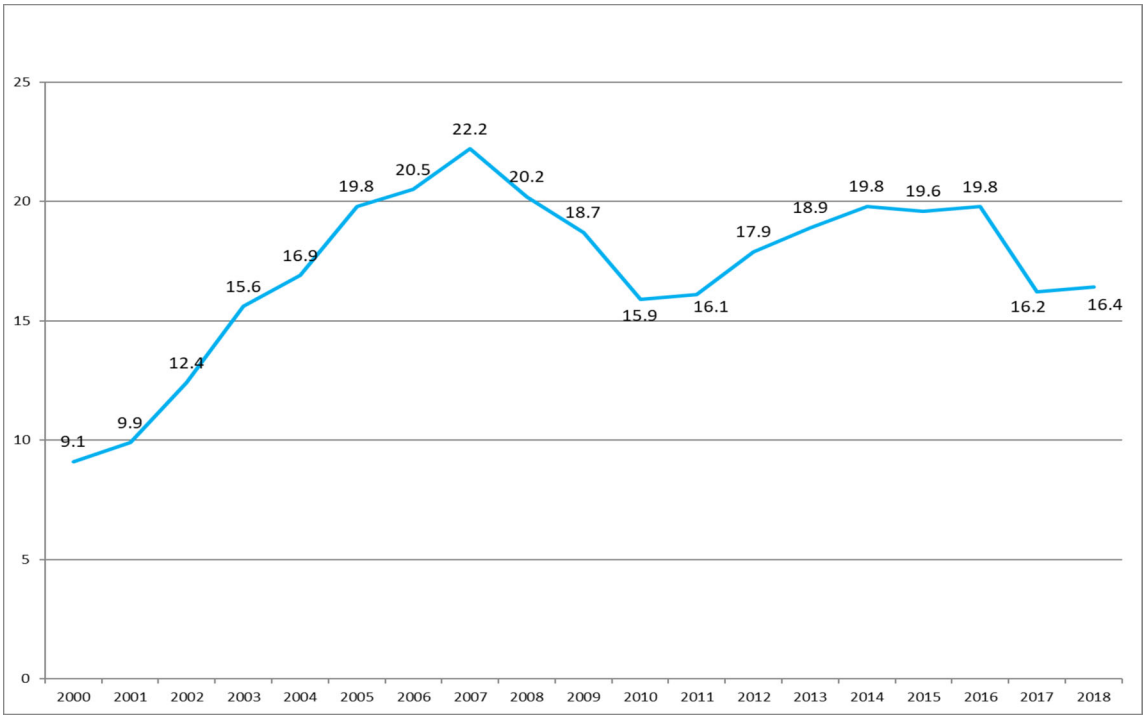
Hypothesis 5: Rate of overdose deaths due to opioids will decrease.

Utah has experienced a sharp increase in opioid related deaths since 2000[9]. The Division of Substance Abuse and Mental Health (DSAMH has statutory oversight of substance abuse and mental health treatment services statewide through local county authority programs. While some SUD services have

been available to Medicaid members statewide, this waiver expands the continuum of care to include SUD residential treatment in Institution for Mental Disease (IMD) for eligible individuals. This adds a critical service to address the needs of Medicaid members.[10]

Recent data suggests that the number of deaths due to opioids peaked initially in 2007, then showed a promising decreasing trend through 2010, before increasing dramatically once more from 2011 through 2017 (see Figure 11 below).

Figure 11. Rate of opioid deaths in Utah, Adults 18+ years, per 100,000 population, 2000-2018



Additionally, in response to the challenges related to opioid-related deaths, UDOH established an Opioid Fatality Review Committee (OFRC) in January 2018 to conduct in-depth reviews on select opioid deaths in the state. The purpose of a fatality review is to gather accurate data about events leading up to and surrounding an opioid-related death and make recommendations to prevent future fatalities. The work of the OFCR and others, including partner agencies such as DSAMH has been instrumental in the establishment of local Mobile Crisis Outreach Teams. While these teams have existed in the major urban counties in the state, additional rural areas have begun to operate MCOT services. One of the priority areas of these MCOT's is to follow up with patients who may be considered high risk of suicide when released from psychiatric facilities or hospital emergency departments. The purpose of the follow-up is to ensure a "warm handoff" takes place so the patient is connected to community-based mental health services during a period of potential need.

Table 63. SUD-related overdose deaths among Medicaid beneficiaries

Year	Overdose deaths	Rate of overdose deaths per 1,000
2018	159	0.42
2019	161	0.42
2020	210	0.52

While it appears the overall opioid overdose deaths in the general population may have reached its high point followed by a potential downward trend that is encouraging. The timing of Medicaid expansion in Utah and the limited specific data points among Medicaid beneficiaries (see Table 63 above) cannot yield a meaningful interpretation of the status of SUD-related overdose deaths at this time.

Hypothesis 6: Will the number of individuals receiving emergency department services for substance use disorder decrease in waiver implementing counties?

All measures met the assumptions, were analyzed with CITS, and the results are shown in the tables (as rates or percentages) and figures (displayed as rates) below. SUD emergency department visits and SUD inpatient services were not found to be significant at the 0.05 level. However, SUD outpatient services and SUD withdrawal management services were found to be significant at the 0.05 level.

Table 64. Distribution of SUD Emergency Department Visit per 1,000 Medicaid Beneficiaries

Year	SUD Emergency Department Visit	Total Eligible Members	SUD ED Visits per 1,000 Medicaid Beneficiaries
2015	3,055	98,760	39.0
2016	9,436	139,816	67.5
2017	9,543	139,204	68.6
2018	11,239	138,424	81.2
2019	18,487	174,144	106.2
2020	15,267	162,945	93.7

Table 65. Distribution of SUD Emergency Department Visit per 1,000 Medicaid Beneficiaries by Group

Year	Group	SUD Emergency Department Visit	Total Eligible Members	SUD ED Visits per 1,000 Medicaid Beneficiaries
2015				
	Target	1,488	37,630	39.5
	Comparison	1,567	37,630	25.6
2016				
	Target	4,234	52,497	80.7
	Comparison	5,202	87,319	59.6
2017				
	Target	4,223	52,091	81.1
	Comparison	5,320	87,113	61.1
2018				
	Target	5,266	52,267	100.8
	Comparison	5,973	86,157	69.3
2019				
	Target	8,384	66,454	126.2
	Comparison	10,103	107,690	93.8
2020				
	Target	6,938	62,290	111.4
	Comparison	8,329	100,655	82.7

*Data only available for first 6 months of 2020

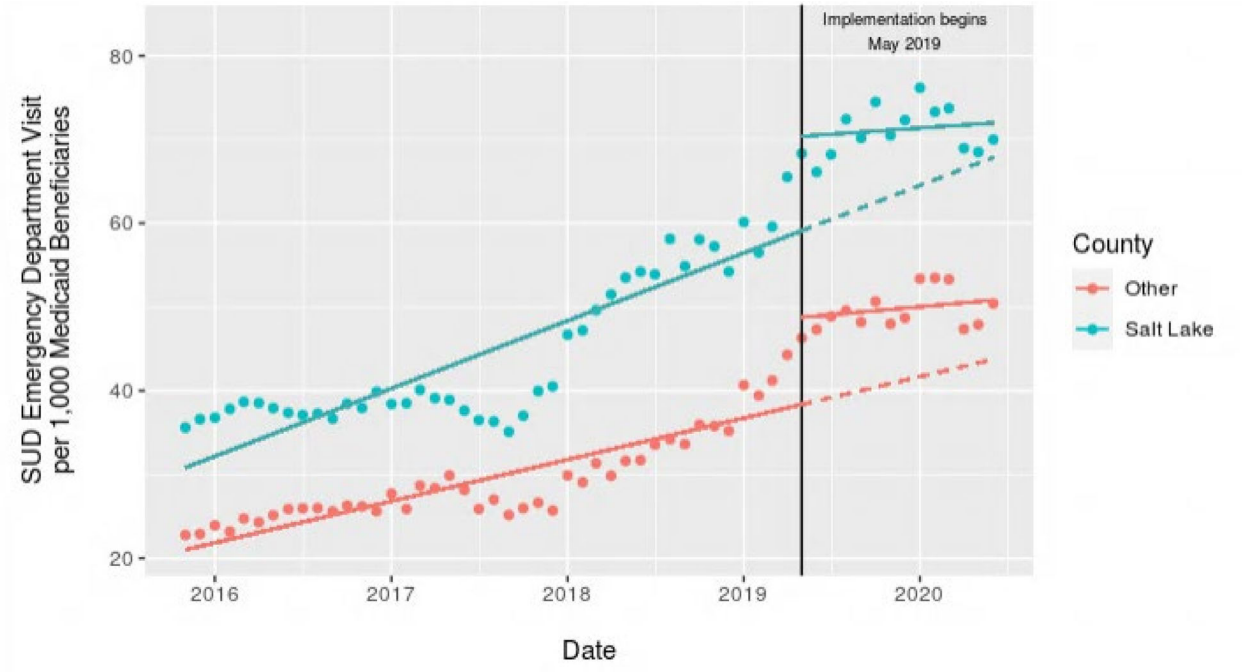
Tables 64 and 65 above shows the rate of SUD emergency department visits per 1,000 Medicaid beneficiaries increasing each year except for 2020. However, this decrease could be due to the data only including the first six months of 2020. As shown below in Table 66, both target and comparison groups show an increase in SUD emergency department visits (31.34 per 1,000 Medicaid beneficiaries and 27.38 per 1,000 Medicaid beneficiaries, respectively). Before and after implementation, the SUD emergency department visit rate was higher in the target group compared to the comparison group. Overall, there is a 3.96 per 1,000 Medicaid beneficiaries increase in the difference of the difference for SUD emergency

department visit rates in the target group compared to the comparison group. This difference was not found to be significant at the 0.05 level. Figure 12 below shows the SUD emergency department visit rate between groups from the pre-implementation period to the post-implementation period. The dotted lines represent the expected trend if there was no implementation and the solid lines represent the observed trends for each group.

Table 66. Difference in Differences of SUD Emergency Department Visit Rates by Group and Time

Variable	Target	Comparison	Difference
SUD ED services per 1,000 Medicaid beneficiaries before implementation	52.09	45.54	6.54
SUD ED service per 1,000 Medicaid beneficiaries after implementation	83.43	72.92	10.51
Change in SUD ED service rate	31.34	27.38	3.96

Figure 12. SUD Emergency Department Visits per 1,000 Medicaid Beneficiaries by Month and County



Hypothesis 7: Will ED expenditures decrease for substance use disorder services in implementing counties?

Table 67. Distribution of SUD Emergency Department Cost per Person

Year	SUD Emergency Department Visit	Eligible Medicaid Beneficiaries	Mean SUD ED cost per person
2015	3,619	305,140	$2,507.72
2016	11,308	397,499	$3,039.47
2017	11,365	388,166	$2,402.91
2018	13,306	374,374	$3,626.44
2019	21,436	398,535	$3,817.09
2020	17,351	356,255	$4,431.20

Table 68. Distribution of SUD Emergency Department Cost per Person

Year	Group	SUD Emergency Department Visit	Eligible Medicaid Beneficiaries	Mean SUD ED cost per person
2015				
	Target	1,753	115,528	$2,837.62
	Comparison	1,873	190,237	$2,227.27
2016				
	Target	5,163	152,759	$3,052.29
	Comparison	6,294	252,746	$3,027.81
2017				
	Target	5,118	148,280	$3,492.57
	Comparison	6,387	247,676	$3,292.92
2018				
	Target	6,380	142,556	$3,623.54

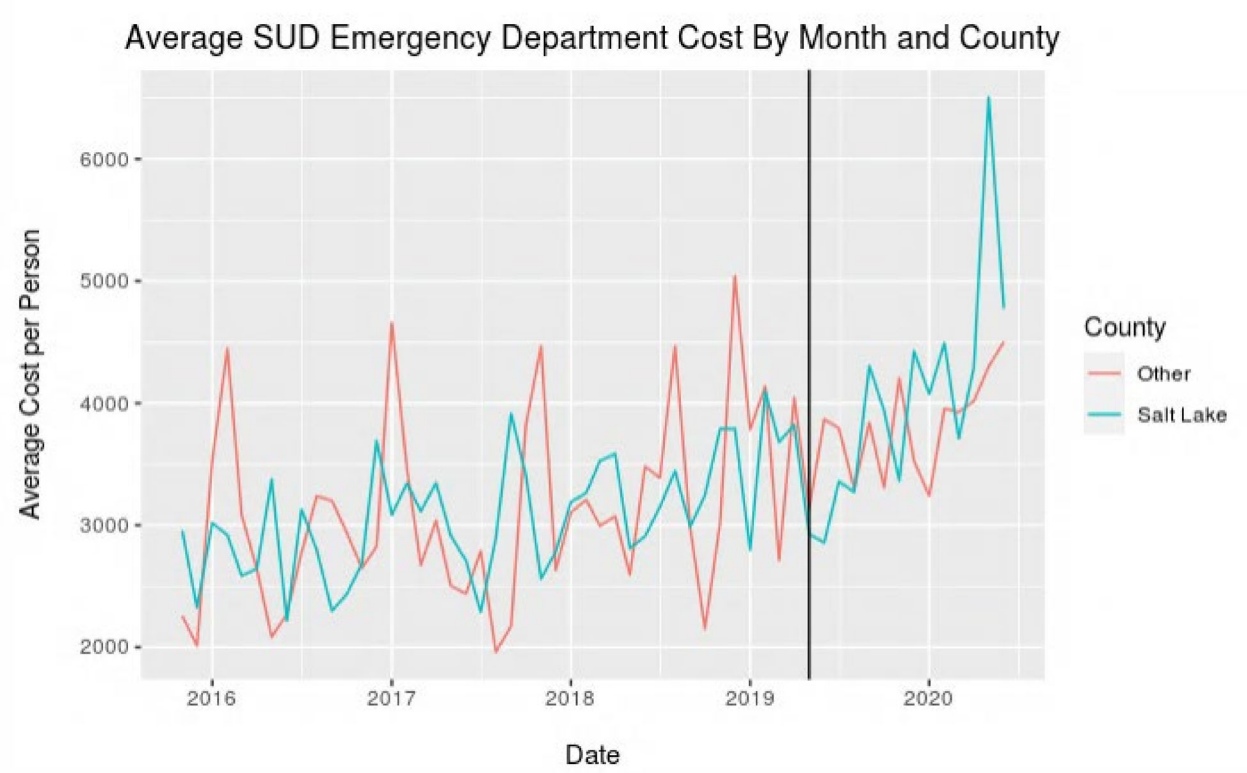
	Comparison	7,160	239,067	$3,604.15
2019				
	Target	10,046	152,323	$3,824.02
	Comparison	11,828	254,097	$3,776.57
2020				
	Target	8,088	134,741	$4,875.97
	Comparison	9,492	225,278	$4,035.70

Tables 67 and 68 above shows the cost of SUD emergency department visits per person increasing each year and in each group. As shown below in Table 69, both target and comparison groups show an increase in SUD emergency department cost per person ($564.61 and $573.06, respectively). Before and after implementation, the SUD emergency department visit cost per person was higher in the target group compared to the comparison group. Overall, there is a $8.45 increase in the difference of the difference for SUD emergency department visit costs per person in the target group compared to the comparison group. This difference was not found to be significant at the 0.05 level. Figure 13 shows the SUD emergency department visit rate between groups from the pre-implementation period to the post-implementation period.

Table 69. Difference in Differences of SUD Emergency Department Visit Cost per Person

Variable	Target	Comparison	Difference
ED cost before implementation	$2,480.04	$2,434.13	$45.91
ED cost after implementation	$3,044.65	$3,007.19	$37.46
Change in ED cost rate	$564.61	$573.06	-$8.45

Figure 13. SUD Emergency Department Visit Costs per person by Month and County



Hypothesis 8: Will the number of inpatient hospitalization days for SUD services decrease in waiver implementing counties?

Table 70. Distribution of SUD Inpatient Stays per 1,000 Medicaid Beneficiaries

Year	SUD Inpatient Stays	Total Eligible Members	Inpatient Stays per 1,000 Medicaid Beneficiaries
2015	570	187,737	3.0
2016	4,028	1,136,668	3.5
2017	4,023	1,125,573	3.6
2018	4,411	1,139,212	3.9
2019	7,581	1,363,102	5.6
2020*	5,020	823,170	6.1

*Data for 2020 only includes the first 6 months

Table 71. Distribution of SUD Inpatient Stays per 1,000 Medicaid Beneficiaries by Group

Year	Group	SUD Inpatient Stays	Total Eligible Members	Inpatient Stays per 1,000 Medicaid Beneficiaries
2015				
	Target	285	71,614	4.0
	Comparison	285	116,123	2.5
2016				
	Target	2,024	432,485	4.6
	Comparison	2,024	704,183	2.9
2017				
	Target	1,896	427,743	4.4
	Comparison	2,004	697,830	3.0
2018				
	Target	2,248	437,207	5.1
	Comparison	2,163	702,005	3.1
2019				
	Target	3,648	521,893	7.0
	Comparison	3,933	841,209	4.7
2020*				
	Target	2,381	314,677	7.6
	Comparison	2,639	508,493	5.2

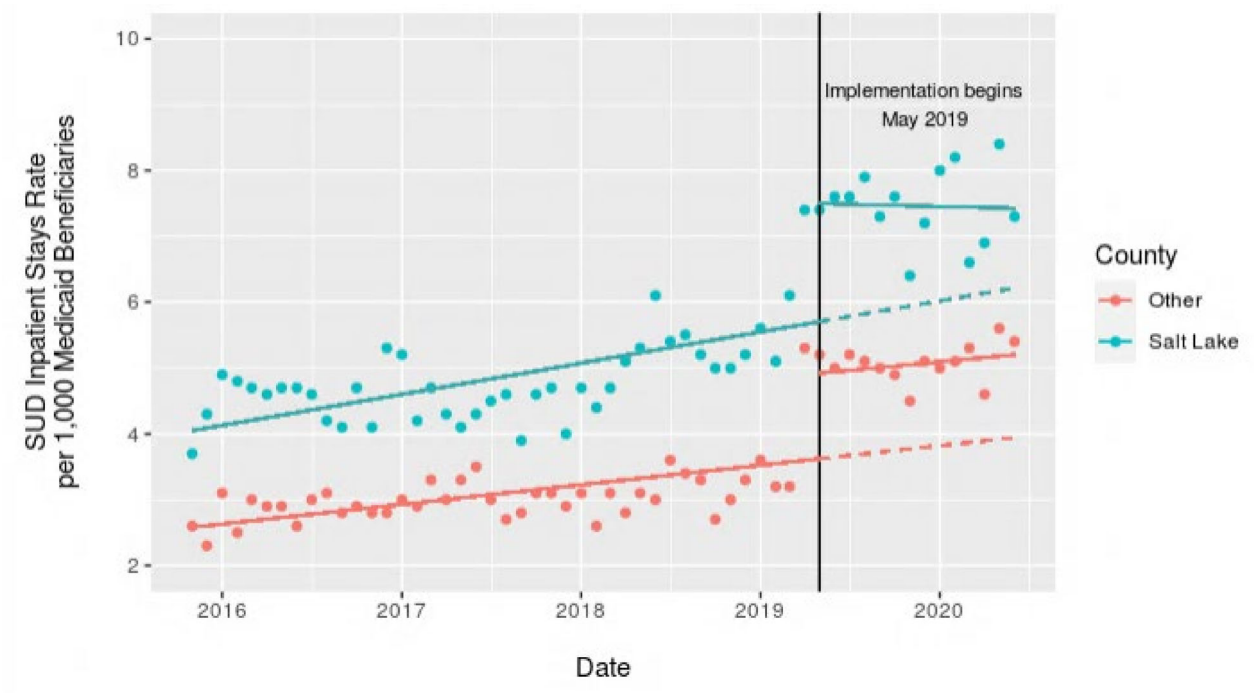
*Data for 2020 only includes the first 6 months

Tables 70 and 71 above shows the rate of SUD inpatient stays per 1,000 Medicaid beneficiaries increasing each year through 2019. Data for 2020 only included the first six months. As shown below in Table 72 both target and comparison groups show an increase in SUD inpatient stays (2.58 per 1,000 Medicaid beneficiaries and 1.96 per 1,000 Medicaid beneficiaries, respectively). Before and after implementation, the SUD inpatient stay rate was higher in the target group compared to the comparison group. Overall, there is a 0.63 per 1,000 Medicaid beneficiaries increase in the difference of the difference for SUD inpatient stay rates in the target group compared to the comparison group. This difference was not found to be significant at the 0.05 level. Figure 14 shows the SUD inpatient services per 1,000 Medicaid beneficiaries between groups from the pre-implementation period to the post-implementation period. The dotted lines represent the expected trend if there was no implementation, and the solid lines represent the observed trends for each group.

Table 72. Difference in Differences of SUD Inpatient Stay Rates

Variable	Target	Comparison	Difference
SUD inpatient services per 1,000 Medicaid beneficiaries before implementation	4.88	3.10	1.77
SUD inpatient services per 1,000 Medicaid beneficiaries after implementation	7.46	5.06	2.40
Change in SUD inpatient services per 1,000 Medicaid beneficiaries	2.58	1.96	0.63

Figure 14. SUD Inpatient Stays per 1,000 Medicaid Beneficiaries by Month and County



Hypothesis 8: Will the number of outpatient (OP), intensive outpatient (IOP), or partial hospitalization visits for SUD services increase in Salt Lake County?

Table 73. Distribution of Outpatient Services for Eligible Members with SUD Diagnosis

Year	SUD Outpatient Service	Eligible Members with SUD Diagnosis	Percentage
2015	1,620	3,815	42.46%
2016	5,194	11,295	45.98%
2017	5,620	11,514	48.81%
2018	7,157	13,598	52.63%
2019	12,140	22,300	54.44%
2020*	9,738	18,475	52.71%

*Data for 2020 only includes the first 6 months

Table 74. Distribution of Outpatient Services for Eligible Members with SUD Diagnosis by Group

Year	Group	SUD Outpatient Service	Eligible Members with SUD Diagnosis	Percentage
2015				
	Target	779	1,853	42.04%
	Comparison	841	1,962	42.86%
2016				
	Target	2,311	5,031	45.94%
	Comparison	2,883	6,264	46.02%
2017				
	Target	2,256	5,074	44.46%
	Comparison	3,364	6,440	52.24%
2018				
	Target	3,102	6,286	49.35%

	Comparison	4,055	7,312	55.46%
2019				
	Target	5,294	10,025	52.81%
	Comparison	6,846	12,275	55.77%
2020*				
	Target	4,313	8,346	51.68%
	Comparison	5,425	10,129	53.56%

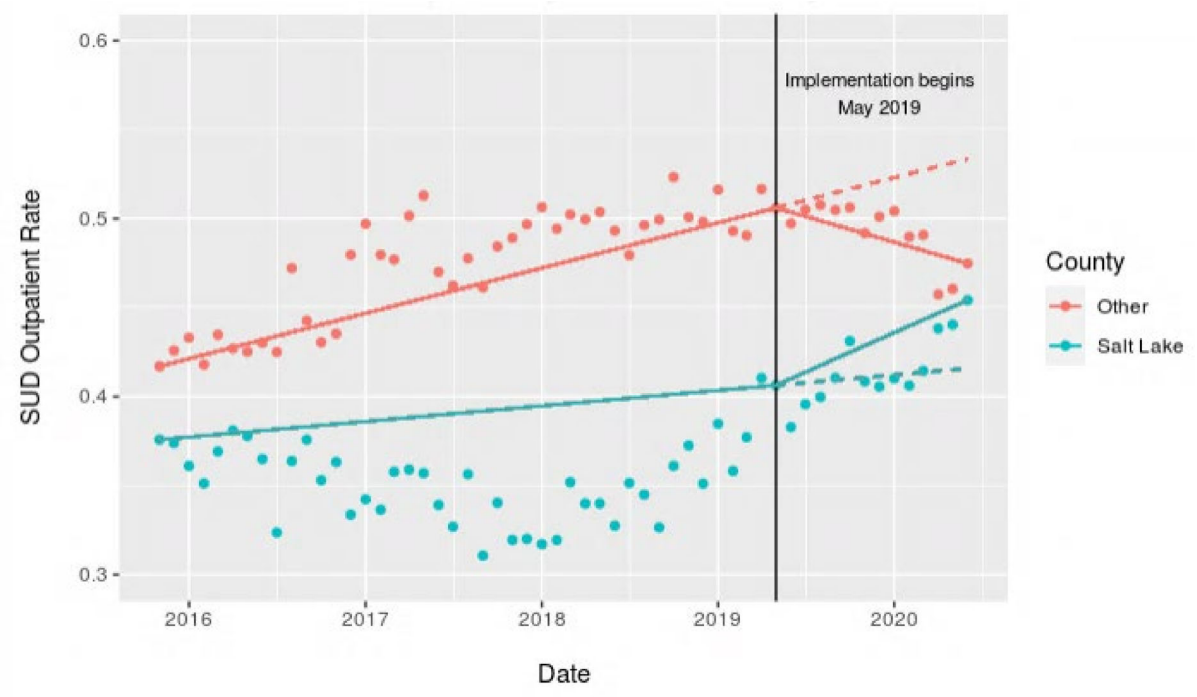
*Data for 2020 only includes the first 6 months

Tables 73 and 74 above shows the rate of SUD outpatient service increasing each year through 2019. Data for 2020 only included the first six months. As shown below in Table 75, both target and comparison groups show an increase in SUD outpatient services (6.27% and 1.46%, respectively). Before and after implementation, the SUD outpatient service rate was higher in the comparison group compared to the target group. Overall, there is a 4.81% increase in the difference of the difference for SUD outpatient service rates in the target group compared to the comparison group. This difference was found to be significant at the 0.05 level. Figure 15 shows the SUD outpatient service rate between groups from the pre-implementation period to the post-implementation period. The dotted lines represent the expected trend if there was no implementation and the solid lines represent the observed trends for each group.

Table 76. Difference in Differences of SUD Inpatient Stay Rates

Variable	Target	Comparison	Difference
SUD outpatient rate before implementation	35.48%	48.17%	-12.68%
SUD outpatient rate after implementation	41.75%	49.62%	-7.88%
Change in SUD outpatient rate	6.27%	1.46%	4.81%

Figure 15. SUD Outpatient Services by Month and County



Hypothesis 9: Additional Research Question: Will the number of beneficiaries who utilize withdrawal management services increase in implementing counties?

Table 77. Distribution of SUD Withdrawal Management Services for Eligible Members with SUD Diagnosis

Year	SUD Withdrawal Management Service	Eligible Members with SUD Diagnosis	Percentage
2015	76	3,815	1.99%
2016	310	11,295	2.74%
2017	286	11,514	2.48%
2018	296	13,598	2.18%
2019	1,153	22,300	5.17%
2020*	909	18,475	4.92%

*Data for 2020 only includes the first 6 months

Table 78. Distribution of SUD Withdrawal Management Services for Eligible Members with SUD Diagnosis

Year	Group	SUD Withdrawal Management Service	Eligible Members with SUD Diagnosis	Percentage
2015				
	Target	47	1,853	2.54%
	Comparison	29	1,962	2.54%
2016				
	Target	163	5,031	3.24%
	Comparison	147	6,264	2.35%
2017				
	Target	128	5,074	2.52%
	Comparison	158	6,440	2.45%
2018				
	Target	148	6,286	2.35%
	Comparison	148	7,312	2.02%
2019				
	Target	847	10,025	8.45%
	Comparison	306	12,275	2.49%
2020*				
	Target	634	8,346	7.60%
	Comparison	275	10,129	2.71%

*Data for 2020 only includes the first 6 months

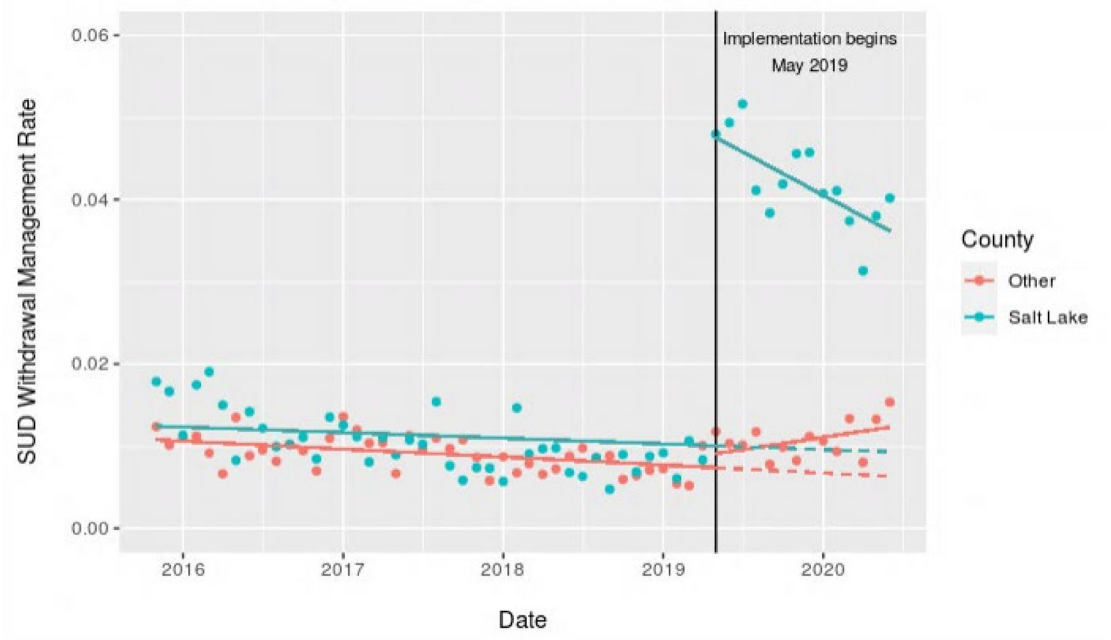
Tables 77 and 78 above shows the rate of SUD withdrawal management service increasing each year through 2019. Data for 2020 only included the first six months. As shown below in Table 79, both target and comparison groups show an increase in SUD withdrawal management services (3.08% and 0.31%,

respectively). Before and after implementation, the SUD withdrawal management service rate was higher in the target group compared to the comparison group. Overall, there is a 2.78% increase in the difference of the difference for SUD withdrawal management service rates in the target group compared to the comparison group. This difference was found to be significant at the 0.05 level. Figure 16 shows the SUD withdrawal management service rate between groups from the pre-implementation period to the post-implementation period. The dotted lines represent the expected trend if there was no implementation and the solid lines represent the observed trends for each group.

Table 79. Difference in Differences of SUD Withdrawal Management Stay Rates

Variable	Target	Comparison	Difference
SUD withdrawal management rate before implementation	1.14%	0.81%	0.33%
SUD withdrawal management rate after implementation	3.63%	0.88%	2.75%
Change in SUD withdrawal management rate	2.49%	0.07%	2.42%

Figure 16. SUD Withdrawal Management Services by Month and County.



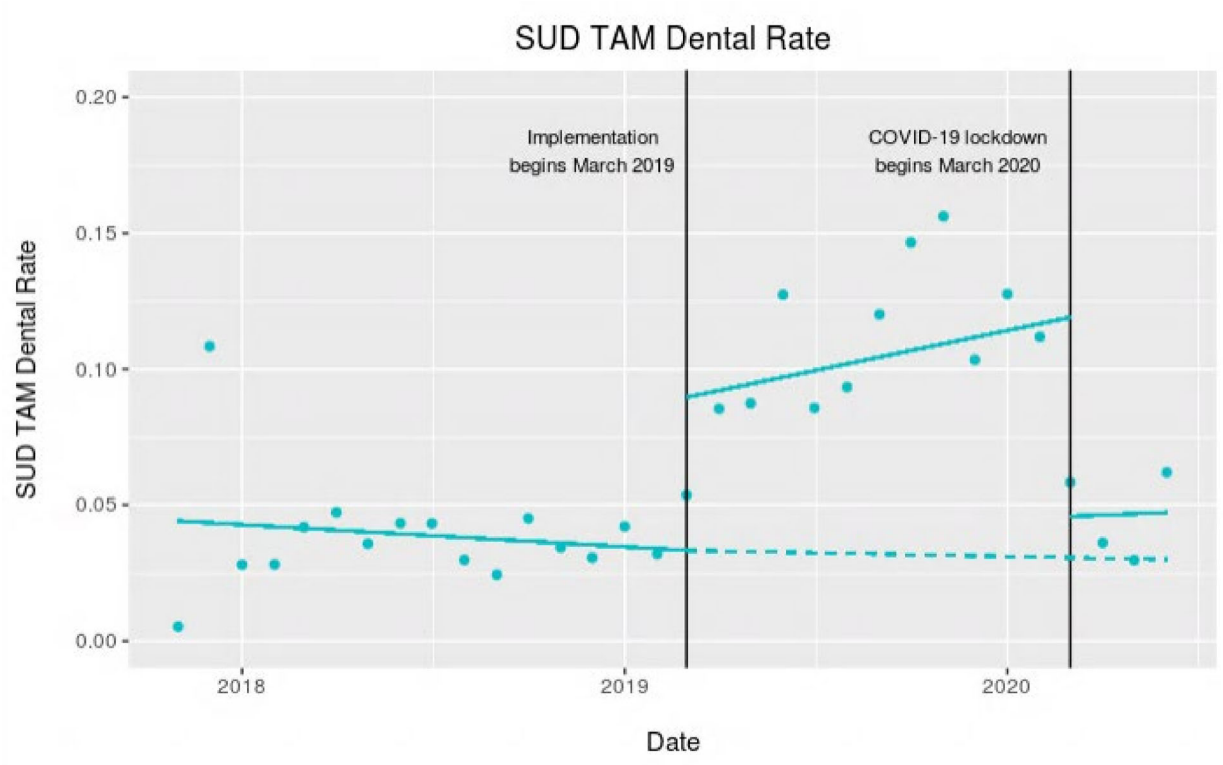
Hypothesis 10: Additional Research Question: Will individuals receiving comprehensive dental treatment have a higher rate of SUD treatment completion?

Table 80: Distribution of Number of Dental Procedures and Total TAM SUD Beneficiaries

Year	Number of Dental Procedures	Total SUD TAM Beneficiaries	Percentage
2017	32	332	9.64%
2018	434	2,831	15.33%
2019	1,893	4,441	42.63%
2020	824	3,688	22.34%

As shown above in Table 80, the number of dental procedures and the total number of SUD TAM beneficiaries increased each year with a decrease in 2020. However, this decrease could be due to the data only including the first six months of 2020. As shown below in Figure 16, the SUD TAM dental rate increased after implementation and decreased after March 2020, which could be due to the COVID-19 lockdown. The dotted line represents the expected trend if there was no implementation and the solid lines represent the observed trends.

Fig 17: SUD TAM Dental Rate by Month



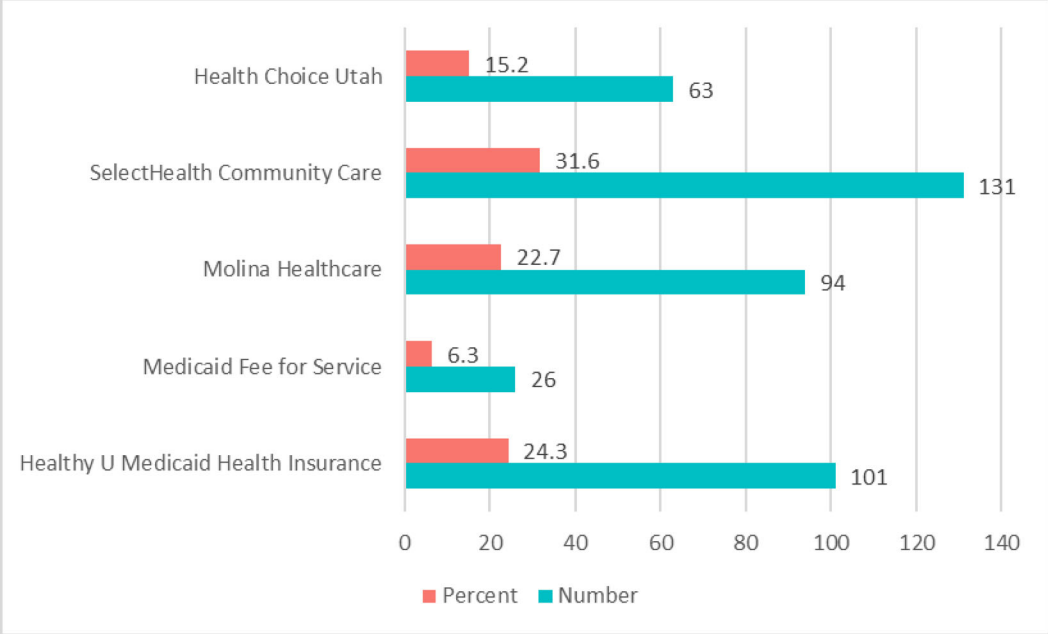
Hypothesis 1 and 2: Research questions answered from beneficiary survey.

Survey response

The statewide cross-sectional survey of Medicaid beneficiaries had 415 completed surveys (see Attachment B for all responses). Respondents were 64% female and 36% male. The average age of respondents was 41.3 years and the median age was 34.0 years. The age range of respondents was 18 to 79 years of age. Eighty-six percent reported their race as White, 4 % were Asian, 3 % were Black or African American, 2 % were American Indian or Alaska Native, and 1 % were Native Hawaiian or Other Pacific Islander. Four percent were Other races. Sixteen percent identified as being Hispanic / Latino.

Survey respondents came from 21 of Utah's 29 Counties, with 80% from the urban areas of the state (Davis, Salt Lake, Utah, and Weber counties). Thirty-two percent of respondents were "Employed for wages", with 8 % "self-employed", 6.5 % were "out of work for 1 year or more", 7.5 % were "out of work for less than 1 year". Ten percent identified themselves as "a homemaker", 8 % as "a student", 6 % as "retired", and 22% "unable to work". The majority of survey respondents (see Figure 18 below) were enrolled in SelectHealth Community Care (32%), with 24% enrolled in Healthy U Medicaid, followed by Molina Healthcare (23%).

Figure 18. Medicaid plan of beneficiary survey respondents, 2020.



Beneficiary experience with care

The first key question focused on beneficiaries' recognition of the availability of mental health (MH) and substance abuse disorder (SUD) services in their community. When asked whether "*there are places in*

your community you could go to get the help needed?" 69% (N=286) responded "yes", while 11% responded "no". Twenty percent reported "they did not know".

The next question focused on beneficiaries' need for mental health and/or substance abuse services. *When asked "in the last 12 months, have you or a member of your household needed counseling, treatment, or medicine for drug or alcohol use?" 55% (N=226) said "yes".* Survey findings for beneficiaries reporting the need to get treatment quickly was positive. When asked "in the last 12 months, when you or a member of your household needed counseling, treatment, or medicine, how often were you or a family member able to see someone *as soon as needed*?" 61% (N=226) responded "usually" or "always". Twenty-seven percent responded "sometimes", with 12% reporting "never". Next, respondents who indicated they or a household member had received counseling or treatment were asked to "rate all the counseling or treatment in the last 12 months from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible." The average rating was 6.43/10. The last beneficiary SUD experience with care question asked "in the last 12 months, how much were you or a member of your household *helped by the counseling, treatment, or medicine*?" Sixty-two percent responded they were helped "a lot" or "somewhat". Twenty-seven percent reported being helped "a little", while 10 percent reported "not at all".

These beneficiary survey findings indicate that the majority of members recognize they have access to mental health and substance abuse services as part of their plan benefits and they know where to go for services, should the need exist. Those members who either experienced a need or who had a household member with a need for these services reported positive experiences with being able to get services quickly. They also rated the overall services that were received favorably.

Supplemental Metrics for SUD Mid-Point Assessment

The purpose of the mid-point assessment of supplemental metrics is to help "CMS assess whether states are making sufficient progress towards meeting their demonstration milestones and monitoring metric targets". In order to complete this assessment, considerable collaboration took place between the independent evaluator and UDOH. For example, UDOH staff shared summary report narrative and process data outcomes for both monthly and annual data metrics used as part of the state's ongoing SUD waiver monitoring procedures. Specific documentation included the SUD Monitoring Workbook (V4) containing: planned metrics and metric report data as well as metric definitions, annual goals, and overall demonstration targets. More specifically, to support the interim review of "critical SUD metrics" UDOH provided 3 years data (SFY 2018, 2019, and 2020) to the independent evaluation research team. This data included a combination of annual and monthly data for 21 identified SUD-related metrics (categorized into 5 milestone target content areas) as well as specifically identified annual and waiver outcome goals.

The independent evaluator undertook a systematic process to conduct the review, consisting of two components. First, 3 unbiased research staff participated in the review. Working independently and objectively, these staff examined the outcome data for each of the 21 metrics and assigned a rating for each one, by applying the evaluation criteria provided in the CMS guidance. Then once each metric was

given a rating, the research staff member provided a composite rating for each of the 5 established milestone categories. Second, following the completion of the independent ratings, all research staff met and reviewed the ratings with additional discussion in order to reconcile any variation in the ratings. This process enabled research staff to establish group consensus on both individual metric and composite milestone rating scores (see Table 81 below). This approach offered a consistent systematic review based on established criteria and provides an assurance the evaluation process is impartial and fair.

Table 81. Assessment of risk associated with not meeting SUD milestones at mid-point.

	SUD Mid-Point Assessment of Critical Metrics	Risk status in achieving milestone		
		LOW	MED.	HIGH
Metric #	Milestone 1. Access to critical levels of care for OUD and other SUDs.	X		
7	Early Intervention	X		
8	Outpatient Services	X		
9	Intensive Outpatient and Partial Hospitalization Services	X		
10	Residential and Inpatient Services	X		
11	Withdrawal Management	X		
12	Medication-Assisted Treatment (MAT)	X		
22	Continuity of Pharmacotherapy for Opioid Use Disorder			X
	Milestone 2. Use of evidence-based, SUD-specific patient placement criteria.		X	
5	Medicaid Beneficiaries Treated in an IMD for SUD	X		
36	Average length of stay in IMDs			X
	Milestone 4. Sufficient provider capacity at each level of care.	X		
13	Provider availability	X		
14	Provider availability - MAT	X		
	Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.			X
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)	N/A		
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)	X		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries			X
27	Overdose death rate			X
	Milestone 6. Improved care coordination and transitions between levels of care.	X		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)		X	
17(1)	Follow-up after Emergency Department Visits for Alcohol or Other Drug Dependence (NQF #2605) AOD 7- Day follow- up	X		
17(1)	Follow-up after Emergency Department Visits for Alcohol or Other Drug Dependence (NQF #2605) AOD 30 - Day follow- up	X		
17(2)	Follow-up after Emergency Department Visits for Mental Illness (NQF #2605) MH 7 - Day Follow-up	X		
17(2)	Follow-up after Emergency Department Visits for Mental Illness (NQF #2605) MH 30 - Day Follow-up	X		
25	Readmissions Among Beneficiaries with SUD		X	

There are no critical metrics identified for Milestone 3 (Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications).

SUD Mid-Point Metric and Milestone Progress

Table 80 contains 21 metrics categorized within 5 milestone content target areas. The independent evaluators rated a total of 14 metrics (70%) as "low risk" of not being achieved by the end of waiver demonstration period. Only 2 metrics (10%) were rated "medium risk" of not being achieved, while 4 metrics (20%) were rated "high risk" of not being achieved. One metric (#18), was not given a rating at this time by the independent evaluator due to changes in the definition of the metric, which compromised this metric assessment. Specifically, during FY2018 the metric was defined as the "*rate per 1,000 beneficiaries* age 18 and older included in the denominator without cancer who received prescriptions for opioids *with a daily dosage greater than 120 morphine milligram equivalents (MME) for 90 consecutive days or longer*." However, the definition changed beginning in FY2019 to *"percentage of beneficiaries* age 18 and older who received prescriptions for opioids with an *average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more."* For this metric, multiple changes occurred: the reporting measure changed from a beneficiary rate to a beneficiary percentage, the prescription daily dosage decreased from 120 MME to 90 MME, and the time period for numerator qualification changed from 90 *consecutive* days or longer to an average over 90 days or more. Additionally, the annual goal and targeted waiver outcome for this metric, was not adjusted to reflect the changing definition between FY2018 and 2019, further complicating an accurate assessment rating.

Given the positive findings that 70% of the individual metrics are rated "low risk" of not being achieved, the composite milestone ratings reflect a similar "low risk" of not being achieved. As noted in Table 29 the "low risk" rating was assigned to milestones 1, 4, and 6. Milestone 2 received a "medium risk" rating and milestone 5 was deemed to be "high risk" of not being achieved.

Several factors contributed to milestone 5 receiving the "high risk" rating. The first was a technical reason, the missing rating (metric #18) previously discussed which represented 25% of the metrics comprising milestone 5 [Implementation of comprehensive treatment and prevention strategies to address opioid abuse and opioid use deaths (OUD)]. The second was due to both metric #23 and #27 receiving "high risk" ratings based on data trends indicating the waiver targets are likely not to be met.

Milestone 2 was rated a "medium risk" of not being achieved since the mid-range rating is reflective of having one metric at low risk while one metric is at high risk of not being achieved.

Milestones 1, 4, and 6 were all given the "low risk" rating as a result of strong outcome data reflecting the state has *either* already achieved outcomes surpassing established goals or the 3-year trend indicates the goals are at "low risk" of not being achieved.

Other Findings

UDOH Implementation Plan Monitoring

UDOH has been proactive in its efforts to collaborate with the Utah Division of Substance Abuse and Mental Health (DSAMH) and SUD service providers throughout waiver planning and implementation. For example, to strengthen and ensure state-wide capacity to implement evidence-based SUD treatment and trainings on ASAM assessment, treatment planning, and motivational interviewing have been provided several times by DSAMH. To support the waiver changes, the state established a policy requiring prior authorization for clinically managed low-intensity residential services and included guidance for members enrolled in Pre-paid Mental Health Plan and traditional Fee-for-Service members. Further, contracts with the Pre-paid Mental Health Plans have been clarified to include the use of ASAM for placement criteria and the utilization review process. These and other implementation efforts by UDOH and collaborators at DSAMH and other SUD service providing entities began in the early stages of demonstration roll out and have continued throughout these initial couple of years. But even with these early efforts, SUD service providers continue to report additional demand for treatment slots which creates delays for those seeking treatment.

COVID – 19 Adaptations

COVID-19 has impacted many aspects of the healthcare system, including SUD treatment services and programming. Two of the most important actions have been to quarantine beneficiaries before entering residential SUD treatment and to successfully transition outpatient individual and group therapeutic treatments from in-person to telehealth practice.

SUD Beneficiary Experience with Services

As previously described in the results section (SUD beneficiary experience with care) a beneficiary survey was conducted in the spring of 2020. Survey findings related to beneficiary understanding of the mental health and SUD service coverage provided, including service access availability, timeliness of services, and overall perceived quality of the services provided was encouraging. While beneficiary experience with care is not part of the SUD mid-point assessment of critical metrics per se, these findings do offer further evidence supporting the overall trend in positive SUD demonstration outcomes in Utah.

Conclusions

For many of the 1115 waiver hypotheses the results to date are largely preliminary, reflective of early stages in the demonstration projects and early analysis of available data. One must take pause in making any definitive conclusions from the descriptive statistics provided here due primarily to the absence of adjustment for critical demographic and health factors in the changing enrollment populations. Tests of significance indicated by p-values, given large samples, are not meaningful at this juncture, from the standpoint of clinical significance. All conclusions are therefore tentative and await that fuller assessment in forthcoming reports in subsequent years.

These preliminary results do not yet demonstrate improved access and utilization of appropriate health care and associated health outcomes. Further, the reduction in costs is not yet reflected in the summary statistics associated with the demonstration populations, despite incentivizing preventive and primary care in lieu of more expensive care such as that provided in the emergency room.

Some tentative results that appear to align with affirming certain hypotheses, however, merit attention. CE enrollees, for example, had an increase in hypertension prescriptions per member diagnosed with hypertension between 2018 and 2019. Increased access to preventive care, in other words, may have contributed to this increase of quality management.

Also, there was reduced non-emergent use of the ED over the period assessed for CE enrollees that drove the reduction in overall ED among that population.

It is unclear what drove such apparent improvements. Given the longer tenure of the CE program, this may suggest that it will take some time for reduction in non-emergent use to arise among more recent programs. It would reinforce that enhanced access to care may result early on in increased ED utilization, both emergent and non-emergent, but over time, as preventive and continuous ambulatory care is improved and incentivized, such enrollees may exhibit reductions in ED use. Of course, more definitive assessments of outcomes await further experience with the program and more data.

Substantial and increased enrollment in several of the demonstrations between 2018 and 2019 also suggest that the programs are meeting significant need. This is evident among the TA demonstration, where enrollment nearly doubled during that period. Smoking cessation program utilization increased concomitantly, as did antidepressant prescriptions and primary care visitations. These results all align with the intent of the demonstration, and better assessment of such access and utilization on health outcomes and cost await longer term data analysis.

Among the BDD program, there also appears to be a substantial increase in utilization of preventive dental services that swamped a far more modest increase in ED dental services. Again, ED dental utilization may subside with longer exposure to such enhanced access.

The Utah Premium Partnership (UPP) is one program where enrollment has languished as a small number. Access to employer-provided health insurance for this low-income population is likely not substantial, and it is also possible that the incentives in the program for employers to offer such insurance is not significant enough to achieve broader success.

The results for 2020, as noted in several instances, were likely reflective of the impact of the COVID-19 pandemic, and ought not to be considered at this juncture as indicative of trends. More detailed study of the effects of the pandemic of care among those enrolled in the demonstrations merit more attention.

Overall, most of the outcome measures are trending in the hypothesized direction, however as of 2018, none of the difference-in-difference models were significant which means there was no detectable impact of the demonstration on the outcomes.

For the SUD hypotheses, there were both positive and limited outcomes to date. Hypothesis 1, both Initiation and engagement of treatment had an increase in percentage over time as hypothesized, but there was no significant change. It is possible that the IMD expansion is not yet having an impact on this outcome or other external factors could have an influence. The same may be true for all the metrics.

For Hypothesis 2, Continuity of Pharmacotherapy had an increase in percentage over time in both groups but the difference was not significant. Continuity of pharmacotherapy for OUD has a decrease in both groups with a greater decrease in the comparison group. The difference in difference was not significant. For Any SUD treatment, there was a slight decrease in the target and a slight increase in the comparison but there were no significant changes.

For Hypothesis 3, Follow-up after ED had a decrease for 7 days and a decrease for 30 days with no significance. The rate for Inpatient stays for SUD had a small decrease that was not significant. The total number of inpatient stays decreased from 2016 to 2018 which is the desired direction but the total eligible population also decreased so the rates stayed similar in 2018 and were not significant. This could mean that the decrease was due more to the decrease in the number of eligible and that the IMD's had not yet been able to make an impact on the outcome in 2018.

For Hypothesis 4, preventative health care/ambulatory visits had an increase that was not significant. This may suggest, again, that the intervention is not yet having a detectable difference in the outcome because the demonstration policy hasn't been in place long enough. Bringing about population-based changes such as increasing preventive health services takes time. It is also critically important to both improving the health of individuals and reducing the overall costs of health care.

For Hypothesis 5, decreasing the rate of overdose deaths due to opioids has not been observed in both the number of deaths and rate thus far since demonstration implementation. This is likely due to the complex and multifaceted nature of opioid overdoses. These include factors such as: lack of awareness or understanding of the health risks of opioid usage on the respiratory system, overprescribing of opioids for pain relief, potential opioid drug interactions with other prescribed medications, and or alcohol or other illicit drugs. In order to bring about the desired reduction in opioid deaths, a well-designed implementation strategy that is tailored to address each of these factors will be required.

TAM

The rate of dental services for TAM (SUD) increased after implementation and decreased after March 2020. However, changes in dental rates could be due to other factors besides the TAM dental expansion. The COVID-19 lockdown could also account for the decrease in dental services after March 2020.

Clinically Managed Residential Withdrawal

For Hypothesis 1, emergency department utilization for SUD had an increase in rate over time in both groups which suggests there are external factors over time that have led to an increase such as Medicaid expansion or other policy changes. There was no significant difference between the target and comparison groups after the implementation of clinically managed withdraw services which indicates that clinically

managed withdraw services have not yet led to the hypothesized decrease in emergency department utilization rates for the target group as a whole.

For Hypothesis 2, mean emergency department expenditures had an increase in cost over time in both groups with a greater increase in the comparison group. However, there was no significant difference between the target and comparison groups after the implementation of clinically managed withdraw services which indicates that these services have not yet led to the hypothesized decrease in emergency department expenditures for the target group as a whole.

For Hypothesis 3, the number of inpatient services for SUD had an increase in percentage over time in both groups. The target group had a greater increase than the comparison group. SUD inpatient length of stay had a decrease in the target group and an increase in the comparison group. However, there was no significant difference between the target and comparison groups after the implementation of clinically managed withdraw services which indicates that these services have not yet led to the hypothesized decrease in the number of inpatient services or the length of stay in inpatient services for the target group as a whole. For the first three hypotheses, it is possible that the reach of the program is not yet sufficient to create a detectable direct impact on the outcome, or there may be other external factors that we could not account for that may influence the outcome.

For Hypothesis 4, the number of outpatient services for SUD had an increase in percentage over time in both groups with a greater increase in the target group. This change was significant with an 4.81% increase in the difference of the differences for outpatient services in the target group compared to the comparison group. This indicates that the implementation of clinically managed withdraw services may influence an increased utilization of outpatient services.

For Hypothesis 5, the number of withdrawal management for SUD had an increase in percentage over time in both groups with a greater increase in the target group. This change was significant with a 2.42% increase in the difference of the differences for withdrawal services in the target group compared to the comparison group. Since clinically managed withdraw services are a component of this metric, it is fairly intuitive that there was a significant increase in withdrawal management utilization in the target group compared to the comparison group.

For research questions related to Hypothesis 1 and 2, beneficiary experience with MH / SUD services appears to be quite positive. The vast majority of beneficiaries responding to the survey recognize there are specific services available in their community to address this specialized health care service, if needed. Of those members indicating they or a household member needed these services (in the previous 12 months) 61% agreed they were able to obtain care “as soon as needed”. When asked to provide a rating of counseling or treatment received in the last 12 months the average rating was 6.43/10. Additionally, and perhaps the most important beneficiary finding was that respondents rated the care they received, with 62% found the counseling or treatment helped (somewhat or a lot).

Finally, supplemental monitoring metrics for this interim evaluation were largely trending positively in the direction desired, indicating UDOH is likely on-track to achieve nearly all of their identified goals.

Specifically, of the individual monitoring metrics, 14 were rated as “low risk” of not being achieved by the end of waiver demonstration period. Only 2 were rated “medium risk” of not being achieved, and 4 metrics were rated “high risk” of not being achieved.

In summary, although none of the waiver hypotheses demonstrated statistically significant change in the expected direction at mid-point in the demonstration, this does not mean significant progress with implementation of additional SUD services has not been achieved yet. On the contrary, there has been rapid expansion of new SUD services to many beneficiaries with significant needs. There has also been extensive programming instituted to strengthen and build a strong foundation statewide for the SUD treatment agencies and individual providers.

Interpretations, Policy Implications and Interactions with Other State Initiatives

It is too early as yet to make conclusive judgments regarding policy implications to date of the demonstrations analyzed, given the tentativeness of the results noted above in section F above. Progress in achieving enhanced and more efficient access to care, and the resultant improved health outcomes and potential reductions in cost for these low-income populations likely encounter additional barriers associated, for example, with longstanding habits, the lack of conveyance of easily digested and culturally appropriate information, stigma in the provider and broader community, and stringent demands in an often-disruptive life.

On the other hand, there is distinct evidence that when resources are made available, that the eligible population makes use of services. And, as indicated in Section F above, there is also some indication that in programs that have a longer tenure, such as CE, distinct improvements in care and outcome may be manifest, partly as a result of new incentives incorporated in the program.

Although there were no significant differences in the first year after the demonstration, change can be slow with systematic implementation of interventions. More time with the SUD treatment interventions will be needed in order to determine if the implementation of IMD’s in the state are effective at improving the hypothesized outcomes. It can take a while for implementation to reach the level of fidelity where we would expect results. Treatment change can be slow when working with the high-risk SUD population. Bed space in IMD’s is continuing to increase which will improve access and may make year to year changes more detectable in the data if they are indeed effective. There is a small nominal improvement in most of the metrics from 2016 to 2018, with some indication that the rates are continuing to improve into 2019. It may be promising that the rates are moving in the hypothesized direction, even if the difference is not yet significant.

Beneficiary survey findings generally indicate a positive patient experience accessing services, doing so in a timely manner, and giving notable ratings to both the quality and helpfulness of the services received. Despite this and the changes policy supporting expanded SUD benefits, demand for services continues to exceed treatment slots and bed availability in the State. While the collaboration between UDOH and

DSAMH to strengthen the capacity of SUD treatment agencies and the professionals they employ has been key to the rapid roll out, ongoing long-term engagement between these entities and other SUD treatment agencies must continue to more fully realize the goals of the demonstration.

Lessons Learned and Recommendations

At this early stage of evaluation, the lessons learned are tentative, and therefore there are no attendant recommendations other than sustaining the 1115 Waiver demonstrations are likely worthwhile until greater experience with the programs are attained and more analysis with subsequent years of data are subject to evaluation. Given the stark impact of the COVID-19 pandemic on the health care system and upon its utilization, results from 2020 ought not to be considered indicative of trends.

In Utah, the Department of Health, Office of Health Care Statistics issued a report Preliminary COVID-19 Healthcare Trends: A Snapshot from Utah's All Payer Claims Database & Healthcare Facility Database (Updated December 2020). This report sought to highlight emerging healthcare consumption trends, utilizing insurance providers and hospitals with complete data for the entire period of analysis. They examined a wide variety of issues from telehealth to emergency department acute myocardial infarction, alcohol related disorders, and strokes. The utilization of nearly every condition saw significant decreases in March and April 2020. While these findings were not based on the experience of Medicaid beneficiaries, one specific finding related to preventive care visits and telehealth utilization demonstrated significant adoption of telehealth during the first and second quarter of 2020. This finding suggests there are further opportunities of utilizing telehealth. Similarly, behavioral health including SUD treatment quickly pivoted to utilize this technology.

Within the realm of SUD demonstration several lessons have been learned to date. First, the Utah implementation of additional SUD services could have prevented design changes by beginning collaboration with evaluators earlier in the demonstration planning process. The original evaluation design (DiD) will have to be changed to a single group longitudinal study design, because expansion of IMD facilities in the geographical location planned as a comparison site had a confounding effect on the design and analysis. The revised design will support examining change with appropriate controls in subsequent years of the demonstration. Systematic change can often take time to see results particularly considering that IMD's were not all implemented at once and the number of beds has continued to increase throughout the duration of the demonstration. As such, one year of data may not have been enough time to detect significant changes in the analyses.

Second, based on the rapid expansion and enrollment of beneficiaries in SUD services as well as the impressive monitoring outcomes achieved to date for many of the supplemental metrics, there appears to be a need to adjust some of the demonstration goals. For example, Milestone 1. "Access to critical levels of care for OUD and other SUDs" have some metrics (e.g. #7 – early intervention, #8 – outpatient services, and #10 residential and inpatient services) with overall demonstration target goals established with a "5% increase". This goal, given the progress to date appears to be too low as all three metrics have in three years doubled and in one case tripled the original goal. Similar outcomes were also achieved in a

number of other milestones and metrics. On the other end of the spectrum, there may also be the need to adjust and or change other target goals as achieving them may be unrealistic. An example of this would be with metric #18 whose definition changed after the first year, but the overall target waiver goal was not adjusted. A specific detailed discussion of this was included in the Supplemental Metrics section of this report.

Third, the central tenet of SUD treatment focuses on the goal of individual client behavior change. Accomplishing this goal at the individual level is a significant challenge for the most effective therapists. This is due to multiple factors including: the addictive nature of SUD, the involuntary participation of many in SUD treatment due to justice-system involvement, and other barriers that negatively impact effective treatment such as lack of jobs and inadequate housing supports for those seeking treatment.

Given these learnings, one recommendation regarding implementation of waiver policies and programs would be to have a well-developed implementation logic model for the provision of evidence-based SUD services. The logic model would serve as the key driver of all implementation efforts that focus on the policy goal and program service delivery. The logic model would also serve as a reference document to guide program implementation and monitoring efforts. Specifically, the logic model would enumerate actionable items that would ensure implementation of evidence-based practices (e.g. implementation of ASAM patient placement criteria) to fidelity. The logic model would also guide service providers to utilize fidelity checklists and other efforts to ensure other evidence-based therapeutic practices were being used by clinical staff.

References

1. Utah 1115 Demonstration Waiver. Project Number: 11-W-00145/8 & 21-W-0054/8 Quarterly Monitoring Report. Reporting Period Demonstration Year: 16 (07/01/2017 – 06/30/2018) Demonstration Quarter: 2 (10/01/2017 -12/31/2017)
2. Utah Primary Care Network. Approval Period: November 1, 2017 through June 30, 2022. Amendment Approved: December 23, 2019 CMS Expenditure Authority 11-W-00145/8 (Title XIX, 21-W-00054/8 (Title XXI)
3. SUD Evaluation Design TA 1: Substance Use Disorder (SUD) Section 1115 Demonstration Evaluation Design -- Technical Assistance March 6, 2019
4. Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations. (June 2018) White Paper. Mathematica Policy Research.
5. Somers, M. A., Zhu, P., Jacob, R., & Bloom, H. (2013). The Validity and Precision of the Comparative Interrupted Time Series Design and the Difference-in-Difference Design in Educational Evaluation. MDRC.
6. Hallberg, K., Williams, R., Swanlund, A., & Eno, J. (2018). Short comparative interrupted time series using aggregate school-level data in education research. Educational Researcher, 47(5), 295-306.
7. CAHPS Experience of Care and Health Outcomes (ECHO) Survey. Adult Managed Behavioral Healthcare Organization 3.0, Agency for Healthcare Research and Quality (AHRQ), Rockville, MD.
8. Coady, W., Simon, K., and Bello-Gomez, R. Designing Difference in Difference Studies: Best Practices for Public Health Policy Research, Annu. Rev. Public Health, 2018. 39:453-69. https://doi.org/10.1146/annurev-publhealth-040617-013507
9. Utah's Opioid Crisis Consequence and Resource Assessment. (2017). Utah Department of Human Services, Division of Substance Abuse and Mental Health.
10. Utah 1115 Demonstration Waiver Renewal Application. (2016). Utah Department of Health. 96-99.

Attachment A

A.1: Initiation in Alcohol and Other Drug Dependence Treatment Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-1.0597	0.1243	-8.5234	<0.0001
Group ● 1 = target ● 0 = comparison	-0.0149	0.0700	-0.2129	0.8314
Post ● 1 = 2018 ● 0 = 2016	0.0810	0.0835	0.9698	0.3322
DiD (interaction of Group and Post)	**0.0016**	**0.0994**	**0.0162**	**0.9870**
Gender ● 1 = male ● 0 = female	0.0987	0.0474	2.0817	0.0374
Race ● 1 = white ● 0 = other or unknown	-0.1527	0.0470	-3.2472	0.0012
Hispanic	0.0750	0.0720	1.0414	0.2977
Alcohol SUD	0.2408	0.0502	4.7971	<0.0001
Opioid SUD	0.2882	0.0488	5.9093	<0.0001
Other SUD	0.2745	0.0498	5.5090	<0.0001
Mental Health Diagnosis	-0.0107	0.0727	-0.1467	0.8834
Age	0.0049	0.0016	2.9905	0.0028

A.2: Engagement in Alcohol and Other Drug Dependence Treatment Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-0.8286	0.1983	-4.178	<0.001
Group • 1 = target • 0 = comparison	-0.3226	0.1218	-2.649	0.0081
Post • 1 = 2018 • 0 = 2016	0.2047	0.1370	1.494	0.1352
DiD	**0.1869**	**0.1680**	**1.112**	**0.2660**
Gender • 1 = male • 0 = female	0.0403	0.0825	0.488	0.6252
Race • 1 = white • 0 = other or unknown	-0.0175	0.0821	-0.213	0.8309
Hispanic	0.2059	0.1159	1.776	0.0758
Alcohol SUD	0.0928	0.0863	1.075	0.2821
Opioid SUD	0.3781	0.0836	4.521	<0.001
Other SUD	0.2623	0.0894	2.933	0.0034
Mental Health Diagnosis	-0.5177	0.1116	-4.637	<0.001
Age	-0.0353	0.0031	-11.355	<0.001

A.3: Continuity of Pharmacotherapy for OUD Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	0.4272	0.2806	2.32	0.1280
Group • 1 = target • 0 = comparison	-0.0806	0.2054	0.15	0.6948
Post • 1 = 2018 • 0 = 2016	-0.6338	0.2208	8.24	0.0041
DiD	**0.3281**	**0.2491**	**1.73**	**0.1879**
Gender • 1 = male • 0 = female	-0.0111	0.1258	0.01	0.1879
Race • 1 = white • 0 = other or unknown	0.3120	0.1178	7.02	0.0081
Hispanic	-0.2855	0.1885	2.29	0.1299
Alcohol SUD	-0.2505	0.2121	2.73	0.0984
Other SUD	-1.0829	0.1239	76.39	<0.0001
Mental Health Diagnosis	-0.6169	0.1247	24.48	<0.0001
Age	0.0164	0.0049	11.19	0.0008

A.4: Any SUD Treatment Service, Facility Claim, or Pharmacy Claim Logistic Regression Results.

Coefficient	Estimate	Std. Error	Wald	Pr(>|W|)
(Intercept)	-6.2971	0.05371	-117.25	<0.001
Group ● 1 = target ● 0 = comparison	0.1178	0.0453	2.60	0.0093
Post ● 1 = 2018 ● 0 = 2016	0.0216	0.0543	0.40	0.6903
Group*Post	**-0.0682**	**0.0650**	**-1.05**	**0.2939**
Gender ● 1 = male ● 0 = female	0.2058	0.0301	6.67	<0.001
Race ● 1 = white ● 0 = other or unknown	0.0656	0.0308	2.13	0.0330
Hispanic	-0.1826	0.0435	-4.20	<0.001
Alcohol SUD	6.7523	0.0618	109.28	<0.001
Opioid SUD	6.2182	0.0522	119.20	<0.001
Other SUD	6.4027	0.0501	127.87	<0.001
Mental Health Diagnosis	0.6231	0.0369	16.87	<0.001
Age	0.0051	0.0011	4.83	<0.001

A.5: Emergency Department Follow-up Within 7 Days Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-3.6150	0.5534	-6.5317	<0.0001
Group ● 1 = target ● 0 = comparison	0.0237	0.3196	0.0741	0.9409
Post ● 1 = 2018 ● 0 = 2016	-0.3896	0.4638	-0.8402	0.4008
DiD	**0.2829**	**0.5229**	**0.5411**	**0.5884**
Gender ● 1 = male ● 0 = female	0.0193	0.2166	0.0891	0.9290
Race ● 1 = white ● 0 = other or unknown	0.5823	0.2231	2.6107	0.0090
Hispanic	0.0936	0.4103	0.2280	0.8196
Opioid SUD	1.0966	0.2467	4.4460	<0.0001
Other SUD	0.0890	0.2412	0.3688	0.7123
Mental Health Diagnosis	0.5527	0.3347	1.6511	0.0987
Age	0.0145	0.0080	0.1898	0.0688

A.6: Emergency Department Follow-up Within 30 Days Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-3.5137	0.4809	-7.3069	<0.0001
Group ● 1 = target ● 0 = comparison	0.0567	0.2706	0.2097	0.8339
Post ● 1 = 2018 ● 0 = 2016	-0.1315	0.3633	-0.3619	0.7174
DiD	**0.0513**	**0.4165**	**0.1232**	**0.9019**
Gender ● 1 = male ● 0 = female	0.0795	0.1811	0.4389	0.6608
Race ● 1 = white ● 0 = other or unknown	0.2085	0.1804	1.1558	0.2478
Hispanic	0.2383	0.3405	0.6999	0.4840
Opioid SUD	0.8125	0.2184	3.7201	0.0002
Other SUD	0.1263	0.2025	0.6239	0.5327
Mental Health Diagnosis	0.9695	0.2973	3.2609	0.0011
Age	0.0208	0.0067	3.1187	0.0018

A.7: Inpatient Stays for SUD Logistic Regression Results.

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-6.6489	0.0605	-109.8601	<0.001
Group • 1 = target • 0 = comparison	-0.2685	0.0476	-5.6394	<0.001
Post • 1 = 2018 • 0 = 2016	-0.2057	0.0569	-3.6135	0.0003
DiD	**0.0487**	**0.0692**	**0.7043**	**0.4812**
Gender • 1 = male • 0 = female	-0.1345	0.0337	-3.9885	0.0001
Race • 1 = white • 0 = other or unknown	-0.1927	0.0331	-5.8279	<0.001
Hispanic	-0.1457	0.0515	-2.8298	0.0047
Alcohol SUD	3.5034	0.0420	83.3438	<0.001
Opioid SUD	2.8997	0.0380	76.2940	<0.001
Other SUD	3.2030	0.0360	88.8981	<0.001
Mental Health Diagnosis	0.9542	0.0377	25.2811	<0.001
Age	0.0293	0.0008	36.2006	<0.001

A.8: Access to Preventive/Ambulatory Health Services Logistic Regression Results.

Coefficient	Estimate	Std. Error	Wald	Pr(>|z|)
(Intercept)	-0.7128	0.1282	30.897	<0.001
Group • 1 = target • 0 = comparison	-0.0812	0.0744	1.190	0.2753
Post • 1 = 2018 • 0 = 2016	0.1948	0.0904	4.640	0.0312
Group*Post	**-0.0570**	**0.1066**	**0.286**	**0.5925**
Gender • 1 = male • 0 = female	-0.3036	0.0535	32.171	<0.001
Race • 1 = white • 0 = other or unknown	0.3111	0.0513	36.824	<0.001
Hispanic	0.1018	0.0852	1.426	0.2324
Alcohol SUD	-0.1375	0.0673	4.172	0.0411
Opioid SUD	0.4573	0.0654	48.941	<0.001
Other SUD	-0.3126	0.0607	26.561	<0.001
Mental Health Diagnosis	1.8117	0.0513	1245.627	<0.001
Age	0.0315	0.0021	223.789	<0.001

A.9: SUD Emergency Department Visit Logistic Regression Results

Coefficient	Estimate	Std. Error	z-value	Pr (>|z|)
(Intercept)	-3.3219	0.0125	-265.1204	<0.0001
Group • 1 = target • 0 = comparison	0.3983	0.0116	34.4264	<0.001
Post • 1 = After implementation • 0 = Before implementation	0.0245	0.0101	2.4319	0.0150
Time (months starting Nov 2015)	0.0050	0.0003	16.8460	<0.001
Group*Time (Interaction of Group and Time)	-0.0029	0.0004	-6.7586	<0.001
DiD (interaction of Group and Post)	**0.0256**	**0.0143**	**1.7936**	**0.0729**
Hispanic • 1 = yes • 0 = no	-0.1954	0.0076	-25.8015	<0.001
Age	0.0074	0.0002	46.6643	<0.001
Demonstration population: Blind/Disabled - Dental Eligible	-0.6484	0.0076	-85.1366	<0.001
Demonstration population: Current eligible CHIP Children	-12.5365	9.5791	-1.3087	0.1906
Demonstration population: Current Eligibles - PCR	-0.5219	0.0079	-66.3487	<0.001
Demonstration population: Demonstration population #3	-7.2908	1.000	-7.2904	<0.001

Demonstration population: Non-1115 waiver	-3.2939	0.0102	-321.7179	<0.001
Demonstration population: Targeted adults	1.7091	0.0086	198.4212	<0.001

A.10: SUD Inpatient Service Logistic Regression Results

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-3.4558	0.0129	-267.6510	<0.001
Group • 1 = target • 0 = comparison	0.3895	0.0120	32.5198	<0.001
Post • 1 = After implementation • 0 = Before implementation	0.0297	0.0104	2.9649	0.0042
Time (months starting Nov 2015)	0.0055	0.0003	17.8598	<0.001
Group*Time (Interaction of Group and Time)	-0.0027	0.0004	-6.1814	<0.001
DiD (interaction of Group and Post)	**0.0196**	**0.0147**	**1.3359**	**0.1816**
Hispanic • 1 = yes • 0 = no	-0.2226	0.0079	-28.2653	<0.001
Age	0.0087	0.0002	53.0586	<0.001
Demonstration population: Blind/Disabled - Dental Eligible	-0.6600	0.0078	-84.33=223	<0.001
Demonstration population: Current eligible CHIP Children	-13.4243	15.7920	-.08501	0.3953
Demonstration population: Current Eligibles - PCR	-0.4868	0.0081	-60.4257	<0.001
Demonstration population: Demonstration population #3	-13.6603	15.2376	-0.8I<965	0.3700
Demonstration population: Non-1115 waiver	-3.2788	0.0106	-309.9731	<0.001

Demonstration population: Targeted adults	1.6995	0.0088	193.1223	<0.001

A.11: SUD Outpatient Services

Coefficient	**Estimate**	**Std. Error**	**z-value**	**Pr(>|z|)**
(Intercept)	-0.2016	0.0230	-8.7595	<0.001
Group • 1 = target • 0 = comparison	-0.3708	0.0206	-18.0181	<0.001
Post • 1 = After implementation • 0 = Before implementation	-0.1234	0.0172	-7.1796	<0.001
Time (months starting Nov 2015)	0.0056	0.0005	11.0640	<0.001
Group*Time (Interaction of Group and Time)	-0.0059	0.0007	-7.8887	<0.001
DiD (interaction of Group and Post)	**0.3576**	**0.0248**	**14.4337**	**<0.001**
Gender • 1 = male • 0 = female	-0.2039	0.0079	-25.6940	<0.001
Age	0.0023	0.0003	6.7124	<0.001
Demonstration population: Blind/Disabled - Dental Eligible	-0.1539	0.0138	-11.1793	<0.001
Demonstration population: Current Eligibles - PCR	0.0927	0.0142	6.5161	<0.001
Demonstration population: Non-1115 waiver	-0.0421	0.0161	-2.6185	0.0088
Demonstration population: Targeted adults	0.2057	0.0141	14.5471	<0.001

A.12. SUD Withdrawal Management Services Logistic Regression Results

Coefficient	Estimate	Std. Error	z-value	Pr(>|z|)
(Intercept)	-4.1691	0.1008	-41.3585	<0.001
Group • 1 = target • 0 = comparison	0.1802	0.0963	1.8719	0.0612
Post • 1 = After implementation • 0 = Before implementation	0.2374	0.0877	2.7065	0.0068
Time (months starting Nov 2015)	-0.0099	0.0027	-3.7222	0.0002
Group*Time (Interaction of Group and Time)	0.0011	0.0035	0.3190	0.7497
DiD (interaction of Group and Post)	**1.0375**	**0.1118**	**9.2834**	**<0.001**
Gender • 1 = male • 0 = female	0.2252	0.0313	7.1952	<0.001
Age	0.0031	0.0014	2.2081	0.0272
Demonstration population: Blind/Disabled - Dental Eligible	-0.6072	0.0589	-12.4248	<0.001
Demonstration population: Current Eligibles - PCR	-0.3714	0.0515	-7.2079	<0.001
Demonstration population: Non-1115 waiver	-1.1692	0.0777	-15.0455	<0.001
Demonstration population: Targeted adults	-0.0800	0.0425	-1.8800	0.0601

Attachment B

2020 Utah Medicaid Beneficiary Survey

Start of Block: Default Question Block

QAge How old are you (in years)?

_____

Skip To: End of Block If Condition: How old are you (in years)? Is Less Than 18. Skip To: End of Block.

QReside In which state do you currently reside?

▼ Alabama (1) ... I do not reside in the United States (53)

Skip To: End of Block If 50 States, D.C. and Puerto Rico != Utah

QEnrolled Are you currently enrolled in Medicaid?

○ Yes (1)

○ No (2)

Skip To: End of Block If Are you currently enrolled in Medicaid? = No

Page Break

Q1 What is the name of your Medicaid medical plan?

- ○ Healthy U Medicaid Health Insurance (1)
- ○ Medicaid Fee for Service (2)
- ○ Molina Healthcare (3)
- ○ SelectHealth Community Care (4)
- ○ Health Choice Utah (5)

Q2 How long have you received health care through your medical plan?

- ○ Less than 6 months (1)
- ○ 6 months to 12 months (2)
- ○ More than 12 months (3)

Page Break

Q3BRFSS Prior to being enrolled in your current medical plan, did you have other health care coverage, including health insurance, prepaid plans such as HMO's or government plans such as Medicare, or Indian Health Service?

- ○ Yes (1)
- ○ No (2)

Skip To: Q4 If Prior to being enrolled in your current medical plan, did you have other health care coverage, in... = Yes

Skip To: Q5BRFSS If Prior to being enrolled in your current medical plan, did you have other health care coverage, in... = No

Q4 How long were you enrolled in that coverage?

- ○ Less than 6 months (1)
- ○ 6 months to 11 months (2)
- ○ 2 months to 23 months (3)
- ○ More than 24 months (4)

Q5BRFSS Was there a time before you were enrolled in your current medical plan when you needed to see a doctor but could not because of cost?

- ○ Yes (1)
- ○ No (2)

Q6CAHPS
Prior to being enrolled in your medical plan, how would you rate your overall physical health?

- ○ Excellent (1)
- ○ Very good (2)
- ○ Good (3)
- ○ Fair (4)
- ○ Poor (5)

Q7CAHPS
Prior to being enrolled in your medical plan, how would you rate your overall mental or emotional health?

- ○ Excellent (1)
- ○ Very good (2)
- ○ Good (3)
- ○ Fair (4)
- ○ Poor (5)

Page Break

Q8CAHPS Your Health Care in the Last 6 Months: These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room or doctor's office?

- ○ Yes (1)
- ○ No (2)

Skip To: Q9CAHPS If Your Health Care in the Last 6 Months: These questions ask about your own health care. Do not in... = Yes

Skip To: Q12CAHPS If Your Health Care in the Last 6 Months: These questions ask about your own health care. Do not in... = No

Q9CAHPS In the last 6 months, when you needed care right away, how often did you get care as soon as you needed it?

- ○ Never (1)
- ○ Sometimes (2)
- ○ Usually (3)
- ○ Always (4)

Q10ED When you needed care right away, did you go to an emergency room?

- ○ Yes (1)
- ○ No (2)

Skip To: Q11ED$ If When you needed care right away, did you go to an emergency room? = Yes
Skip To: Q12CAHPS If When you needed care right away, did you go to an emergency room? = No

Q11ED$ When you received medical treatment in the emergency room, were you required to pay a surcharge?

- ○ Yes (1)
- ○ No (2)

Q12CAHPS In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

- ○ Yes (1)
- ○ No (2)

Q13CAHPS In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

- None (1)
- 1 time (2)
- 2 times (3)
- 3 times (4)
- 4 times (5)
- 5-9 times (6)
- 10 or more times (7)

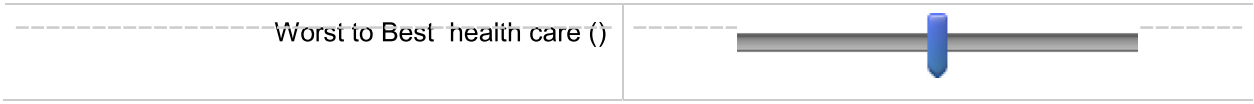
Skip To: Q15CAHPS If In the last 6 months, not counting the times you went to an emergency room, how many times did yo... = None

Q14CAHPS In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

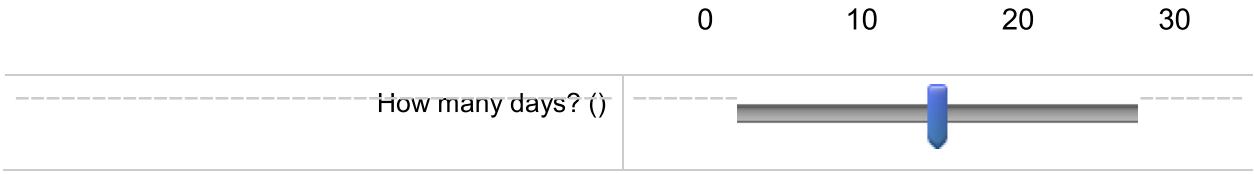
- Never (1)
- Sometimes (2)
- Usually (3)
- Always (4)

Q15CAHPS What number would you use to rate all your health care?

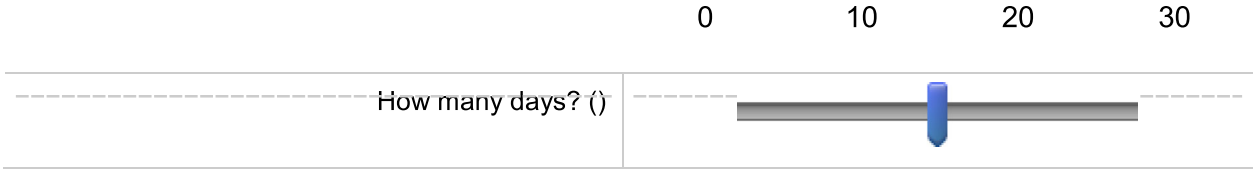
WORST POSSIBLE										BEST POSSIBLE
0	1	2	3	4	5	6	7	8	9	10



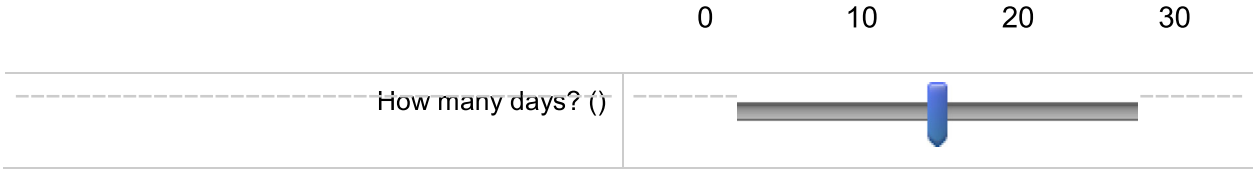
Q16BRFSS In thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?



Q17BRFSS In thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?



Q18BRFSS During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?



Page Break

Q19CAHPS Your Personal Doctor: This is someone you would see if you need a check-up, want advice about a health problem, or get sick or hurt.

Do you have a personal doctor?

- ○ Yes (1)
- ○ No (2)

Skip To: Q20CAHPS If Your Personal Doctor: This is someone you would see if you need a check-up, want advice about a h... = Yes

Skip To: Q26CAHPS If Your Personal Doctor: This is someone you would see if you need a check-up, want advice about a h... = No

Q20CAHPS In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

- ○ None (1)
- ○ 1 time (2)
- ○ 2 times (3)
- ○ 3 times (4)
- ○ 4 times (5)
- ○ 5 to 9 times (6)
- ○ 10 or more times (7)

Q21CAHPS In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

- ○ Never (1)
- ○ Sometimes (2)
- ○ Usually (3)
- ○ Always (4)

Q22CAHPS In the last 6 months, how often did your personal doctor listen carefully to you?

- ○ Never (1)
- ○ Sometimes (2)
- ○ Usually (3)
- ○ Always (4)

Q23CAPHS In the last 6 months, how often did your personal doctor show respect for what you had to say?

- ○ Never (1)
- ○ Sometimes (2)
- ○ Usually (3)
- ○ Always (4)

Q24CAHPS In the last 6 months, how often did your personal doctor spend enough time with you?

- ○ Never (1)
- ○ Sometimes (2)
- ○ Usually (3)
- ○ Always (4)

Q25CAHPS What number would you use to rate your personal doctor?

WORST POSSIBLE BEST POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

Worst to Best doctor ()

Page Break

Q26CAHPS Getting Dental Care: The next set of questions ask about your dental care, including any orthodontic procedures.

In the last 6 months did you make any appointments to see a dentist?

- ○ Yes (1)
- ○ No (2)

Skip To: Q27CAHPS If Getting Dental Care: The next set of questions ask about your dental care, including any orthodon... = Yes

Skip To: Q30ECHO If Getting Dental Care: The next set of questions ask about your dental care, including any orthodon... = No

Q27CAHPS
In the last 6 months, how often was it easy to get the care or treatment you needed?

- Never (1)
- Sometimes (2)
- Usually (3)
- Always (4)
- My Medicaid health plan does not include dental care (5)

Q28CAHPS In the last 6 months, how often did you get an appointment to see a dentist as soon as you needed?

- Never (1)
- Sometimes (2)
- Usually (3)
- Always (4)

Q29CAHPS What number would you use to rate the dentist or orthodontist you saw most often in the last 6 months?

WORST POSSIBLE BEST POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

Worst to Best Dentist ()

Page Break

Q30ECHO Your Health Plan: The next questions ask about your experience with other benefits available as part of your health care plan. For example, people can get counseling, treatment or medicine for many different reasons, such as:

- For feeling depressed, anxious, or “stressed out”
- Personal problems (like when a loved one dies or when there are problems at work)
- Family problems (like marriage problems or when parents and children have trouble getting along)
- Needing help with drug or alcohol use
- For mental or emotional illness

Are these health care services covered as part of your health care plan?

- ○ Yes (1)
- ○ No (2)
- ○ Don't know (3)

Q31ECHO If you felt depressed, needed assistance with drug or alcohol use, or mental or emotional illness are there places in your community you could go to get the help needed?

- ○ Yes (8)
- ○ No (9)
- ○ Don't know (10)

Q32ECHO In the last 12 months, have you or a member of your household needed counseling, treatment, or medicine for depression, drug or alcohol use, or mental or emotional illness?

- ○ Yes (8)
- ○ No (9)

Skip To: Q33ECHO If In the last 12 months, have you or a member of your household needed counseling, treatment, or me... = Yes

Skip To: Q36CAHPS If In the last 12 months, have you or a member of your household needed counseling, treatment, or me... = No

Q33ECHO In the last 12 months, when you or a member of your household needed counseling, treatment, or medicine , how often were you or a family member able to see someone as soon as needed?

- Never (1)
- Sometimes (2)
- Usually (3)
- Always (4)

Q34ECHO Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all the counseling or treatment in the last 12 months?

WORST POSSIBLE BEST POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

Worst to Best counseling or treatment ()

Q35ECHO In the last 12 months, how much were you or a member of your household helped by the counseling, treatment, or medicine?

- Not at all (1)
- A little (2)
- Somewhat (3)
- A lot (4)

Page Break

Q36CAHPS The last few questions ask about you?

In general, how would you rate your overall physical health?

- Excellent (1)
- Very good (2)
- Good (3)
- Fair (4)
- Poor (5)

Q37CAHPS
In general, how would you rate your overall mental or emotional health?

- Excellent (1)
- Very good (2)
- Good (3)
- Fair (4)
- Poor (5)

Q38CAHPS Are you male or female?

- Male (1)
- Female (2)

Q39 What language do you mainly speak at home?

- ○ English (1)
- ○ Spanish (2)
- ○ Other (3) _____

Q40CAHPS What is the highest grade or level of school you have completed?

- ○ 8th grade or less (1)
- ○ Some high school, but did not graduate (2)
- ○ High school graduate or GED (3)
- ○ Some college or 2-year degree (4)
- ○ 4-year college graduate (5)
- ○ More than 4-year college degree (6)

Q41CAHPS Are you of Hispanic or Latino origin or descent?

- ○ Yes, Hispanic or Latino (1)
- ○ No, not Hispanic or Latino (2)

Q42CAHPS What is your race?

- ○ White (1)
- ○ Black or African American (2)
- ○ Asian (3)
- ○ Native Hawaiian or Other Pacific Islander (4)
- ○ American Indian or Alaska Native (5)
- ○ Other (6) _____

Q43 Which county do you live in?

▼ Beaver (1) ... Weber (29)

Q44BRFSS Are you currently. . ?

- ○ Employed for wages (1)
- ○ Self-employed (2)
- ○ Out of work for 1 year or more (3)
- ○ Out of work for less than 1 year (4)
- ○ A Homemaker (5)
- ○ A Student (6)
- ○ Retired (7)
- ○ Unable to work (8)

End of Block: Default Question Block

Medicaid Beneficiary Survey Frequency Tables

How old are you (in years)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.57	1	.2	.2	.2
	18.00	17	4.1	4.1	4.3
	19.00	9	2.2	2.2	6.5
	20.00	20	4.8	4.8	11.3
	21.00	17	4.1	4.1	15.4
	22.00	10	2.4	2.4	17.8
	23.00	5	1.2	1.2	19.0
	24.00	15	3.6	3.6	22.7
	25.00	11	2.7	2.7	25.3
	26.00	17	4.1	4.1	29.4
	27.00	7	1.7	1.7	31.1
	28.00	15	3.6	3.6	34.7
	29.00	10	2.4	2.4	37.1
	30.00	10	2.4	2.4	39.5
	31.00	9	2.2	2.2	41.7
	32.00	16	3.9	3.9	45.5
	33.00	14	3.4	3.4	48.9
	34.00	10	2.4	2.4	51.3
	35.00	11	2.7	2.7	54.0
	36.00	13	3.1	3.1	57.1
	37.00	13	3.1	3.1	60.2
	38.00	9	2.2	2.2	62.4

	39.00	7	1.7	1.7	64.1
	40.00	7	1.7	1.7	65.8
	41.00	12	2.9	2.9	68.7
	42.00	7	1.7	1.7	70.4
	43.00	5	1.2	1.2	71.6
	44.00	6	1.4	1.4	73.0
	45.00	5	1.2	1.2	74.2
	46.00	6	1.4	1.4	75.7
	47.00	7	1.7	1.7	77.3
	48.00	9	2.2	2.2	79.5
	49.00	8	1.9	1.9	81.4
	50.00	9	2.2	2.2	83.6
	51.00	7	1.7	1.7	85.3
	52.00	6	1.4	1.4	86.7
	53.00	4	1.0	1.0	87.7
	54.00	3	.7	.7	88.4
	55.00	2	.5	.5	88.9
	57.00	2	.5	.5	89.4
	58.00	3	.7	.7	90.1
	59.00	2	.5	.5	90.6
	60.00	5	1.2	1.2	91.8
	61.00	4	1.0	1.0	92.8
	62.00	1	.2	.2	93.0
	63.00	1	.2	.2	93.3
	64.00	4	1.0	1.0	94.2
	65.00	3	.7	.7	94.9

	66.00	2	.5	.5	95.4
	67.00	1	.2	.2	95.7
	68.00	2	.5	.5	96.1
	69.00	2	.5	.5	96.6
	70.00	2	.5	.5	97.1
	71.00	2	.5	.5	97.6
	72.00	4	1.0	1.0	98.6
	74.00	2	.5	.5	99.0
	75.00	2	.5	.5	99.5
	79.00	1	.2	.2	99.8
	1999.00	1	.2	.2	100.0
	Total	415	100.0	100.0	

State of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Utah	415	100.0	100.0	100.0

Are you currently enrolled in Medicaid?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	415	100.0	100.0	100.0

What is the name of your Medicaid medical plan?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Healthy U Medicaid Health Insurance	101	24.3	24.3	24.3
	Medicaid Fee for Service	26	6.3	6.3	30.6
	Molina Healthcare	94	22.7	22.7	53.3
	SelectHealth Community Care	131	31.6	31.6	84.8
	Health Choice Utah	63	15.2	15.2	100.0
	Total	415	100.0	100.0	

How long have you received health care through your medical plan?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 6 months	100	24.1	24.1	24.1
	6 months to 12 months	102	24.6	24.6	48.7
	More than 12 months	213	51.3	51.3	100.0
	Total	415	100.0	100.0	

Prior to being enrolled in your current medical plan, did you have other health care coverage, including health insurance, prepaid plans such as HMO's or government plans such as Medicare, or Indian Health Service?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	179	43.1	43.1	43.1
	No	236	56.9	56.9	100.0
	Total	415	100.0	100.0	

How long were you enrolled in that coverage?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 6 months	13	3.1	7.3	7.3
	6 months to 11 months	28	6.7	15.6	22.9
	2 months to 23 months	32	7.7	17.9	40.8
	More than 24 months	106	25.5	59.2	100.0
	Total	179	43.1	100.0	
Missing	System	236	56.9		
Total		415	100.0		

Was there a time before you were enrolled in your current medical plan when you needed to see a doctor but could not because of cost?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	249	60.0	60.0	60.0
	No	166	40.0	40.0	100.0
	Total	415	100.0	100.0	

Prior to being enrolled in your medical plan, how would you rate your overall physical health?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	52	12.5	12.5	12.5
	Very good	85	20.5	20.5	33.0
	Good	139	33.5	33.5	66.5
	Fair	97	23.4	23.4	89.9
	Poor	42	10.1	10.1	100.0
	Total	415	100.0	100.0	

Prior to being enrolled in your medical plan, how would you rate your overall mental or emotional health?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	65	15.7	15.7	15.7
	Very good	64	15.4	15.4	31.1
	Good	111	26.7	26.7	57.8
	Fair	109	26.3	26.3	84.1
	Poor	66	15.9	15.9	100.0
	Total	415	100.0	100.0	

Your Health Care in the Last 6 Months: These questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

In the last 6 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room or doctor's office?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	199	48.0	48.0	48.0
	No	216	52.0	52.0	100.0
	Total	415	100.0	100.0	

In the last 6 months, when you needed care right away, how often did you get care as soon as you needed it?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	10	2.4	5.0	5.0
	Sometimes	64	15.4	32.2	37.2
	Usually	63	15.2	31.7	68.8
	Always	62	14.9	31.2	100.0
	Total	199	48.0	100.0	
Missing	System	216	52.0		
Total		415	100.0		

When you needed care right away, did you go to an emergency room?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	141	34.0	70.9	70.9
	No	58	14.0	29.1	100.0
	Total	199	48.0	100.0	
Missing	System	216	52.0		
Total		415	100.0		

When you received medical treatment in the emergency room, were you required to pay a surcharge?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	41	9.9	29.1	29.1
	No	100	24.1	70.9	100.0
	Total	141	34.0	100.0	
Missing	System	274	66.0		
Total		415	100.0		

In the last 6 months, did you make any appointments for a check-up or routine care at a doctor's office or clinic?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	285	68.7	68.7	68.7
	No	130	31.3	31.3	100.0
	Total	415	100.0	100.0	

In the last 6 months, not counting the times you went to an emergency room, how many times did you go to a doctor's office or clinic to get health care for yourself?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	107	25.8	25.8	25.8
	1 time	72	17.3	17.3	43.1
	2 times	78	18.8	18.8	61.9
	3 times	60	14.5	14.5	76.4
	4 times	25	6.0	6.0	82.4
	5-9 times	44	10.6	10.6	93.0
	10 or more times	29	7.0	7.0	100.0
	Total	415	100.0	100.0	

In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	16	3.9	5.2	5.2
	Sometimes	113	27.2	36.7	41.9
	Usually	109	26.3	35.4	77.3
	Always	70	16.9	22.7	100.0
	Total	308	74.2	100.0	
Missing	System	107	25.8		
Total		415	100.0		

What number would you use to rate all your health care? - Worst to Best health care

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	3	.7	.7	.7
	1.00	3	.7	.7	1.4
	2.00	9	2.2	2.2	3.6
	3.00	11	2.7	2.7	6.3
	4.00	18	4.3	4.3	10.6
	5.00	53	12.8	12.8	23.4
	6.00	48	11.6	11.6	34.9
	7.00	63	15.2	15.2	50.1
	8.00	81	19.5	19.5	69.6
	9.00	60	14.5	14.5	84.1
	10.00	66	15.9	15.9	100.0
	Total	415	100.0	100.0	

In thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? - How many days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	56	13.5	13.5	13.5
	1.00	36	8.7	8.7	22.2
	2.00	27	6.5	6.5	28.7
	3.00	29	7.0	7.0	35.7
	4.00	24	5.8	5.8	41.4
	5.00	28	6.7	6.7	48.2
	6.00	17	4.1	4.1	52.3
	7.00	12	2.9	2.9	55.2
	8.00	9	2.2	2.2	57.3
	9.00	10	2.4	2.4	59.8
	10.00	23	5.5	5.5	65.3
	11.00	14	3.4	3.4	68.7
	12.00	7	1.7	1.7	70.4
	13.00	8	1.9	1.9	72.3
	14.00	6	1.4	1.4	73.7
	15.00	13	3.1	3.1	76.9
	16.00	6	1.4	1.4	78.3
	17.00	4	1.0	1.0	79.3
	18.00	1	.2	.2	79.5
	19.00	4	1.0	1.0	80.5
	20.00	12	2.9	2.9	83.4
	21.00	8	1.9	1.9	85.3

	22.00	4	1.0	1.0	86.3
	23.00	6	1.4	1.4	87.7
	24.00	4	1.0	1.0	88.7
	25.00	5	1.2	1.2	89.9
	26.00	6	1.4	1.4	91.3
	27.00	3	.7	.7	92.0
	28.00	3	.7	.7	92.8
	29.00	1	.2	.2	93.0
	30.00	29	7.0	7.0	100.0
	Total	415	100.0	100.0	

In thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? - How many days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	43	10.4	10.4	10.4
	1.00	23	5.5	5.5	15.9
	2.00	22	5.3	5.3	21.2
	3.00	15	3.6	3.6	24.8
	4.00	14	3.4	3.4	28.2
	5.00	21	5.1	5.1	33.3
	6.00	17	4.1	4.1	37.3
	7.00	13	3.1	3.1	40.5
	8.00	8	1.9	1.9	42.4
	9.00	7	1.7	1.7	44.1

	10.00	28	6.7	6.7	50.8
	11.00	7	1.7	1.7	52.5
	12.00	11	2.7	2.7	55.2
	13.00	8	1.9	1.9	57.1
	14.00	8	1.9	1.9	59.0
	15.00	17	4.1	4.1	63.1
	16.00	14	3.4	3.4	66.5
	17.00	8	1.9	1.9	68.4
	18.00	6	1.4	1.4	69.9
	19.00	5	1.2	1.2	71.1
	20.00	25	6.0	6.0	77.1
	21.00	12	2.9	2.9	80.0
	22.00	6	1.4	1.4	81.4
	23.00	3	.7	.7	82.2
	24.00	4	1.0	1.0	83.1
	25.00	17	4.1	4.1	87.2
	26.00	4	1.0	1.0	88.2
	27.00	5	1.2	1.2	89.4
	28.00	5	1.2	1.2	90.6
	29.00	1	.2	.2	90.8
	30.00	38	9.2	9.2	100.0
	Total	415	100.0	100.0	

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? - How many days?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	56	13.5	13.5	13.5
	1.00	35	8.4	8.4	21.9
	2.00	26	6.3	6.3	28.2
	3.00	17	4.1	4.1	32.3
	4.00	13	3.1	3.1	35.4
	5.00	15	3.6	3.6	39.0
	6.00	13	3.1	3.1	42.2
	7.00	11	2.7	2.7	44.8
	8.00	9	2.2	2.2	47.0
	9.00	7	1.7	1.7	48.7
	10.00	16	3.9	3.9	52.5
	11.00	9	2.2	2.2	54.7
	12.00	11	2.7	2.7	57.3
	13.00	6	1.4	1.4	58.8
	14.00	15	3.6	3.6	62.4
	15.00	18	4.3	4.3	66.7
	16.00	7	1.7	1.7	68.4
	17.00	5	1.2	1.2	69.6
	18.00	5	1.2	1.2	70.8
	19.00	4	1.0	1.0	71.8
	20.00	22	5.3	5.3	77.1
	21.00	15	3.6	3.6	80.7

	22.00	8	1.9	1.9	82.7
	23.00	10	2.4	2.4	85.1
	24.00	4	1.0	1.0	86.0
	25.00	8	1.9	1.9	88.0
	26.00	3	.7	.7	88.7
	27.00	2	.5	.5	89.2
	28.00	4	1.0	1.0	90.1
	29.00	1	.2	.2	90.4
	30.00	40	9.6	9.6	100.0
	Total	415	100.0	100.0	

Your Personal Doctor: This is someone you would see if you need a check-up, want advice about a health problem, or get sick or hurt.

Do you have a personal doctor?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	293	70.6	70.6	70.6
	No	122	29.4	29.4	100.0
	Total	415	100.0	100.0	

In the last 6 months, how many times did you visit your personal doctor to get care for yourself?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	36	8.7	12.3	12.3
	1 time	79	19.0	27.0	39.2
	2 times	65	15.7	22.2	61.4
	3 times	52	12.5	17.7	79.2
	4 times	22	5.3	7.5	86.7
	5 to 9 times	26	6.3	8.9	95.6
	10 or more times	13	3.1	4.4	100.0
	Total	293	70.6	100.0	
Missing	System	122	29.4		
Total		415	100.0		

In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	25	6.0	8.5	8.5
	Sometimes	35	8.4	11.9	20.5
	Usually	76	18.3	25.9	46.4
	Always	157	37.8	53.6	100.0
	Total	293	70.6	100.0	
Missing	System	122	29.4		
Total		415	100.0		

In the last 6 months, how often did your personal doctor listen carefully to you?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	22	5.3	7.5	7.5
	Sometimes	38	9.2	13.0	20.5
	Usually	76	18.3	25.9	46.4
	Always	157	37.8	53.6	100.0
	Total	293	70.6	100.0	
Missing	System	122	29.4		
Total		415	100.0		

In the last 6 months, how often did your personal doctor show respect for what you had to say?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	23	5.5	7.8	7.8
	Sometimes	30	7.2	10.2	18.1
	Usually	71	17.1	24.2	42.3
	Always	169	40.7	57.7	100.0
	Total	293	70.6	100.0	
Missing	System	122	29.4		
Total		415	100.0		

In the last 6 months, how often did your personal doctor spend enough time with you?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	20	4.8	6.8	6.8
	Sometimes	56	13.5	19.1	25.9
	Usually	93	22.4	31.7	57.7
	Always	124	29.9	42.3	100.0
	Total	293	70.6	100.0	
Missing	System	122	29.4		
Total		415	100.0		

What number would you use to rate your personal doctor? - Worst to Best doctor

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	1.0	1.4	1.4
	1.00	4	1.0	1.4	2.7
	3.00	8	1.9	2.7	5.5
	4.00	12	2.9	4.1	9.6
	5.00	21	5.1	7.2	16.7
	6.00	8	1.9	2.7	19.5
	7.00	27	6.5	9.2	28.7
	8.00	36	8.7	12.3	41.0
	9.00	48	11.6	16.4	57.3
	10.00	125	30.1	42.7	100.0
	Total	293	70.6	100.0	

Missing	System	122	29.4		
Total		415	100.0		

Getting Dental Care: The next set of questions ask about your dental care, including any orthodontic procedures.

In the last 6 months did you make any appointments to see a dentist?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	164	39.5	39.5	39.5
	No	251	60.5	60.5	100.0
	Total	415	100.0	100.0	

In the last 6 months, how often was it easy to get the care or treatment you needed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	10	2.4	6.1	6.1
	Sometimes	29	7.0	17.7	23.8
	Usually	44	10.6	26.8	50.6
	Always	52	12.5	31.7	82.3
	My Medicaid health plan does not include dental care	29	7.0	17.7	100.0
	Total	164	39.5	100.0	
Missing	System	251	60.5		
Total		415	100.0		

In the last 6 months, how often did you get an appointment to see a dentist as soon as you needed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	16	3.9	9.8	9.8
	Sometimes	54	13.0	32.9	42.7
	Usually	40	9.6	24.4	67.1
	Always	54	13.0	32.9	100.0
	Total	164	39.5	100.0	
Missing	System	251	60.5		
Total		415	100.0		

What number would you use to rate the dentist or orthodontist you saw most often in the last 6 months? - Worst to Best Dentist

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	1.0	2.4	2.4
	1.00	2	.5	1.2	3.7
	2.00	3	.7	1.8	5.5
	3.00	8	1.9	4.9	10.4
	4.00	6	1.4	3.7	14.0
	5.00	9	2.2	5.5	19.5
	6.00	18	4.3	11.0	30.5
	7.00	17	4.1	10.4	40.9
	8.00	21	5.1	12.8	53.7
	9.00	26	6.3	15.9	69.5
	10.00	50	12.0	30.5	100.0

	Total	164	39.5	100.0	
Missing	System	251	60.5		
Total		415	100.0		

Your Health Plan: The next questions ask about your experience with other benefits available as part of your health care plan. For example, people can get counseling, treatment or medicine for many different reasons, such as:

- **For feeling depressed, anxious, or "stressed out"**
- **Personal problems (like when a loved one dies or when there are problems at work)**
- **Family problems (like marriage problems or when parents and children have trouble getting along)**
- **Needing help with drug or alcohol use**
- **For mental or emotional illness**

Are these health care services covered as part of your health care plan?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	227	54.7	79.9	79.9
	No	57	13.7	20.1	100.0
	Total	284	68.4	100.0	
Missing	System	131	31.6		
Total		415	100.0		

If you felt depressed, needed assistance with drug or alcohol use, or mental or emotional illness are there places in your community you could go to get the help needed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	286	68.9	68.9	68.9
	No	46	11.1	11.1	80.0
	Don't know	83	20.0	20.0	100.0
	Total	415	100.0	100.0	

In the last 12 months, have you or a member of your household needed counseling, treatment, or medicine for depression, drug or alcohol use, or mental or emotional illness?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	226	54.5	54.5	54.5
	No	189	45.5	45.5	100.0
	Total	415	100.0	100.0	

In the last 12 months, when you or a member of your household needed counseling, treatment, or medicine , how often were you or a family member able to see someone as soon as needed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	26	6.3	11.5	11.5
	Sometimes	62	14.9	27.4	38.9
	Usually	80	19.3	35.4	74.3
	Always	58	14.0	25.7	100.0
	Total	226	54.5	100.0	
Missing	System	189	45.5		
Total		415	100.0		

Using any number from 0 to 10, where 0 is the worst counseling or treatment possible and 10 is the best counseling or treatment possible, what number would you use to rate all the counseling or treatment in the last 12 months? - Worst to Best counseling or treatment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	8	1.9	3.5	3.5
	1.00	5	1.2	2.2	5.8
	2.00	15	3.6	6.6	12.4
	3.00	12	2.9	5.3	17.7
	4.00	19	4.6	8.4	26.1
	5.00	19	4.6	8.4	34.5
	6.00	21	5.1	9.3	43.8
	7.00	31	7.5	13.7	57.5
	8.00	32	7.7	14.2	71.7
	9.00	27	6.5	11.9	83.6
	10.00	37	8.9	16.4	100.0
	Total	226	54.5	100.0	
Missing	System	189	45.5		
Total		415	100.0		

In the last 12 months, how much were you or a member of your household helped by the counseling, treatment, or medicine?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Not at all	24	5.8	10.6	10.6
	A little	62	14.9	27.4	38.1
	Somewhat	76	18.3	33.6	71.7
	A lot	64	15.4	28.3	100.0
	Total	226	54.5	100.0	
Missing	System	189	45.5		
Total		415	100.0		

The last few questions ask about you?

In general, how would you rate your overall physical health?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	51	12.3	12.3	12.3
	Very good	87	21.0	21.0	33.3
	Good	136	32.8	32.8	66.0
	Fair	103	24.8	24.8	90.8
	Poor	38	9.2	9.2	100.0
	Total	415	100.0	100.0	

In general, how would you rate your overall mental or emotional health?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Excellent	50	12.0	12.0	12.0
	Very good	71	17.1	17.1	29.2
	Good	113	27.2	27.2	56.4
	Fair	129	31.1	31.1	87.5
	Poor	52	12.5	12.5	100.0
	Total	415	100.0	100.0	

Are you male or female?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	150	36.1	36.1	36.1
	Female	265	63.9	63.9	100.0
	Total	415	100.0	100.0	

What language do you mainly speak at home? - Selected Choice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	English	400	96.4	96.4	96.4
	Spanish	9	2.2	2.2	98.6
	Other	6	1.4	1.4	100.0
	Total	415	100.0	100.0	

What language do you mainly speak at home? - Other - Text

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		410	98.8	98.8	98.8
	Arabic	2	.5	.5	99.3
	Karen	1	.2	.2	99.5
	Vietnamese	2	.5	.5	100.0
	Total	415	100.0	100.0	

What is the highest grade or level of school you have completed?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	8th grade or less	9	2.2	2.2	2.2
	Some high school, but did not graduate	31	7.5	7.5	9.6
	High school graduate or GED	143	34.5	34.5	44.1
	Some college or 2-year degree	152	36.6	36.6	80.7
	4-year college graduate	55	13.3	13.3	94.0
	More than 4-year college degree	25	6.0	6.0	100.0
	Total	415	100.0	100.0	

Are you of Hispanic or Latino origin or descent?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes, Hispanic or Latino	64	15.4	15.5	15.5
	No, not Hispanic or Latino	349	84.1	84.5	100.0
	Total	413	99.5	100.0	
Missing	System	2	.5		
Total		415	100.0		

What is your race? - Selected Choice

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	356	85.8	85.8	85.8
	Black or African American	13	3.1	3.1	88.9
	Asian	15	3.6	3.6	92.5
	Native Hawaiian or Other Pacific Islander	6	1.4	1.4	94.0
	American Indian or Alaska Native	8	1.9	1.9	95.9
	Other	17	4.1	4.1	100.0
	Total	415	100.0	100.0	

What is your race? - Other - Text

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		399	96.1	96.1	96.1
	American Chileno	1	.2	.2	96.4
	Black and white	2	.5	.5	96.9
	Egyptian	1	.2	.2	97.1
	Hidpanic	1	.2	.2	97.3
	hispanic	1	.2	.2	97.6
	Hispanic	4	1.0	1.0	98.6
	latino	1	.2	.2	98.8
	Latino	1	.2	.2	99.0
	Mexican	1	.2	.2	99.3
	Mixed	1	.2	.2	99.5

	Multi racial	1	.2	.2	99.8
	white,black,and native american	1	.2	.2	100.0
	Total	415	100.0	100.0	

Which county do you live in?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Box Elder	7	1.7	1.7	1.7
	Cache	8	1.9	1.9	3.6
	Carbon	3	.7	.7	4.3
	Davis	28	6.7	6.8	11.1
	Duchesne	6	1.4	1.4	12.6
	Emery	1	.2	.2	12.8
	Iron	11	2.7	2.7	15.5
	Juab	2	.5	.5	15.9
	Millard	2	.5	.5	16.4
	Salt Lake	157	37.8	37.9	54.3
	San Juan	1	.2	.2	54.6
	Sanpete	5	1.2	1.2	55.8
	Sevier	3	.7	.7	56.5
	Summit	2	.5	.5	57.0
	Tooele	6	1.4	1.4	58.5
	Uintah	2	.5	.5	58.9
	Utah	101	24.3	24.4	83.3
	Wasatch	6	1.4	1.4	84.8
	Washington	13	3.1	3.1	87.9

	Weber	50	12.0	12.1	100.0
	Total	414	99.8	100.0	
Missing	System	1	.2		
Total		415	100.0		

Are you currently. . ?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Employed for wages	132	31.8	31.8	31.8
	Self-employed	34	8.2	8.2	40.0
	Out of work for 1 year or more	27	6.5	6.5	46.5
	Out of work for less than 1 year	31	7.5	7.5	54.0
	A Homemaker	40	9.6	9.6	63.6
	A Student	32	7.7	7.7	71.3
	Retired	26	6.3	6.3	77.6
	Unable to work	93	22.4	22.4	100.0
	Total	415	100.0	100.0	

Attachment C

CMS-approved Evaluation Design

UTAH 1115 PRIMARY CARE NETWORK DEMONSTRATION WAIVER

SUBSTANCE USE DISORDER EVALUATION DESIGN

Prepared by: Rodney W. Hopkins, M.S.
Kristen West, MPA

Social Research Institute
College of Social Work
THE UNIVERSITY OF UTAH

INTRODUCTION

In October 2017, the Utah Department of Health (UDOH), Division of Medicaid and Health Financing (DMHF) received a five-year extension to its 1115 Primary Care Network (PCN) Demonstration Waiver. This extension adds covered benefits and continues providing health coverage to eight vulnerable population groups, some of whom are not eligible for Medicaid under the state plan.

This proposal will both track the general performance of the 1115 waiver and evaluate demonstration impacts and outcomes. Results of the evaluation will be presented in a series of annual reports, as well as interim and final evaluation reports. This draft proposal identifies the general design and approach of the evaluation in response to the required Special Terms and Conditions (STC's).

A. GENERAL BACKGROUND INFORMATION

Utah's 1115 PCN Demonstration Waiver (hereinafter referred to as "Demonstration") is a statewide waiver that was originally approved on February 8, 2002 and implemented on July 1, 2002. Since that time, the Demonstration has been extended and amended several times to add additional benefits and Medical programs. Most recently, the Demonstration was amended and approved on October 31, 2017 with an approval period through June 30, 2022. The evaluation will cover the Demonstration approval period.

Waiver Population Groups
The Demonstration authorizes the State of Utah to administer the following medical programs and benefits:

- PCN Program (Demonstration Population I) - Provides a limited package of preventive and primary care benefits to adults age 19-64.
- Current Eligibles - Provides a slightly reduced benefit package for adults receiving Parent/Caretaker Relative (PCR) Medicaid.
- Utah's Premium Partnership Program (UPP) (Demonstration Populations III, V & VI) - Provides premium assistance to pay the individual's or family's share of monthly premium costs of employer sponsored insurance or COBRA.
- Targeted Adult Medicaid- Provides state plan Medicaid benefits to a targeted group of adults without dependent children.
- Former Foster Care Youth from Another State- Provides state plan Medicaid benefits to former foster care youth from another state up to age 26.
- Dental Benefits for Individuals who are Blind or Disabled- Provides dental benefits to individuals age 18 and older with blindness or disabilities.
- Substance Use Disorder (SUD) Residential Treatment- Allows the State to provide a broad continuum of care which includes SUD residential treatment in an Institution for Mental Disease (IMD) for all Medicaid eligible individuals.

This Evaluation Design will focus on the SUD component of the Demonstration, which provides a broad continuum of care for all Medicaid eligible individuals. This is an important Medicaid addition due to the significant impact substance use disorders have on the health and well-being of Utahans.

Prior to the approval of this demonstration, individuals who were receiving SUD residential treatment in an IMD were not eligible to receive Medicaid. SUD services provided in residential and inpatient treatment settings that qualified as an IMD, were not otherwise matchable expenditures under section 1903 of the Act. Individuals needing treatment waited months to receive residential treatment due to the low number of treatment beds available in smaller facilities. Prior to implementation of the demonstration, there were approximately 50 treatment beds available. Since implementation, approximately 490 additional treatment beds have been added Statewide. The State currently has seven SUD treatment facilities that meet the definition of a SUD IMD facility.

Substance Use Disorders in the United States

Behavioral health disorders, which include substance use and mental health disorders, affect millions of adolescents and adults in the United States and contribute heavily to the burden of disease.[1,2,3] Illicit drug use, including the misuse of prescription medications, affects the health and well-being of millions of Americans. Cardiovascular disease, stroke, cancer, infection with the human immunodeficiency virus (HIV), hepatitis, and lung disease can all be affected by drug use. Some of these effects occur when drugs are used at high doses or after prolonged use. However, other adverse effects can occur after only one or a few occasions of use.[4] Addressing the impact of substance use alone is estimated to cost Americans more than $600 billion each year.[5]

Reducing SUD and related problems is critical to Americans' mental and physical health, safety, and quality of life. SUDs occur when the recurrent use of alcohol or other drugs (or both) causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. These disorders contribute heavily to the burden of disease in the United States. Excessive substance use and SUDs are costly to our nation due to lost productivity, health care, and crime. [6, 7, 8] Approximately 23.3 million people aged 12 or older in 2016 had SUDs in the past year, including 15.6 million people with an alcohol use disorder and 7.4 million people with an illicit drug use disorder. [9]

Among those dealing with SUDs, opioid misuse, overdose and addiction, occurs in only a subset of individuals prescribed opioid medications for pain relief. However, because many individuals take opioids, the number of Americans affected is significant. According to the Centers for Disease Control and Prevention (CDC), deaths due to prescription opioid pain medication overdose in the US have more than quadrupled from 1999 to 2011. [10] In addition to the increase in drug-related deaths, the rise in opioid

prescribing has led to increases in the prevalence of opioid use disorder. [11] Other research has demonstrated that the so-called opioid epidemic has a disproportionate impact on Medicaid beneficiaries. Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times the risk of prescription painkillers overdose.[12], [13] North Carolina found that while the Medicaid population represented approximately 20 percent of the overall state population, it accounted for one-third of drug overdose deaths, the majority of which were caused by prescription opioids. [14] One study from the state of Washington found that 45 percent of people who died from prescription opioid overdoses were Medicaid enrollees. [15]

Substance Use Disorders in Utah

According to the 2016 National Survey of Drug Use and Health, in Utah there were an estimated 134,764 adults in need of treatment for alcohol and/or drug dependence or abuse.[16] For youth in grades 6 through 12 in 2017 there were 11,804 in need of treatment. However, only 13,780 adults and 1,179 youth received SUD treatment services in FY 2017. [17] Of those in treatment, 46% received outpatient, 21% received intensive outpatient, 21% participated in detox, and 12% participated in residential treatment. Seventy-one percent of those in treatment were retained for 60 or more days. In 2017, Opioids were the top drug of choice at admission (32%). [18]

Utah has experienced a sharp increase in opioid related deaths since 2000. Recent data suggests that the number of deaths due to opioids peaked initially in 2007, then showed a promising decreasing trend through 2010, before increasing dramatically once more from 2011 through 2015. Emergency department encounters data over the same timeframe shows a steady increase through 2012, with a small decrease observed from 2012 to 2014. Males accounted for approximately 60% of opioid deaths in 2013, but the gap between males and females has shrunk so that by 2015 males accounted for only 54% of deaths. For emergency department encounters, the opposite has been true. In the past, females have traditionally accounted for more visits than males. However, similar to the death data, the gap between females and males has been closing. In 2014, the percentage of emergency department encounters for males and females was essentially even (50.3% vs. 49.7% for females and males, respectively). [19]

However, SUDs are preventable and treatable. The Utah State Division of Substance Abuse and Mental Health (DSAMH) has statutory oversight of substance abuse and mental health treatment services statewide through local county authority programs. SUD services are available to all Medicaid members statewide. A full continuum of SUD services becomes even more critical in an effort to address the needs of Medicaid members. [20]

B. EVALUATION QUESTIONS & HYPOTHESES

The primary goals of the waiver are to increase access, improve quality, and expand coverage to eligible Utahans. To accomplish these goals, the Demonstration includes several key activities including enrollment of new populations, quality improvement, and benefit additions or changes. This evaluation

plan will describe how the University of Utah's Social Research Institute (SRI) will document the implementation of the key goals of the Demonstration, the changes associated with the waiver including the service outputs, and most importantly, the outcomes achieved over the course of the Demonstration.

Evaluation Purpose

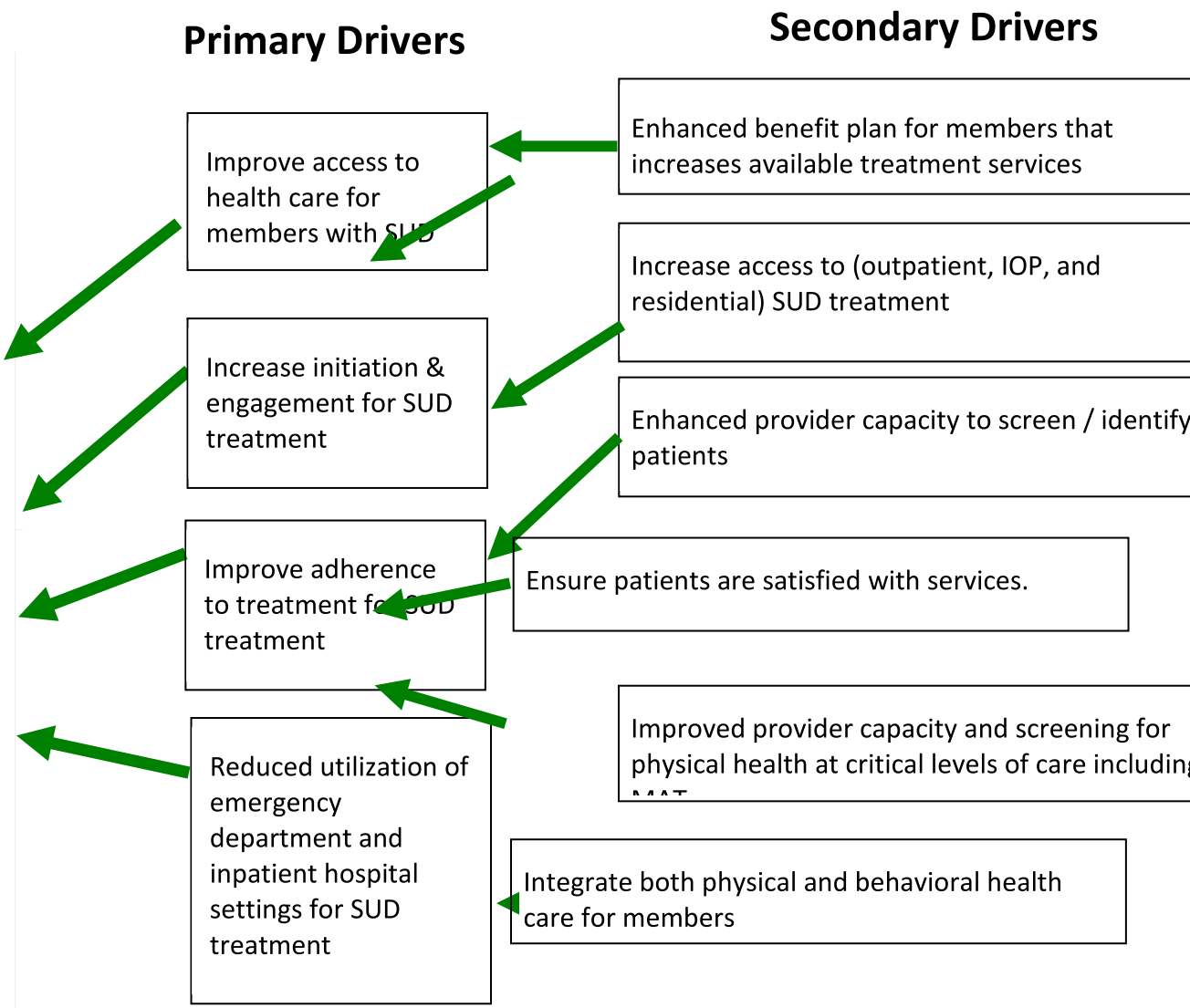
SRI will conduct an evaluation of the Utah 1115 PCN Demonstration Waiver by establishing research questions and a study design that is responsive to the hypotheses identified by UDOH. SRI will collaborate with UDOH and DSAMH to obtain the appropriate data to conduct the analysis needed to complete the required evaluation reports on an annual basis, and at each subsequent renewal or extension of the demonstration waiver. This includes an evaluation of the overall waiver and the SUD component. The SUD evaluation is addressed in this document.

Driver Diagram

Aim: 1115 Demonstration Waiver SUD treatment will improve access, utilization, and health for members

Outcome Measures:

1. Increased access to SUD treatment
2. Increased utilization of SUD treatment
3. Improved health outcomes in SUD members
4. Reduce opioid-related overdose deaths
5. Slow the rate of growth of total cost of care for SUD members

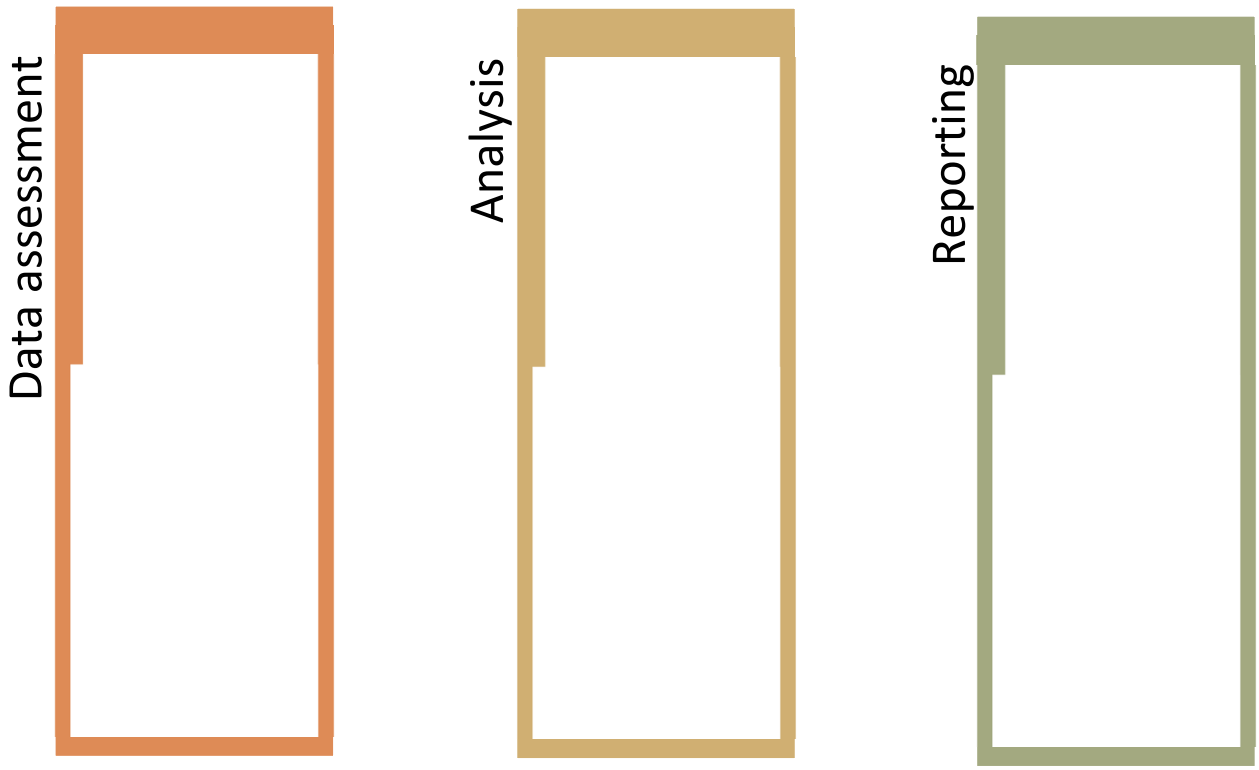


C. METHODOLOGY

Evaluation Approach

To evaluate the different components of the waiver demonstration, we envision three main phases of work: (1) data assessment and collection, (2) analysis, and (3) reporting. The last phase will include both reporting of waiver findings to UDOH in response to the STC's and also providing written summary reports for submission to the Centers for Medicare and Medicaid Services (CMS). The first key task—development of the evaluation design plan—appears at the top of Figure 1. This plan will specify the key research questions the evaluation will address for each demonstration component, as well as the primary data sources and methodologies that will be used. This plan will guide decision making at all levels of the study and drive the content of the reporting tasks.

Figure 1. Project vision



1. Evaluation Design

Due to the unique target population groups included in the Demonstration evaluation, a combination of design approaches will be implemented. First, for several of the SUD hypotheses demonstration components pre / post comparison will be conducted. Second, other SUD hypotheses will consist of a pre / post comparison where the target population will serve as its own control group. A time series design will be employed for most of the individual analysis using pre-Demonstration as a baseline and then using the first year as baseline where no pre-Demonstration data are available due to the nature of the individual target population. A quasi-experimental design (difference-in-difference, DiD) approach will be used to estimate the effect by comparing the SUD (IMD) residential treatment service expansion in Salt Lake and Utah Counties with other counties (Davis, Weber, and Washington). The use of both quantitative and qualitative data will be important to this design. Quantitative data will come from Utah Medicaid claims. Qualitative data will come from a SUD beneficiary survey.

The specific evaluation questions to be addressed are based on the following criteria:
1) Potential for improvement, consistent with the key goals of the Demonstration;
2) Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time; and
3) Potential to coordinate with the UDOH's ongoing performance evaluation and monitoring efforts.
Once research questions are selected to address the Demonstration's major program goals and activities, specific variables and measures will then be identified to correspond to each research question. Finally, a process for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions will be identified. The evaluation team will use all available data sources. The timing of data collection periods will vary depending on the data source, and on the specific Demonstration activity.

2. Target and Comparison Populations

The target population includes any Medicaid beneficiary with a substance abuse disorder (SUD) diagnosis. Several comparison population groups will be used in this evaluation. The first will be comprised of the target population, which will serve as its own comparison group longitudinally, where the research question will compare service utilization differences across the demonstration period. The second group that will be used as a comparison population for some of the SUD components will be members who previously received SUD treatment services in counties without access to an IMD. A difference-in-difference (DiD) approach will be used to estimate the effect by comparing the SUD (IMD) residential treatment service expansion in Salt Lake and Utah Counties with counties (Davis, Weber, and Washington) where there was no residential expansion. At the present time, these three counties have elected not to establish an IMD residential facility. Table 1 below summarizes the residential population and those that have received SUD treatment in the counties through publicly funded treatment programs. The source of these data is DSAMH Treatment Episode DataSet (TEDS). These five counties will be included in the DiD design comparison.

Table 1: Summary of target populations in SUD DiD design counties in Utah.

Counties w / IMD Expansion	County Population	# of clients served	Percent of Admissions in Outpatient / IOP/ Residential / Detox		
			2016	2017	2018
Salt Lake	1,152,633	7,497	36/21/10/33	35/19/13/33	30/17/17/36
Utah	622,213	1,229	29/29/27/15	29/29/28/14	33/27/21/18
Counties w / No Expansion					
Davis	351,713	1,548	55/31/14/0	58/29/13/0	75/19/6/0
Washington	171,700	596	44/35/21/0	48/31/21/0	53/28/19/0
Weber	256,359	1,757	81/14/5/0	77/18/5/0	73/22/5/0

The third comparison population will include patients in publicly funded treatment programs receiving substance services who complete annual MHSIP survey which will serve as a comparison group for the consumer survey that will be administered to SUD beneficiaries.

3. Evaluation Period

The SUD waiver evaluation components will use pre-demonstration data from January 2016 to October 2017 to understand trends in treatment services and for state-level benchmarking of treatment outcomes. The State is aware that many measures with an established measure steward require reporting according to calendar year. This includes:

- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment;
- Continuity of Pharmacotherapy for OUD; and
- Follow-up after Emergency department visit for alcohol and other drug abuse or dependence

For these measures, the State will use a pre-post approach. Calendar year 2016 will serve as the pre-demonstration year. Calendar year 2017 will be reported and observed for trend, however it will be a partial-demonstration year due to the demonstration begin date of November 1, 2017. Calendar year 2018 will serve as the first full post-demonstration year.

The 1st year of the waiver will serve as the baseline using a post-only approach for some State-created measures as noted in Table 2 below. The post-only approach will be used due to the lack of a national benchmark in these measures that may inform the State on relevant performance. Data to be used for the evaluation will span the entire Demonstration period (11/1/2017 – 6/30/2022) for the targeted population groups and for the comparison groups identified.

4. Evaluation Measures

The measures to be used in the SUD evaluation include nationally standardized data collection protocols such as NFQ #0004, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, Continuity of Pharmacotherapy for OUD (NQF #3175), and qualitative data from a beneficiary survey

that focuses on health care satisfaction, access, and quality. The specific measures are listed in Table 2 below.

5. Data Sources

The State will use four data sources to conduct the evaluation plan. First, UDOH's Medicaid HIPAA transaction set consisting of all Utah claims and encounters data. Data from this source is available prior to the November 2017 waiver approval and throughout the demonstration. Second, the DSAMH TEDS Admission and Discharge record is an electronic client data file that includes data from all publicly funded SUD treatment service providers in Utah. This data file includes required standardized variables that are submitted to the Substance Abuse and Mental Health Administration (SAMHSA) for its State Outcomes Measurement and Management System (SOMMS) as well as variables that are required for the National Outcome Measures (NOMS). The file includes more than 100 variables ranging from most current diagnosis (ASAM levels), Drug Court Submissions, referral sources, waiting time to enter treatment, to criminogenic risk level. TEDS data is also available prior to the waiver and annually moving forward. Third, the State will conduct a SUD beneficiary survey annually. Fourth, the State's Vital Records dataset will be used to identify overdose deaths.

6. Analytic Methods

A combination of quantitative statistical methods will be used for the analysis. Specific measures will be utilized for each demonstration as detailed in Table 2. While the Demonstration seeks to increase service provision and promote quality care, observed changes may be attributed to the Demonstration itself and/or external factors, including other State- or national-level policy or market changes or trends. For each Demonstration activity, a conceptual framework will be developed depicting how specific Demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis for the evaluation methodology. Methods chosen will attempt to account for any known or possible external influences and their potential interactions with the Demonstration's goals and activities. The evaluation will seek to isolate the effects of the Demonstration on the observed outcomes in several ways:

First, the evaluation will incorporate baseline measures and account for trends for each of the selected variables included in the evaluation. Medicaid data for each of the targeted variables and measures will be analyzed annually so that outcome measures and variables can be monitored on a regular basis. The hypotheses in Table 2 involving the DiD design compare SUD residential expansion counties with SUD residential services in non-expansion counties.

Second, the evaluation will use known state benchmarks for publicly funded SUD treatment annually to measure Demonstration outcomes related to domains of consumer experience with treatment services. Specifically, those seven domains are: Satisfaction, Access, Quality, Participation, Outcomes, Social Connectedness, and Functioning.[21] These variables are collected by the DSAMH annually among publicly funded SUD service providers. This DSAMH data cannot be linked to specific Medicaid

enrollees, therefore, the waiver evaluation will conduct its own SUD beneficiary survey. The Utah MHSIP data collected during State fiscal year 2020-2022 will be used as a state benchmark for comparison to the SUD beneficiary survey results. Since the MHSIP survey has demonstrated modest correlations in magnitude in the predicted directions, with greater patient satisfaction being associated with lower symptoms and more positive outcomes,[22] the same questions will be used in the Demonstration survey. This data will be analyzed with descriptive statistics such as frequencies, percentages, and t-tests.

Table 2: Summary of Demonstration Populations, Hypotheses, Evaluation Questions, Data Sources, and Analytic Approaches.

Evaluation Question: Does the demonstration increase access to and utilization of SUD treatment services?						
Demonstration Goal: Increased rates of identification, initiation, and engagement in treatment for SUDs. **Evaluation Hypothesis: The demonstration will increase the percentage of members who are referred and engage in treatment for SUDs.**						
Driver	Measure Description	Steward	Numerator	Denominator	Evaluation Period	Analytic Approach /Target or Comparison Population
Primary Driver *(Increase the rates of initiation and engagement in treatment for SUDs)*	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NQF #0004	Initiation: number of patients who began initiation of treatment through an inpatient admission, outpatient visits, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (frequencies and percentages); Linear regression. **Comparison population**. SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
			Engagement: Initiation of treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any alcohol or drug diagnosis within 30 days after the date of the initiation encounter	Patients who were diagnosed with a new episode of alcohol or drug dependency during the first 10 and ½ months of the measurement year		

Secondary Drivers *(Enhance provider and plan capabilities to screen/identify patients for engagement and intervention; Improve community knowledge of available treatment and services)*	Community knowledge of available treatment and services	University of Utah / SRI	Beneficiary survey Adult SUD consumer satisfaction survey		State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population**: SUD members. **Comparison population**. Patients in publicly funded programs receiving SUD services who complete annual MSHIP survey.
Demonstration Goal: Increased adherence to and retention in treatment for SUDs. Evaluation Hypothesis: The demonstration will increase the percentage of members who adhere to treatment of SUDs.						
Primary Drivers *(Increase the rates of initiation and engagement in treatment for OUD and SUDs; Improve adherence to treatment for SUDs)*	Continuity of Pharmacotherapy for OUD	NQF #3175	Number of members who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days	Members who had a diagnosis of OUD and at least one claim for an OUD medication	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (Frequencies and percentages); Linear regression. **Target population:** SUD members receiving MAT **Comparison population**. SUD expansion (IMD) in
	Percentage of members with a SUD diagnosis including those with OUD who used services per month	N/A	Number of members who receive a service during the measurement period by service type	Number of members	First year of waiver is baseline compared to years 2 through 5 of the waiver.	

Secondary Drivers *(Increase access to outpatient, intensive outpatient, and residential treatment for SUD; Improve care coordination and transitions between levels of care)*	Length of engagement in treatment	NBHQF Goal 1	Number of members completing 4th treatment session within 30 days	Number of members receiving treatment	First year of waiver is baseline compared to years 2 through 5 of the waiver.	Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
Secondary Driver *(Ensure patients are satisfied with services)*	Patient experience of care	University of Utah / SRI	Adult SUD beneficiary satisfaction survey		State fiscal year 2020-2022	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population:** SUD members. **Comparison population**. Patients in publicly funded programs receiving SUD services who complete annual MSHIP survey.
Demonstration Goal: Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Evaluation Hypothesis: The demonstration will decrease the rate of emergency department and inpatient visits within the beneficiary population for SUD.						

Primary Drivers *(Reduced utilization of emergency department and inpatient hospital settings for SUD treatment)*	Follow-up after emergency department visit for alcohol and other drug abuse or dependence	NQF 2605	An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7/30 days after emergency department discharge	Members treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence in the measurement year/1000 member months	Calendar years 2016(Pre) 2017(Interim) 2018-2022(Post)	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. **Comparison population** SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control variables for age and gender will be used.
	Inpatient admissions for SUD and specifically OUD	N/A	Number of members with an inpatient admission for SUD and specifically for OUD	Total number of members/1000 member months	First year of waiver is baseline compared to years 2 through 5 of the waiver.	
Evaluation Question: Do members receiving SUD services experience improved health outcomes?						
Demonstration Goal: Improved access to care for co-morbid physical health conditions commonly associated with SUD among members. Evaluation Hypothesis: The demonstration will increase the percentage of members with SUD who experience care for comorbid conditions.						
Primary Drivers *(Improve access to care for co-morbid physical health conditions among beneficiaries with SUD)*	Number of routine office visits by people with SUD	N/A	Number of members with an SUD diagnosis, and specifically those with OUD, who access physical health care.	Total number of members	First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Descriptive statistics** (frequencies and percentages); Linear regression. **Target population**: SUD members with OUD diagnosis. **Comparison population** SUD expansion (IMD) in Salt Lake and Utah Counties compared to Davis, Washington, and Weber Counties (DiD design). Control

						variables for age and gender will be used.
Evaluation Question: Are rates of opioid-related overdose deaths impacted by the demonstration?						
Demonstration Goal: Reduction in overdose deaths, particularly those due to opioids. Evaluation Hypothesis: The demonstration will decrease the rate of overdose deaths due to opioids.						
Primary Driver *(Reduce opioid-related opioid overdose deaths)*	Rate of overdose deaths, specifically overdose deaths due to any opioid	UDOH	Number of overdose deaths per month and per year	Number of members/1000	First year of waiver is baseline compared to years 2 through 5 of the waiver.	**Descriptive statistics** (Frequencies and percentages); t-test. **Target population:** SUD members. **Comparison population**. State General Population.

D. METHODOLOGICAL LIMITATIONS

The first potential limitation is ensuring each individual analysis is based on unduplicated data. SRI staff will work closely with Utah Medicaid data personnel and DSAMH to ensure the data used for final analysis is as accurate as possible and that error in matching the TEDS Admission and Discharge data set to Medicaid claims data has been minimized to avoid duplication. There are also limitations of conducting a time series analysis without a comparison group. For example, data collected at different times are not mutually independent, which means a single chance event may affect all later data points. As a result, the true pattern or trend underlying time series data can be difficult to discern.

E. ATTACHMENTS

A. Independent Evaluator

The Social Research Institute (SRI) will conduct all activities related to this proposal to fulfill the evaluation requirements of Utah's 1115 PCN Waiver with specific emphasis on conducting data analysis to ensure timely reporting. SRI was established in 1982 as the research arm of the College of Social Work. Its goal is to be responsive to the needs of community, state, national and international service systems and the people these systems serve. Through collaborative efforts, SRI facilitates innovative research, training and demonstration projects. SRI provides technical assistance and research services in the following functional areas: conducting quantitative and qualitative research; designing and administering surveys; analyzing and reporting data analysis; designing and conducting needs assessments of public health and social service problems and service systems; planning and implementing service delivery programs; evaluating program and policy impacts; training in research methods and data analysis; providing technical assistance.

SRI staff are experienced in complying with state and federal laws regarding protecting human subjects and assuring confidentiality of data. SRI will complete the required IRB applications for this project including any data sharing agreements that may be necessary. SRI staff comply with generally accepted procedures to safeguard data by ensuring all data is stored on password protected and encrypted computers. Specifically, we use two-factor authentication (2FA) verification as an extra layer of security. All data collection and analysis SRI is responsible for will be based on the agreed upon data collection plan and in accordance with HIPAA-compliant data management systems available to University of Utah researchers.

Data Security and Storage

SRI will store UDOH's Medicaid (HIPPA transaction set) in the University's REDCap application. REDCap is a secure database with the ability to create web-accessible forms, continuous auditing, and a flexible reporting system. Controls within REDCap allow researchers to specify differential levels of data

access to individuals involved with a REDCap project, including restrictions to HIPAA-sensitive identifiers. REDCap is located on a secure, 21 CFR Part11 compliant server farm within the Center for High Performance Computing (CHPC) at University of Utah. Data are backed up every hour with the hourly backups being incorporated into the regular backup-recovery data process (nightly, weekly, and monthly), which includes off-site storage. Routine data recovery and disaster recovery plans are in place for all research data. During analysis, de - identified data may be maintained on University of Utah-encrypted computers or hard-drives in compliance with University policy.

Independent Evaluator Selection Process

SRI staff have contracted with the Utah Department of Human Services, Division of Child and Family Services (DCFS) to evaluation their IV-E waiver demonstration project for the past 4 years. Simultaneously, SRI also served as the independent evaluator for the State of Idaho's IV-E waiver demonstration for two years. Within the past year, key research staff from DCFS who were familiar with the work performed by SRI staff changed jobs and now work for UDOH Office of Health Care Statistics. As result, when UDOH was trying to locate an independent evaluator a referral was provided and several preliminary meetings and discussions were held. This led to SRI developing a proposal for UDOH to conduct the Demonstration evaluation.

The research team will consist of Rodney W. Hopkins, M.S., Research Assistant Professor, Kristen West, MPA., Senior Research Analyst, and Jennifer Zenger, BA, Project Administrator.

Mr. Hopkins in an Assistant Research Professor and has 25 years' experience in conducting program evaluations for local, state, and federal agencies. He has an M.S. and will be the project lead, with responsibility for evaluation design and implementation, data collection, and reporting. He will be .45 FTE.

Kristen West, MPA (.25 FTE) is a Senior Research Analyst with experience conducting multi-year program evaluations for DCFS and JJS. She has expertise with a variety of statistical software programs to analyze data including multi-level regression models, linear regression, and descriptive statistics (SPSS and R). She also has experience developing and data visualization dashboards. Jennifer Zenger (.05 FTE) is SRI's Project Administrator and has 25 years' experience in budgeting, accounts payable, and working with state and federal agencies. She will be responsible for contract setup, monitoring, and accounting services.

An interdepartmental consortium has been established between SRI and the University of Utah's Department of Economics and the Department of Family and Consumer Studies. The Department of Economics, Economic Evaluation Unit led by Department Chair, Norm Waitzman, Ph.D., (.03 FTE) a Health Economist who has extensive health care utilization and cost analysis experience will lead this effort. The other principal researcher is Jaewhan Kim, Ph.D. (.21 FTE) a Health Economist and Statistician with a broad background in health care utilization and cost analysis, statistical design and data analysis including cohort studies and cross-sectional studies. He currently co-directs the Health Economics Core, Center for Clinical & Transitional Science (CCTS) at the University of Utah School of Medicine. He has expertise in analyzing claims databases for health care utilization and costs and has

worked on multiple federal studies of health care utilization using diverse claims data such as Medicare, Medicare-SEER, Medicaid, MarketScan, PHARMetrics, University of Utah Health Plan's claims data and Utah's All Payers Claims Database (APCD). He was one of the original l developers of the APCD, published the first paper with Utah's APCD data, and has worked collaboratively with other researchers to successfully conduct more than 20 studies using the APCD. They will also be supported by a to-be-named Graduate Research Assistant (1.0 FTE).

Conflict of interest document attached.

B. Evaluation Budget

The initially proposed budget (3/2018) of projected costs for the 1115 Demonstration evaluation are detailed below. Costs include all personnel (salary + benefits), study related costs (mileage), and university indirect (reduced from 49.9% to 14.8% state rate). Year 1 budget begins April 1, 2018 and ends June 30, 2018. Year 2-5 are based on the state fiscal year. An additional 90-day period has also been included, during which SRI will complete the Year 5 Annual Report, Waiver Final Report, and SUD Final Report.

Proposed budget

Salaries	ABA	FTE	SALARY	BENEFITS	YEAR I	YEAR II	YEAR III	YEAR IV	YEAR V	90-DAY	
Faculty											
Matt Davis	$102,000	5%	$ 5,100	$ 2,059	$ 1,785	$ 7,283	$ 7,428	$ 7,577	$ 7,729	$ 1,971	
Rod Hopkins	$ 91,997	15%	$ 13,800	$ 5,877	$ 4,919	$ 20,170	$ 20,471	$ 20,880	$ 21,298	$ 5,431	
			$ 18,900	$ 7,936	$ 6,704	$ 27,453	$ 27,899	$ 28,457	$ 29,027	$ 7,402	
Staff											
Kristen West	$ 57,222	15%	$ 8,583	$ 3,433	$ 3,004	$ 12,257	$ 12,502	$ 12,752	$ 13,007	$ 3,318	
Jennifer Zenger	$ 85,435	5%	$ 4,272	$ 1,709	$ 1,495	$ 6,100	$ 6,222	$ 6,347	$ 6,473	$ 1,650	
			$ 12,855	$ 5,142	$ 4,499	$ 18,357	$ 18,724	$ 19,099	$ 19,481	$ 4,968	
Total Staff					$4,499	$18,357	$ 18,724	$ 19,099	$ 19,481	$ 4,968	
Total Faculty Salaries					$6,704	$27,453	$ 27,899	$ 28,457	$ 29,027	$ 7,402	
Total Fringe Benefits					added in abov	added in above	added in above	added in above	added in above		
Travel (1 trip per month to UDOH & DSAMH)					$65	$250	$250	$250	$ 250	$ 65	
Total Direct					**$11,268**	**$46,060**	**$ 46,874**	**$ 47,806**	**$ 48,757**	**$ 12,435**	
Indirect (F&A) Cost				*14.80%*	**$1,668**	**$ 6,817**	**$ 6,937**	**$ 7,075**	**$ 7,216**	**$ 1,840**	
Grand Total					**$12,936**	**$52,877**	**$ 53,811**	**$ 54,881**	**$ 55,973**	**$ 14,275**	**$244,754**

Budget Narrative

Rodney Hopkins, M.S., Assistant Research Professor will be the lead on this project and will be responsible for day-to-day activities. He will work (.15 FTE) closely with UDOH and DSAMH staff to

ensure appropriate data is available to answer the research questions and execute the data analysis and reporting. Dr. Davis (.05 FTE) will bring his considerable experience with quantitative analysis to this project. Kristen West, MPA, Senior Research Analyst (.15 FTE) will assist with data analysis and reporting, including data visualization. Jennifer Zenger (.05 FT) is SRI's Project Administrator. She oversees contract monitoring and the budget.

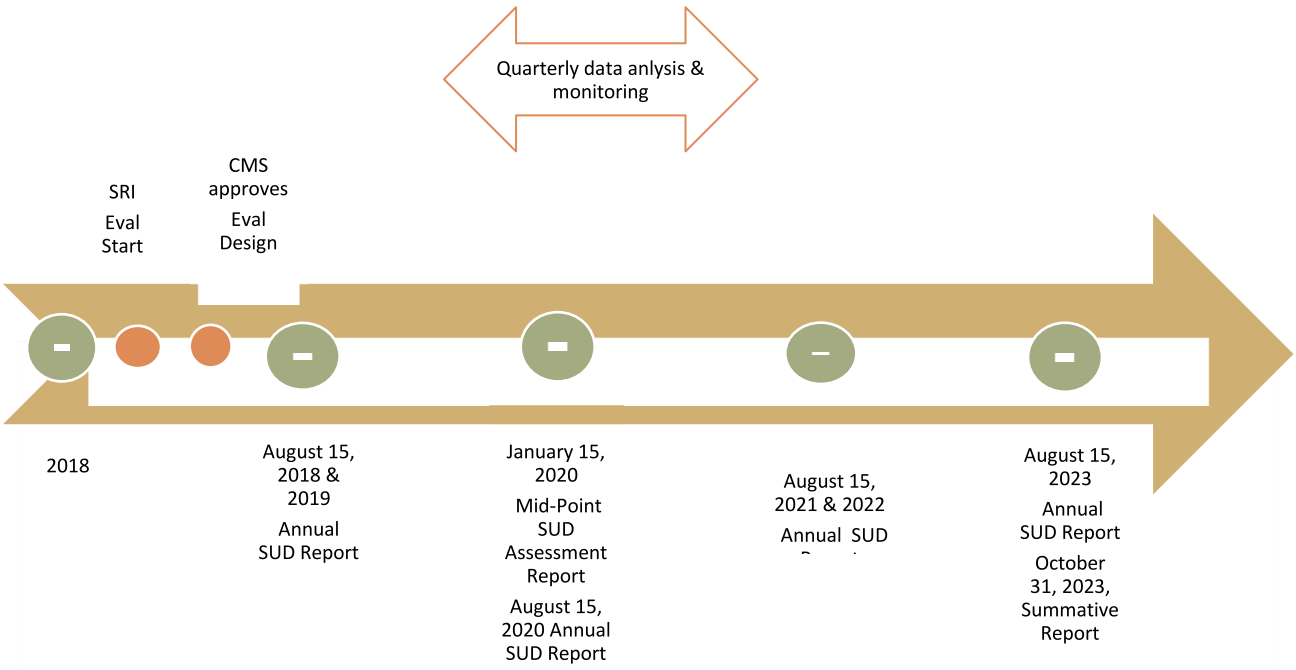
A strength this team brings to the project will be its ability to conduct a thorough and accurate data analysis and provide a professional report that will address each component of the waiver demonstration. Salaries calculated include a 2% increase as of July 1 of each year. University of Utah benefits are calculated at 40%. Year 1 is only a 6-month budget (April 1, 2018 – Sept. 30, 2018).

Local travel will be needed for SRI faculty and staff to attend meetings with UDOH and DSAMH staff. We anticipate one meeting per month.

UDOH state agency to state agency indirect costs calculated at 14.8%.

C. Timeline and Major Milestones

Figure 2. Waiver Evaluation Timeline



D. References

1. World Health Organization. (2013). Mental health action plan 2013–2020. Retrieved from http://www.who.int/mental_health/ publications/action_plan/en/

2. Reeves, W. C., Strine, T. W., Pratt, L. A., Thompson, W., Ahluwalia, I., Dhingra, S. S., McKnight-Eily, L. R., Harrison, L., D'Angelo, D. V., Williams, L., Morrow, B., Gould, D., & Safran, M. A. (2011). Mental illness surveillance among adults in the United States. Morbidity and Mortality Weekly Report CDC Surveillance Summaries, 60(Suppl. 3), 1-29.

3. Murray, C. J. L., & Lopez, A. D. (2013). Measuring the global burden of disease. New England Journal of Medicine, 369, 448-457. doi:10.1056/ NEJMra1201534

4. National Institute on Drug Abuse. (2012, November). Medical consequences of drug abuse. Retrieved from http://www.drugabuse.gov/ related-topics/medical-consequences-drug-abuse

5. Substance Abuse and Mental Health Services Administration. (2014, October 3). Prevention of substance abuse and mental illness. Retrieved from http://www.samhsa.gov/prevention

6. Bouchery, E. E., Harwood, H. J., Sacks, J. J., Simon, C. J., & Brewer, R. D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. American Journal of Preventive Medicine, 41, 516-524. doi:10.1016/j.amepre.2011.06.045

7. Office of National Drug Control Policy, Executive Office of the President. (2011). How illicit drug use affects business and the economy. Retrieved from http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/ effects_of_drugs_on_economy_jw_5-24-11_0.pdf

8. National Drug Intelligence Center. (2011). National Drug Threat Assessment 2011 (Product No. 2011-Q0317-001). Retrieved from http:// www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf

9. 2016 National Survey of Drug Use and Health (NSDUH)

10. Chen LH, Hedegaard H, Warner M. Drug-poisoning deaths involving opioid analgesics: United States, 1999–2011. NCHS data brief, no 166. Hyattsville, MD: National Center for Health Statistics. 2014.

11. Paulozzi LJ, Jones CM, Mack KA, Rudd RA. Vital Signs: Overdoses of Prescription Opioid Pain Relievers --- United States, 1999—2008. MMWR 60(43); 1487-1492.

12. Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003-2012. *Morb Mortal Wkly Rep* 2015; 64:377-380.

13. Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep.* 2009; 58:1171-1175.

14. Whitemire JT, Adams, GW. Unintentional overdose deaths in the North Carolina Medicaid population: prevalence, prescription drug use, and medical care services. *State Center for Health Studies*. August 2010(162):1-11.

15. Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep.* 2009; 58:1171-1175.

16. National Survey on Drug Use and Health. (2016). Substance Abuse and Mental Health Services Administration. Reports and Detailed Tables.

17. FY2017 Utah Substance Abuse Treatment Outcome Measures Scorecard for all clients. (2017). Utah Department of Human Services, Division of Substance Abuse and Mental Health.

18. FY2017 Utah Substance Abuse Treatment Outcome Measures Scorecard for all clients. (2017). Utah Department of Human Services, Division of Substance Abuse and Mental Health.

19. Utah's Opioid Crisis Consequence and Resource Assessment. (2017). Utah Department of Human Services, Division of Substance Abuse and Mental Health.

20. Utah 1115 Demonstration Waiver Renewal Application. (2016). Utah Department of Health. 96-99.

21. http://www.nri-inc.org/projects/SDICC/tech_assist.cfm

22. Shafer, A. and Ang, R. The Mental Health Statistics Improvement Plan (MHSIP) Adult Consumer Satisfaction Survey Factor Structure and Relation to External Criteria. The Journal of Behavioral Health Services & Research. October 2018 (45) 565-578.

ATTACHMENT 2

Annual External Quality Review Report

State of Utah

Division of Medicaid and Health Financing

Bureau of Managed Health Care

Annual External Quality Review Report of Results

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) require states to prepare an annual technical report that describes the way data from external quality review (EQR) activities conducted in accordance with 42 Code of Federal Regulations (CFR) §438.358 were aggregated and analyzed. In May 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Medicaid managed care regulations, and in February 2018 the Children's Health Insurance Program (CHIP) was reauthorized via House Bill 195 and the Bipartisan Budget Act of 2018. This EQR technical report is presented to comply with 42 CFR §438.364 as articulated in the May 2016 regulations. The Utah Department of Health (UDOH) is the Utah State agency responsible for the administration of Utah's Medicaid program and CHIP. UDOH has contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to prepare this report. This is the sixth year HSAG has produced the EQR annual technical report of results for UDOH under the current EQRO contract.

To provide medical services in calendar year (CY) 2020, UDOH contracted with Medicaid managed care organizations (MCOs) to serve the Medicaid and CHIP populations, accountable care organizations (ACOs) to serve the Medicaid population, and prepaid mental health plans (PMHPs) that are prepaid inpatient health plans (PIHPs) to serve the Medicaid population. To provide dental services, UDOH contracted with two dental prepaid ambulatory health plans (PAHPs)—one serving the Medicaid population and one serving both the Medicaid and CHIP populations. Throughout this report, these entities may be referred to as "health plans" unless there is a need to distinguish a particular health plan type.

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2020 by Type and Operating Authority

Health Plan Type	Operating Authority
Four Medicaid ACOs	1915(b) Choice of Health Care Delivery (CHCD) waiver
One Medicaid mental and physical health MCO	1915(a) contracting authority
Four Medicaid mental and physical health MCOs	1115 Demonstration waiver
Twelve PMHPs; 11 PIHPs and one PAHP	1915(b) Prepaid Mental Health Plan (PMHP) waiver
Two CHIP MCOs	CHIP authority
Two Medicaid dental PAHPs	1915(b) Choice of Dental Care Delivery Program waiver
One CHIP dental PAHP	CHIP authority

Four ACOs Operating Under the 1915(b) CHCD Waiver

UDOH has been operating the 1915(b) CHCD waiver program since 1982. Under this waiver, physical health care has been provided through MCOs. Since 1995, enrollment in an MCO has been mandatory for members living in Utah's urban counties. Effective January 1, 2013, the MCOs began administering the Medicaid pharmacy benefit for their members with the exception of mental health, substance use disorder (SUD), hemophilia, and transplant immunosuppressant drugs. In 2015, UDOH expanded mandatory ACO enrollment to include nine rural counties. During CY 2020, UDOH contracted with the following ACOs:

Health Choice Utah (Health Choice)

Healthy U

Molina Healthcare of Utah (Molina)

SelectHealth Community Care (SelectHealth)

One MCO Operating Under 1915(a) Contracting Authority

In 2001, UDOH implemented a specialty MCO, Healthy Outcomes Medical Excellence (HOME), under 1915(a) contracting authority. HOME provides both physical health and mental health services using a medical home model of care for members who are dually diagnosed with a developmental disability and a mental illness. Enrollment into HOME is voluntary. In 2006, UDOH transformed HOME into a risk-based capitated MCO.

Four MCOs Operating Under an 1115 Demonstration Waiver

In 2020, UDOH contracted with its four ACOs to provide both physical health and behavioral health services to the Medicaid expansion population.

Health Choice Utah (Health Choice UMIC)

Healthy U (Healthy U UMIC)

Molina Healthcare of Utah (Molina UMIC)

SelectHealth Community Care (SelectHealth UMIC)

Twelve PMHPs Operating Under the 1915(b) Prepaid Mental Health Plan Waiver

UDOH has been operating the 1915(b) PMHP waiver program since 1991. Under this waiver, behavioral health care has been provided through the PMHPs. Enrollment in the PMHPs is mandatory. In June 2020, the contracts with Valley Behavioral Health and the Utah County Department of Drug and Alcohol Prevention and Treatment ended. In September 2020, UDOH entered into a PMHP contract with Healthy U. This report represents EQR activities conducted with the following 12 PMHPs during CY 2020.

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Healthy U

Northeastern Counseling Center (Northeastern)

Salt Lake County Division of Behavioral Health (Salt Lake)

Southwest Behavioral Health (Southwest)

Utah County Department of Drug and Alcohol Prevention and Treatment (Utah County)

Valley Behavioral Health (Valley)

Wasatch Behavioral Health (formerly Wasatch Mental Health [Wasatch])

Weber Human Services (Weber)

Two MCOs Operating Under Title XXI Authority

Created in 1997 under Title XXI of the Social Security Act, CHIP provides low-cost health insurance coverage for children in working families who do not qualify for Medicaid. Utah began operating its CHIP program in 1997. In CY 2019, UDOH contracted with the following CHIP MCOs:

Molina Healthcare of Utah (Molina)

SelectHealth

Two Medicaid Dental PAHPs Operating Under the 1915(b) Choice of Dental Care Delivery Program Waiver

Premier Access (Premier)

MCNA Dental [MCNA Insurance Company and Managed Care of North America, Inc.] (MCNA)

One CHIP Dental PAHP Operating Under Title XXI Authority

Premier Access

The State of Utah Managed Care Quality Strategy

Consistent with CMS recommendations, the UDOH Quality Strategy provides a blueprint for advancing the State's commitment to improving quality health care delivered through the contracted health plans. Utah's primary system of health care delivery and payment is designed to improve the quality of care that Utah's Medicaid and CHIP members receive. The UDOH Quality Strategy outlines goals

designated as the Triple Aim to achieve better care, better health, and better value for members enrolled in Utah's managed Medicaid and CHIP health plans.

Utah's CY 2020 draft Managed Care Quality Strategy (the Strategy) addressed key elements required pursuant to 42 CFR §438.340 including, but not limited to, performance improvement projects (PIPs) to be implemented; the State's transition of care policy; the State's plan to identify, evaluate, and reduce health disparities; planned use of intermediate sanctions when appropriate; and arrangements for EQR.

While the Strategy effectively describes processes designed to improve the quality of care provided by the managed care health plans, HSAG recommends that stated goals be revised to be more clearly measurable and include performance targets and outcomes anticipated to be published on the State's website as required in accordance with §438.10(c)(3). HSAG also recommends that UDOH focus on two or three prioritized, measurable goals to achieve in each of the next three years until the Strategy is next assessed. UDOH might consider developing benchmarks for performance measures for which national averages are not available, such as customized Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] measures used for the PMHPs.

In several instances, the Strategy refers the reader to contract standards to demonstrate that the health plans are required to comply with the standards set forth. HSAG recommends expanding these sections to describe the contract standards and expectations for measurable outcomes related to these standards.

UDOH continues to develop innovative strategies for improving the quality of care and services to Utah Medicaid members. In September 2019, UDOH entered into a new contract with Healthy U to administer an additional PMHP. In January 2020, UDOH contracted with the four existing ACOs to administer a new integrated program to provide both physical and behavioral health care services to a specific population of Medicaid beneficiaries.

Purpose of the Report

This report provides the results of the four mandatory EQR activities completed in CY 2020. UDOH contracted with HSAG to conduct validation of PIPs (2012 EQR Protocol 3)[1-2]; validation of performance measures (EQR Protocol 2)[1-3]; an assessment of compliance with Medicaid managed care regulations

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-2] New CMS EQR Protocols were released October 2019 and posted to the CMS website in January 2020. PIP validation activities were already underway at this time; therefore, HSAG used *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 for conducting PIP validation activities in CY 2020.

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf, Accessed on: Feb 22, 2021.

(EQR Protocol 3)[1-4] (i.e., compliance review); and validation of network adequacy (protocol not yet released) for all health plans. This report also presents health plan-specific and statewide assessments of strengths and weaknesses regarding health care quality, timeliness, and access to care; conclusions drawn; and recommendations for performance improvement with statewide recommendations in this section (Section 1—Executive Summary) and health plan-specific recommendations in Section 2—Evaluation of Utah Medicaid and CHIP Health Plans.

HSAG used the following definitions to evaluate and draw conclusions about the performance of the health plans in each of these domains.

Quality

CMS defines "quality" in the 2016 federal health care regulations at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM [primary care case management] entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and through interventions for performance improvement.[1-5]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-6]

NCQA further states that the intent of utilization management standards is to minimize any disruption in the provision of health care. HSAG extends this definition of "timeliness" to include other managed care provisions that impact services to members and that require timely response by the MCO or PIHP, such as processing grievances and appeals, and providing timely follow-up care.

[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf, Accessed on: Feb 22, 2021.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

[1-6] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

Access

CMS defines "access" in the 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).[1-7]

Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities

Validation of Performance Improvement Projects

For CY 2020, each health plan and PAHP submitted one PIP for validation for a total of 26 PIPs. Twenty-one of the 26 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and use of appropriate quality improvement (QI) activities to support improvement of PIP outcomes.

Medicaid ACOs

Three of the four ACOs received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool. Health Choice received an overall *Not Met* validation status with an 84 percent *Met* score on all the applicable evaluation elements.

Utah Medicaid Integrated Care (UMIC) Plans

All four UMIC plans received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool.

CHIP MCOs

Both CHIP MCOs received an overall *Met* validation status for their PIP and achieved 100 percent of all the applicable evaluation elements on HSAG's PIP validation tool.

[1-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

PMHPs and HOME

Ten of the 12 PMHPs and HOME received an overall *Met* validation status for their PIP. Salt Lake and Valley received an overall *Partially Met* validation status with 87 percent and 81 percent *Met* scores, respectively, on all the applicable evaluation elements.

Medicaid and CHIP Dental PAHPs

One PAHP, MCNA, received an overall *Met* validation status for its PIP. Premier's PIP received a *Not Met* validation status with a *Met* score for 84 percent of the applicable evaluation elements, and Premier CHIP received an overall *Partially Met* validation status with a *Met* score for 95 percent of the applicable evaluation elements.

Validation of Performance Measures

Medicaid ACOs

VALIDATION FINDINGS

All but one of the Medicaid ACOs' HEDIS compliance auditors determined that the health plans' information systems (IS) and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020. The HEDIS auditor recommended that the health plan that did not meet all standards investigate the measures impacted and the underlying data to resolve the data issues causing the problem.

PERFORMANCE MEASURE RESULTS

All four ACOs exceeded the 2020 NCQA Quality Compass[1-8] average for the *Appropriate Treatment for Children With Upper Respiratory Infection, Childhood Immunization Status—Combination 3,* and *Immunizations for Adolescents—Combination 1* measures.

In addition, at least three of the four ACOs exceeded the 2020 NCQA Quality Compass Average for the *Controlling High Blood Pressure, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent BMI [body mass index]—Total,* and *Comprehensive Diabetes Care—HbA1C Testing* measures.

The following measure rates demonstrated the most need for improvement, as all four ACOs fell below the 2020 NCQA Quality Compass average: *Breast Cancer Screening; Cervical Cancer Screening; Chlamydia Screening in Women—Total;* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

[1-8] Quality Compass® is a registered trademark of the NCQA.

In addition, at least three of the four ACOs fell below the 2020 NCQA Quality Compass Average for the *Well-Child Visits in the First 15 Months of Life* measure.

With performance consistently falling below the 2020 NCQA Quality Compass average for the ACOs for these measures, improvement efforts could be focused on increasing breast cancer, cervical cancer, and chlamydia screenings for women and required well-child visits for infants and young children.

CHIP MCOs

VALIDATION FINDINGS

One of the CHIP MCOs' HEDIS compliance auditors determined that the health plan's IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020. For the remaining CHIP health plan, the HEDIS auditor recommended the health plan investigate the measures impacted by the unmet standard and the underlying data to resolve the data issues causing the problem.

PERFORMANCE MEASURE RESULTS

Both CHIP MCOs exceeded the 2020 NCQA Quality Compass average for the *Appropriate Treatment for Children With Upper Respiratory Infection, Childhood Immunization Status—Combination 3, Immunizations for Adolescents—Combination 1, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents,* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measures.

Both CHIP MCOs fell below the 2020 NCQA Quality Compass average for *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measure. With performance falling below the 2020 NCQA Quality Compass average for both CHIP MCOs, improvement efforts could be focused on increasing required well-child visits for young children.

PMHPs and HOME

VALIDATION FINDING[1-9]

HSAG determined that 11 of the 12 PMHPs' IS and processes were compliant with IS standards and that the measures calculated by the PMHPs had a status of *Reportable* based on the reporting requirements for the 2020 performance measure validation (PMV).

One PMHP began providing services in September 2019 and did not have any data to report for the designated reporting period.

[1-9] Findings for individual health plans can be found in Section 2 of this report, "Evaluation of Utah Medicaid and CHIP Health Plans."

Table 1-2 describes the two rates that the plans reported for *Follow-Up After Hospitalization for Mental Illness (FUH)*.

Table 1-2—*FUH* Performance Measure Rates

Rate 1: Follow-Up Within 7 Days of Discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days.
Rate 2: Follow-Up Within 30 Days of Discharge	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days.

PERFORMANCE MEASURE RESULTS

For reporting year (RY) 2020, the PMHPs and HOME calculated and reported the state-modified *FUH* measure. Since the PMHPs and HOME used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. This measure helps PMHPs and HOME monitor and ensure that members receive timely follow-up outpatient services after hospital discharge. Timely follow-up can help reduce the risk of rehospitalizations.

Based on performance measure outcomes, six PMHPs exceeded the statewide PMHP average for both *FUH* indicators, and two PMHPs fell below the statewide average for both indicators. HOME and Healthy U were not included in or compared to the statewide PMHP average.

SUD PAHP

VALIDATION FINDINGS

For RY 2020, Utah County calculated and reported results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Since Utah County used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, because Utah County was the only health plan that reported *IET* measure rates, HSAG could not compare the results. Utah County received a *DNR* rating as the PAHP's source code contained errors, its data validation and event categorization also reflected errors, and Utah County was not able to provide sufficient explanation or accurate revised rates to HSAG. Table 1-3 describes the two rates that the SUD PAHP reported for *IET*.

Table 1-3—*IET* Performance Measure Rates

Rate 1: Initiation of AOD Treatment	The percentage of members who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
Rate 2: Engagement of AOD Treatment	The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initial visit.

Medicaid and CHIP Dental PAHPs

VALIDATION FINDINGS

Each PAHP's HEDIS compliance auditor determined that each PAHP's IS and processes were compliant with the applicable IS standards and reporting requirements for HEDIS 2020.

PERFORMANCE MEASURE RESULTS

Each PAHP's performance for the Medicaid population exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age, 4–6 Years of Age, 7–10 Years of Age, 11–14 Years of Age, 15–18 Years of Age, 19–20 Years of Age, and Total* measure rates.

The PAHP's performance for the CHIP population exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age* measure rate but fell below the 2020 NCQA Quality Compass average for the *4–6 Years of Age*, *7–10 Years of Age*, *11–14 Years of Age*, *15–18 Years of Age*, *19–20 Years of Age,* and *Total* measure rates. These results indicate opportunities for improvement for Premier Access CHIP.

Compliance Monitoring

For CY 2020 compliance monitoring activities, HSAG conducted follow-up reviews on requirements that received a *Partially Met* or *Not Met* score in CY 2019 and full compliance reviews for health plans that were new in CY 2020. The new plans included the four UMIC health plans and the Healthy U PMHP that assumed PMHP services for Summit County starting in September 2020. HSAG reviewed a sample of credentialing, denial, appeal, and grievance records for all health plans.

Medicaid ACOs

The four ACOs came into compliance with most of the requirements in 2020; however, following the CY 2020 review, three of the four plans had ongoing findings in the Member Rights and Information standard. Molina had continued required corrective actions for the Grievance and Appeals standard, and Health Choice had continued required corrective actions for the Provider Participation and

Program Integrity standard. All four Medicaid ACO plans were required to complete a corrective action plan (CAP) to address the ongoing required corrective actions.

UMIC Plans

The four UMIC plans underwent a full review of all standards. While required corrective actions were identified in most standards, overall, the plans scored well in the Coordination and Continuity of Care, Subcontracts and Delegations, and Quality Assessment and Performance Improvement (QAPI) standards. All four UMIC plans were required to complete a CAP. The most common required actions related to accuracy and readability of member informational materials and compliance with Section 508 of Section 504 of the Rehabilitation Act.

MCO—HOME

For the CY 2020 compliance review, HOME had ongoing required corrective actions to address in the Member Rights and Information standard as a follow-up to the CY 2019 compliance review. In CY 2020, HSAG found full compliance with the requirements.

CHIP MCOs

The CHIP MCOs came into compliance with most of the requirements in 2020; however, following the CY 2020 review both CHIP health plans had ongoing required corrective actions in Member Rights and Information, and one health plan had continued required corrective actions in the Grievance and Appeals standard. Both CHIP health plans were required to complete a CAP to address the ongoing required corrective actions.

PMHPs

In CY 2020 HSAG conducted compliance monitoring activities for 12 PMHPs. Healthy U assumed PMHP services in Summit county as of September 2020; therefore, HSAG conducted a full review of all requirements. HSAG found full compliance with the Coordination and Continuity of Care and QAPI standards. Healthy U was required to complete a CAP for findings in all other standards.

In CY 2019 Central, Northeastern, and Salt Lake achieved full compliance; therefore, in CY 2020 HSAG only conducted a review of records for these health plans. The other PMHP health plans exhibited significant improvement from CY 2019 to 2020. Only one PMHP (Southwest) had ongoing required corrective actions in the Member Rights and Information standard that required a CAP following the CY 2020 follow-up compliance review activities.

Medicaid and CHIP Dental PAHPs

In CY 2019, MCNA achieved full compliance; therefore, HSAG only conducted a review of records for MCNA in CY 2020. Premier and Premier CHIP had ongoing required corrective actions identified in the

Member Rights and Information and Grievances and Appeals Standards following the CY 2019 review that HSAG found to be in full compliance in CY 2020. Premier CHIP had additional findings in CY 2019 in the Coverage and Authorization standard that HSAG found to be in compliance in CY 2020. Premier and Premier CHIP did not have any ongoing required corrective actions to address in CY 2020.

Validation of Network Adequacy

Overall, the Utah CY 2020 network adequacy validation (NAV) results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider types, (e.g., pediatric specialists). Utah's Medicaid and CHIP plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards. The results of the provider directory validation (PDV) analysis show wide variance in the percentage of sampled providers found in the online directory across different plans. Match percentages between the plan-submitted provider data and the online provider directory varied across health plans but were generally high except for provider county and provider specialty information.

Medicaid ACOs

Geographic network distribution analysis results indicate that the ACOs generally maintained a geographically accessible network, especially in the frontier counties. All ACOs encountered challenges in meeting the time/distance standards for the pediatric specialty providers. Except for county and specialty information, PDV for the ACOs found high match percentages between the submitted provider data and the online directories for the 66.9 percent of sampled providers found in the online directory.

UMIC Plans

The UMIC plans operated only in urban areas and met the majority of the time/distance standards for physical health providers including women's health and specialists. All UMIC plans encountered challenges in meeting the standards for behavioral health facilities and additional physical health facilities such as Mammography and Outpatient/Infusion Chemotherapy. Excluding county information, PDV for the UMIC plans found high match percentages between the submitted provider data and the online directories for the 54.9 percent of sampled providers found in the online directory.

MCO—HOME

Compared to other health plans, HOME had lower member-to-provider ratios but did not meet any time/distance standards at the statewide level for the pediatric specialty providers or behavioral health facilities. HSAG's PDV found the sampled provider in the corresponding online provider directory for 17.0 percent (62 providers) of the reviews and low match percentages for Provider Address 1, Provider ZIP Code, Provider County, and Provider Accepting New Patients fields.

CHIP MCOs

Geographic network distribution analysis results indicate that the CHIP MCOs generally maintained a geographically accessible network in urban counties while struggling to meet standards in rural and frontier counties and for behavioral health provider categories. Excluding county information, PDV for the CHIP MCOs found high match percentages between the submitted provider data and the online directories for the 65.9 percent of sampled providers found in the online directory.

PMHPs

The PMHPs operate regionally and have demonstrated a wide range in the percentage of members with access to providers. Based on the provider network reported by Wasatch, the PMHP did not meet the urban time/distance standard for any of the provider categories in any urbanicity. Conversely, Salt Lake met the time/distance standards for eight of the nine provider categories, indicating a high level of access for its members. HSAG's PDV for the PMHPs found wide variance in the percentage of sampled providers found in the online directory across the different plans.

Medicaid and CHIP Dental PAHPs

The Medicaid dental PAHPs and CHIP PAHP met the time/distance standards in all provider categories in frontier, rural, and urban areas, indicating that members have access to dental providers within the time/distance standards. Except for Provider Address 2, Provider Middle Name, and Provider County information for Premier and Premier CHIP plans, PDV for the PAHPs and CHIP PAHP found high match percentages between the submitted provider data and the online directories for the sampled providers found in the online directory.

Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—Medicaid

Medicaid ACOs Providing Only Physical Health Services

Health Choice Utah (Health Choice)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Health Choice continued its PIP topic: *Breast Cancer Screening*.

Validation Results

Table 2-1 summarizes the validation findings for each stage validated for CY 2020. Overall, 84 percent of all applicable evaluation elements received a score of *Met*.

Table 2-1—CY 2020 Performance Improvement Project Validation Results for Health Choice (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Review the Data Analysis and Interpretation of Results	67% (2/3)	33% (1/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
Implementation Total		**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	0% (0/2)	50% (1/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**50% (1/2)**	**0% (0/2)**	**50% (1/2)**
Percentage Score of Applicable Evaluation Elements *Met*		**84% (16/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90% (9/10)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2020, Health Choice submitted Remeasurement 1 data for its PIP.

For Remeasurement 1, Health Choice reported a breast cancer screening rate of 34.7 percent, a 6.1 percentage point increase over the baseline, which is not considered a statistically significant improvement ($p = 0.0643$).

Table 2-2 displays the data for Health Choice's PIP.

Table 2-2—PIP—*Breast Cancer Screening*
Health Choice

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 Period 01/01/2019–12/31/2019		Sustained Improvement
Breast Cancer Screening	N: 104	28.6%	N: 157	34.7%	*Not Assessed*
	D: 363		D: 452		

*N–Numerator D–Denominator

Health Choice—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Health Choice designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Health Choice also reported the study indicator data accurately. Additionally, Health Choice's study topic addressed CMS' requirements related to outcomes—specifically, the quality, timeliness, and accessibility of care and services. Health Choice's PIP aims to increase the proportion of eligible members receiving a mammogram. According to the PIP documentation, breast cancer screenings are an important preventive measure as early detection improves survival rates, and Health Choice is currently performing below the national average on this measure; therefore, it is an important area for improvement.

Opportunities for Improvement and Recommendations

The PIP received an overall *Not Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 84 percent of overall evaluation elements across all activities completed and validated. This performance suggests a thorough application of the sound PIP design; however, there were opportunities for improvement throughout the Implementation stage, including the interpretation of study results, causal/barrier analysis process, and intervention evaluation results. The Remeasurement 1 results did not achieve statistically significant improvement over the baseline.

As the PIP progresses, HSAG recommends the following:

- Health Choice must document whether there were factors that threaten the validity of the reported remeasurement data.
- Health Choice must clearly and completely describe its QI processes and team used to identify and prioritize the documented barriers.
- Health Choice must report the impact of each intervention by completely documenting evaluation results and outcomes. The next steps for each intervention must be supported by the evaluation results.
- Health Choice must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive study indicator outcomes.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the final audit report (FAR) for HEDIS 2020 based on CY 2019 data showed that Health Choice's HEDIS compliance auditor found Health Choice's IS and processes to be compliant with the applicable IS standards and reporting requirements for HEDIS 2020. Health Choice contracted with

an external software vendor with HEDIS Certified Measures℠[2-1] for measure production and rate calculation. HSAG's review of Health Choice's FAR revealed that Health Choice's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Performance Measure Outcomes

Table 2-3 shows Health Choice's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-3—Health Choice HEDIS 2020 Results

HEDIS Measure	Health Choice 2020 Rate	2020 NCQA Quality Compass Average
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	NA	54.94%
Appropriate Treatment for Upper Respiratory Infection (URI)		
The percentage of children 3 months of age and older who with a diagnosis of URI that did not result in an antibiotic dispensing event. (3 months-17 years)	93.17%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**34.73%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**44.04%**	60.13%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	78.35%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**32.16%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.32%	88.22%

[2-1] HEDIS Certified Measures℠ is a service mark of the NCQA.

HEDIS Measure	Health Choice 2020 Rate	2020 NCQA Quality Compass Average
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**56.93%**	57.11%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	61.19%	60.75%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. (Combination 1)	83.80%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**65.93%**	75.22%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	77.50%	74.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**56.93%**	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	**59.12%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**60.10%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.

Health Choice—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Health Choice exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement and Recommendations

Health Choice fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Health Choice exceeded the 2020 NCQA Quality Compass average for only six of the 14 applicable measure rates (42.86 percent), indicating several opportunities for improvement. Health Choice could focus its improvement efforts on preventive breast cancer, cervical cancer, chlamydia, and postpartum care screenings for women; well-child visits for infants and young children; documentation of BMI percentile for children ages 3 to 17; and appropriate management of diabetes.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Health Choice—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Health Choice's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Health Choice's sample of credentialed providers included three advanced practice nurses, four physicians, a physical therapist, a physician assistant, and a certified social worker. HSAG reviewed a full sample of 10 prior authorization denial records. Health Choice submitted a sample of one grievance record and one prior authorization appeal record for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Health Choice submitted and through conducting a virtual, web-based review consisting of interviews with key Health Choice staff members.

Strengths

HSAG found that Health Choice demonstrated overall improvement from CY 2019 to CY 2020, specifically pertaining to requirements related to access to care and services. Concerning member information requirements, HSAG found that Health Choice improved its website to work toward achieving ongoing full compliance with accessibility guidelines pursuant to Section 508 of Section 504 of the Rehabilitation Act, and W3C's Web Content. In addition, HSAG found that Health Choice had worked to incorporate additional fields into its provider directory to include information determined to be missing during CY 2018 and 2019 reviews (how to access the health plan's website, whether providers had participated in cultural competency training, and whether providers' offices have accommodations for people with physical disabilities).

HSAG found that for each provider credentialing file reviewed, Health Choice had obtained and reviewed a completed application, verified licensure and education, and checked applicants against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing records.

HSAG also found that Health Choice provided denial decisions to members in writing through notices of adverse benefit determination (NABDs), which included the required information, within the required time frames. HSAG also found that Health Choice consistently used a provider with the appropriate clinical expertise to make medical necessity denial determinations. HSAG found full compliance with the prior authorization denial records.

HSAG reviewed the grievance record submitted and found that Health Choice had acknowledged the grievance in a timely manner and had resolved the grievance within the allotted 90-day time frame. HSAG also found that the resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG found that while Health Choice had processes in place to include the required information in its provider directory, Health Choice had not yet updated many provider listings to include all required information. Health Choice stated that it continues outreach to providers who have not completed attestations. HSAG suggests that Health Choice continue its outreach to ensure that the directory includes comprehensive information for all providers.

In CY 2019, HSAG had evaluated Health Choice's searchable provider directory on Health Choice's website using the WAVE Web Accessibility Evaluation Tool (Wave.Webaim.org) accessibility tool and found 21 accessibility errors and 28 contrast errors. In CY 2020, HSAG again reviewed the online searchable provider directory and found 23 general errors and 85 contrast errors. To address this lingering issue, HSAG recommends that Health Choice's leadership develop a mechanism to ensure

that information for members maintained in the provider directory is complete and is readily accessible pursuant to 42 CFR §438.10 to properly accommodate members with visual impairments.

HSAG noted that one grievance (the full sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Health Choice review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

For the one appeal record submitted, Health Choice did not include evidence that an acknowledgement letter had been sent to the member, potentially indicating opportunities for improvement in the quality of and access to care for members.

VALIDATION OF NETWORK ADEQUACY

Table 2-4 displays the match percentage for provider information between the data submitted by Health Choice and all ACOs and the online provider directory. Table 2-5 reflects the percentage of providers who have the service listed as available on Health Choice's online directory as compared to all ACOs.

Table 2-4—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Health Choice and All ACOs

Provider Information	Health Choice			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	220	100.0%	0.0%	958	99.2%	0.8%
Provider Middle Name	220	99.5%	0.5%	958	97.7%	2.3%
Provider Last Name	220	100.0%	0.0%	958	99.8%	0.2%
Provider Address 1	220	92.7%	7.3%	958	90.5%	9.5%
Provider Address 2	220	92.7%	7.3%	958	90.3%	9.7%
Provider City	220	95.9%	4.1%	958	93.8%	6.2%
Provider State	220	100.0%	0.0%	958	99.5%	0.5%
Provider Zip Code	220	97.3%	2.7%	958	93.8%	6.2%
Provider County	220	0.0%	100.0%	958	0.7%	99.3%
Provider Specialty*	220	65.5%	34.5%	958	89.6%	10.4%
Provider Accepting New Patients	220	89.1%	10.9%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-5—Percentage of Provider Service Information Available in Online Directory for Health Choice and All ACOs

Available Services Information	Health Choice			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	220	22.3%	77.7%	958	47.5%	52.5%
Non-English Language Speaking Provider	220	100.0%	0.0%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	220	0.0%	100.0%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	220	0.0%	100.0%	958	37.3%	62.7%
Provider URL	220	0.0%	100.0%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-6 displays the number and percent of provider categories wherein Health Choice met the time/distance standards at the statewide level.

Table 2-6—Compliance With Time/Distance Standards by Provider Domain—Health Choice

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
Prenatal Care (PNC)/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	15	88.2%
Specialists—Pediatric	17	2	11.8%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	0	0.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Health Choice—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Health Choice's PDV indicated that 62.9 percent of the sampled providers were found in the health plan's online provider directory. Of the providers found, Health Choice had higher match percentages compared to all ACOs except for provider county and specialty. Further, Health Choice was the only ACO which had an option for members to be able to request a paper form of the provider directory.

Geographic network distribution analysis indicated that Health Choice met time/distance standards for 94.8 percent of all provider domains in frontier counties and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Additional Physical Health—Providers, Hospitals, Ancillary Facilities, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Health Choice's online provider directory is critical for members to have timely access to appropriate health care providers. Health Choice had a substantially lower match rate for Provider Specialty (65.5 percent) compared to the other ACOs (range: 94.7 percent–99.6 percent). HSAG recommends that Health Choice frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Health Choice have an option for members to report errors using an email address or toll-free number conspicuously displayed on the website. Health Choice should assess including information about the provider uniform resource locator (URL) and additional provider services such as cultural competency training status and physical disability accommodation. Health Choice noted in its response to HSAG's CY 2019 compliance reviews that it will be including cultural competency and Americans with Disabilities Act (ADA) compliance beginning January 2021.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Health Choice should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Health Choice met the time/distance standards for 37 of the 58 (63.8 percent) provider categories. The provider categories that did not meet the standards are listed in the table below. Additionally, Health Choice did not report any Mammography or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Health Choice should continue to assess areas of inadequacy to identify providers who chose not to contract with Health Choice and the inability to identify the providers in the data using the standard definitions.

Table 2-7—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Behavioral Health—Pediatric	Behavioral Health—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
Specialists—Adult	Endocrinology; Infectious Disease
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, submitted a new clinical PIP topic: *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds.*

Validation Results

Table 2-8 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-8—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (15/15)**	**0% (0/15)**	**0% (0/15)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (24/24)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Healthy U reported baseline data for its PIP. The baseline rate for the percentage of members 3 to 6 years of age receiving a well-child visit during the measurement year was 63.7 percent.

Table 2-9 displays data for Healthy U's *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds* PIP.

Table 2-9—PIP—*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*
Healthy U

Study Indicator Results			
Study Indicator	**Baseline (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of children 3–6 years of age who received one or more well-child visits with a primary care provider during the measurement year.	N: 247	63.7%	*Not Assessed*
	D: 388		

N–Numerator D–Denominator

Healthy U—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Healthy U designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process. Healthy U reported and analyzed its baseline data accurately. Healthy U also conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and have the potential to impact study indicator outcomes, and documented appropriate processes to evaluate the effectiveness of the interventions. Additionally, Healthy U's study topic addressed CMS' requirements related to outcomes—specifically, the quality of care and timeliness of services. Healthy U's PIP aims to increase the percentage of members ages 3 to 6 years old receiving annual well-child visits with a primary care provider (PCP).

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Healthy U must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Healthy U's HEDIS compliance auditor found Healthy U's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Healthy U contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Healthy U's FAR revealed that Healthy U's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Performance Measure Outcomes

Table 2-10 shows Healthy U's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-10—Healthy U HEDIS 2020 Results

HEDIS Measure	Healthy U 2020 Rate	2020 NCQA Quality Compass Average
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**50.73%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.12%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**49.39%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**48.18%**	60.13%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	75.43%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**48.28%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.56%	88.22%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	58.64%	57.11%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	80.98%	60.75%

HEDIS Measure	Healthy U 2020 Rate	2020 NCQA Quality Compass Average
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	90.51%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	76.89%	75.22%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**71.76%**	74.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	84.67%	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	**56.69%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**67.97%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

Healthy U—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Healthy U exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Opportunities for Improvement and Recommendations

Healthy U fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Healthy U exceeded the 2020 NCQA Quality Compass average for only eight of the 15 applicable measure rates (53.33 percent), indicating several opportunities for improvement. Healthy U could focus its improvement efforts on medication management; breast cancer, cervical cancer, and chlamydia preventive screenings for women; decreasing unnecessary back imaging; and increasing well-child visits for infants and young children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Healthy U's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included a psychiatrist, a board-certified behavioral analyst (BCBA), a social worker, an advanced practice nurse, a physical therapist, a physician assistant, a family practice physician, an internal medicine physician, and a family practice nurse. HSAG reviewed a full sample of 10 prior authorization denial records and full samples of 10 for both the grievances and appeals record reviews for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Overall, HSAG found that Healthy U demonstrated improvement from CY 2019 to CY 2020. As it pertained to access to care, Healthy U had developed the comprehensive Assessment and Attestation Tool for ADA Compliance and had distributed the tool to its providers to collect information regarding

its network facilities' physical access, accommodations, and accessible equipment available for members with physical and mental disabilities. Healthy U updated its provider directory with the information it had obtained.

In CY 2020, Healthy U had expanded and enhanced cultural diversity training and activities to more broadly address diverse cultural characteristics, behaviors, and beliefs of its members; promote sensitivity and understanding of diverse cultures in delivery of services; and foster cultural competency among its providers, potentially positively impacting the quality of and access to care. Healthy U also tracked provider participation in trainings through provider attestation.

Pertaining to member information, Healthy U positively impacted access to care by:

- Improving the machine-readability of its member handbook and provider directory to assist members with visual impairments.
- Including taglines in large, 18-point font size and prevalent non-English languages describing how to request auxiliary aids and services.
- Including in taglines on written materials which are critical to obtaining services (i.e., provider directories, member handbooks, appeal and grievance notices, and denial and termination notices), how to access written translation, oral interpretation, the toll-free and teletypewriter/telecommunication device (TTY/TDD) phone numbers, the customer service phone number, and availability of materials in alternative formats.
- Including information on Healthy U's website notifying members that the information on the website is available in paper form without charge, upon request, and that the information would be provided within five business days.
- Adding required information to its provider directories, which included network pharmacies, the provider's website URL, whether the provider completed cultural competency training, and whether the provider's office has accommodations for people with physical disabilities.

During the period under review, Healthy U used two credentials verification organizations (CVOs). In each provider's credentialing file reviewed, Healthy U included primary source verification (PSV) reports provided by the CVOs and the provider's Council for Affordable Quality Healthcare, Inc. (CAQH) application. Healthy U processed the application and reviewed licensure, education, and federal exclusion database search results prior to hire. HSAG found full compliance with the credentialing files reviewed.

HSAG found that NABD letters to members and providers met timeliness requirements in all records reviewed. For grievances and appeals, HSAG also found that Healthy U sent all acknowledgement letters in a timely manner. In addition, HSAG found that grievance and appeal acknowledgement and resolution letters were simple, easy to understand, and included all required information.

While some grievance resolution letters contained minimal information about the grievance, Healthy U included information about its telephone calls with the member to provide evidence that additional

dialog took place and the discussion leading up to the resolution involved the member's input. HSAG found that all grievance resolution letters in the sample were sent in a timely manner.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that Healthy U did not have a process to verify that members received services which were represented as delivered to them. Following the review, Healthy U developed a process; however, by CY 2020, Healthy U reported that it had yet to implement the process. HSAG suggests that Healthy U promptly implement its survey as an additional layer to detect fraudulent billing practices.

HSAG found that the grievance resolution letter template included language stating that if the member was unsatisfied with the grievance resolution, he or she may contact Healthy U for a "second review." Healthy U staff members said that this second review was akin to an appeal following an NABD. While a member may reach out to Healthy U for more information about a grievance resolution, a formal process is not articulated in 42 CFR Part 438 for a member to appeal a grievance resolution. According to federal regulations, the grievance resolution is final. HSAG suggests that Healthy U remove this language from its grievance template.

HSAG found that NABD letters to the member often included language that was complex or included medical jargon. HSAG suggests that Healthy U strategize how to ensure that complex language and medical jargon are translated to easy-to-understand language before the letters are sent to the members.

In the sample of appeals, HSAG found that Healthy U sent one appeal resolution letter 35 days following the member's appeal request, which fell outside the 30-day appeal response required time frame, potentially indicating a negative impact in the timeliness domain.

VALIDATION OF NETWORK ADEQUACY

Table 2-11 displays the match percentage for provider information between the data submitted by Healthy U and all ACOs and the online provider directory. Table 2-12 reflects the percentage of providers who have the service listed as available on Healthy U's online directory as compared to all ACOs.

Table 2-11—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All ACOs

Provider Information	Healthy U			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	271	100.0%	0.0%	958	99.2%	0.8%
Provider Middle Name	271	100.0%	0.0%	958	97.7%	2.3%

Provider Information	Healthy U			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider Last Name	271	99.6%	0.4%	958	99.8%	0.2%
Provider Address 1	271	94.8%	5.2%	958	90.5%	9.5%
Provider Address 2	271	94.1%	5.9%	958	90.3%	9.7%
Provider City	271	95.6%	4.4%	958	93.8%	6.2%
Provider State	271	98.9%	1.1%	958	99.5%	0.5%
Provider Zip Code	271	95.6%	4.4%	958	93.8%	6.2%
Provider County	271	1.5%	98.5%	958	0.7%	99.3%
Provider Specialty*	271	95.2%	4.8%	958	89.6%	10.4%
Provider Accepting New Patients	271	93.7%	6.3%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-12—Percentage of Provider Service Information Available in Online Directory for Healthy U and All ACOs

Available Services Information	Healthy U			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	271	4.4%	95.6%	958	47.5%	52.5%
Non-English Language Speaking Provider	271	98.9%	1.1%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	271	35.1%	64.9%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	271	66.8%	33.2%	958	37.3%	62.7%
Provider URL	271	44.3%	55.7%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-13 displays the number and percent of provider categories wherein Healthy U met the time/distance standards at the statewide level.

Table 2-13—Compliance With Time/Distance Standards by Provider Domain—Healthy U

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Specialists—Pediatric	17	4	23.5%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	0	0.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Healthy U—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Healthy U's PDV indicated that 74.5 percent of the sampled providers were found in the health plan's online provider directory. Apart from county information, Healthy U's match rates exceeded 90 percent between submitted data and the online directory for all provider fields.

Geographic network distribution analysis indicated that Healthy U met the most time/distance standards statewide among the ACOs and met 91.4 percent of all provider categories in frontier counties. The health plan met 100 percent of the standards statewide for seven of the 11 provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Compared to other ACOs, only 4.4 percent of Healthy U's providers had information on any practice limitations in the online provider directory. Healthy U needs to assess if this truly reflects the number of providers with practice limitations or a data issue. In CY 2019, as a result of its compliance reviews, HSAG recommended that Healthy U update its provider directory to include cultural competency training and physical disability accommodation information. The CY 2020 PDV found that while the percentage of providers with

cultural competency training information for Healthy U (66.8 percent) is higher than all ACOs, further improvements can be made for including both cultural competency training and ADA compliance. HSAG recommends that Healthy U frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Healthy U have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U met the time/distance standards for 42 of the 58 (72.4 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-14. Additionally, Healthy U did not report any pediatric specialty providers for Allergy & Immunology, Ophthalmology, or Orthopedic Surgery categories in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

Table 2-14—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Pediatric	Behavioral Health—Pediatric
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Molina Healthcare of Utah (Molina)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Molina submitted a new clinical PIP topic: *Medicaid Comprehensive Diabetic Care—Eye Exams.*

Validation Results

Table 2-15 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-15—CY 2020 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (4/4)	0% (0/4)	0% (0/4)
Design Total		**100% (16/16)**	**0% (0/16)**	**0% (0/16)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (25/25)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Molina reported baseline data.

For the baseline measurement period, Molina reported that 52.3 percent of diabetic members 18 to 75 years of age had either a retinal or dilated eye exam, a negative retinal or dilated exam in the prior measurement year, or a bilateral eye enucleation.

Table 2-16 displays data for Molina's PIP.

Table 2-16—PIP—*Medicaid Comprehensive Diabetic Care—Eye Exams*
Molina

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received a retinal eye exam.	N: 215 D: 411	52.3%	*Not Assessed*

N–Numerator D–Denominator

Molina—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Molina designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes and allowed for the successful progression to the next stage of the PIP process. Molina reported and analyzed its baseline data accurately. Molina conducted appropriate QI processes to identify barriers. The implemented interventions were logically linked to the barriers and appear to have the potential to impact study indicator outcomes. Additionally, Molina's study topic addressed CMS' requirements related to outcomes—specifically, the quality, and timeliness of care and services. Molina's PIP aims to improve the eye exam screening rates for its diabetic population ages 18 to 75. For patients with diabetes, regular follow-up with early detection and treatment of vision-threatening retinopathy enables the prevention of visual loss due to diabetic retinopathy.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Molina must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with all applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. HSAG's review of Molina's FAR revealed that Molina's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

Performance Measure Outcomes

Table 2-17 shows Molina's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-17—Molina HEDIS 2020 Results

HEDIS Measure	Molina 2020 Rate	2020 NCQA Quality Compass Average
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	NA	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.26%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**40.00%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**54.99%**	60.13%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	72.02%	70.28%
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**41.14%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	**88.08%**	88.22%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**52.07%**	57.11%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	**60.58%**	60.75%

HEDIS Measure	Molina 2020 Rate	2020 NCQA Quality Compass Average
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	84.43%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**74.70%**	75.22%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	**73.21%**	74.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	79.32%	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	68.86%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**66.18%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.

Molina—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Molina exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

Molina fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Molina exceeded the 2020 NCQA Quality Compass average for only five of the 14 applicable measure rates (35.71 percent), indicating several opportunities for improvement. Molina could focus its improvement efforts on breast cancer, cervical cancer, chlamydia, and postpartum care preventive screenings for women; controlling high blood pressure; appropriate diabetes care; well-child visits for young children; and decreasing unnecessary back imaging.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Molina—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Molina's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Molina's sample of credentialed providers included a physician assistant, a nurse practitioner, a licensed professional counselor, licensed social workers, an orthopedist, an audiologist, a behavioral analyst, an orthopedist, and an obstetrician. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 grievance records. Molina submitted a sample of nine appeal records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Molina submitted and through conducting a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

For the CY 2020 compliance follow-up review, HSAG found that overall Molina demonstrated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that Molina began using an accessibility product, User1st's uRemediate, which has a website application to invert the colors on a page or change to grayscale to help with color contrast. This product also offers an option to better support the viewer's screen reader.

HSAG found that for each provider credentialing file, Molina included all required documentation to demonstrate that it obtained a credentialing application, verified licensure and education, and searched federal exclusion databases prior to appointment. HSAG found full compliance with the credentialing record review.

HSAG reviewed NABD letters and found that Molina had sent all acknowledgement and resolution letters submitted to the members in a timely manner. Molina also demonstrated appropriate procedures for extensions and expedition requests.

Opportunities for Improvement and Recommendations

HSAG found that the prior authorization denial records did not meet the requirements of §438.10 related to format and readability, potentially indicating opportunities for improvement related to the access to and quality and timeliness of care. For example, the Guidelines for Appealing a Medical Denial was written using a font size smaller than the required 12-point font and included the following incorrect information:

- Language requiring members to follow an oral request for an appeal with a written request within five days.
- Language stating that Molina would process expedited appeals within three business days, instead of the required 72 hours.
- Outdated language regarding the continuation of services during an appeal or State fair hearing.

HSAG noted that Molina referred to all denial letters as "notices of action," which is an obsolete term for CMS. NABD is the current term CMS uses for adverse benefit determinations related to 42 CFR §438.404.

HSAG also found that the NABD letters and appeal resolution letters were often confusing, unclear, or written in language that was above a sixth-grade reading level. HSAG suggests that Molina's leadership team review the appeal procedures to ensure compliance with all requirements and incorporate a monitoring system to initiate supervisor review of letters for content and ease of understanding prior to mailing.

HSAG found that internal documentation of some grievances lacked important details. HSAG suggests that Molina work toward more complete documentation in its system notes. HSAG also noted that

grievance topics indicated that lagging eligibility updates in the pharmacy system occurred frequently and suggests that Molina consider investigating this pattern.

In CY 2018, HSAG had reviewed Molina's provider directory content and found that Molina did not include the following information in the provider directory located on its website: website URLs for providers; information concerning whether the provider completed cultural competency training; or whether the provider's office had accommodations for people with physical disabilities, including offices, exam rooms, and equipment. HSAG's review of Molina's provider directory again in CY 2019 revealed the same findings. In CY 2020, HSAG found that Molina's online provider directory did not include website URLs for providers or information concerning whether the provider completed cultural competency training, potentially negatively impacting the quality of and access to care. HSAG suggests that Molina develop a strategy to ensure its provider directory includes all required information.

In CY 2018, HSAG found that Molina's appeal process included provisions that the member must complete a written appeal request within five days of the oral request or the member would lose the right to appeal. In CY 2019, HSAG found that Molina had revised its policy to remove the statement that members may "lose their right to appeal" but did not remove the artificial time frame of five days. Molina's documents stated, "The written, signed Appeal must be received within five working days from the date of the oral Appeal. If the Aggrieved Person does not follow up with a written, signed Appeal, the Contractor has no further obligation to take action on the Aggrieved Persons Appeal." The Preamble to the Medicaid managed care regulations clarifies this topic wherein CMS states that a time limit cannot be imposed on the member's written response to an oral appeal request.

HSAG recommended that Molina's policy stress that Molina will work with the member to provide any assistance needed in filing a written appeal following an oral appeal, to comply with 42 CFR §438.406(a). HSAG also suggests that Molina review 42 CFR §438 Subpart F and revise sections of the Appeals policy, such as Section I. Right to Appeal a Grievance. There seemed to be some confusion regarding the definitions of a "NABD," "notice of action," "grievance," and "appeal." HSAG suggested that Molina remove the outdated term "notice of action" and ensure that the definition for "NABD" is aligned with the federal definition. A table in Molina's Appeal procedure indicated that a member has 30 days to file a request for a State fair hearing rather than the time frame of 120 days (from the appeals resolution). Within its policies, Molina stated that there is an option, sometimes, for a member to appeal a grievance, which is not accurate. HSAG suggested that senior leadership who oversee appeals and grievances thoroughly review policies and procedures to ensure consistency with the federal regulations.

VALIDATION OF NETWORK ADEQUACY

Molina—Quality, Timeliness, and Access to Care—Network Adequacy

Table 2-18 displays the match percentage for provider information between the data submitted by Molina and all ACOs and the online provider directory. Table 2-19 reflects the percentage of providers who have the service listed as available on Molina's online directory as compared to all ACOs.

Table 2-18—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina and All ACOs

Provider Information	Molina			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	277	97.5%	2.5%	958	99.2%	0.8%
Provider Middle Name	277	98.6%	1.4%	958	97.7%	2.3%
Provider Last Name	277	100.0%	0.0%	958	99.8%	0.2%
Provider Address 1	277	94.9%	5.1%	958	90.5%	9.5%
Provider Address 2	277	91.0%	9.0%	958	90.3%	9.7%
Provider City	277	97.5%	2.5%	958	93.8%	6.2%
Provider State	277	100.0%	0.0%	958	99.5%	0.5%
Provider Zip Code	277	96.4%	3.6%	958	93.8%	6.2%
Provider County	277	1.1%	98.9%	958	0.7%	99.3%
Provider Specialty*	277	99.6%	0.4%	958	89.6%	10.4%
Provider Accepting New Patients	277	86.6%	13.4%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-19—Percentage of Provider Service Information Available in Online Directory for Molina and All ACOs

Available Services Information	Molina			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	277	93.5%	6.5%	958	47.5%	52.5%
Non-English Language Speaking Provider	277	98.2%	1.8%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	277	59.2%	40.8%	958	44.9%	55.1%

Available Services Information	Molina			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	277	0.4%	99.6%	958	37.3%	62.7%
Provider URL	277	1.8%	98.2%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-20 displays the number and percent of provider categories wherein Molina met the time/distance standards at the statewide level.

Table 2-20—Compliance With Time/Distance Standards by Provider Domain—Molina

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	16	94.1%
Specialists—Pediatric	17	3	17.6%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	1	100.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Molina—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Molina's PDV indicated that 76.1 percent of the sampled providers were found in the health plan's online provider directory. Molina had more than a 90 percent match between submitted data and the online directory information for all provider fields except Provider County and Provider Accepting New Patients. Additionally, the information on the Molina website noted that the most recent update to the website and paper directory was October 25, 2020, when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina met most of the time/distance standards in rural counties (74.1 percent) and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Hospitals, Behavioral Health—Adult, and Behavioral Health—Pediatric provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training and provider URLs since less than 2 percent of sampled providers included information on these services.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina met the time/distance standards for 38 of the 58 (65.5 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-21. Additionally, Molina did not report any pediatric specialty providers for Dermatology or Ophthalmology and did not include any Mammography facilities or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina and the inability to identify the providers in the data using the standard definitions.

Table 2-21—Provider Categories That Failed to Meet Time/Distance Standards—Molina*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
PCP—Pediatric	PCP—Midlevel—Pediatric
Specialists—Adult	Infectious Disease
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Otolaryngology, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

SelectHealth Community Care (SelectHealth)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth continued its PIP topic: *Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday .*

Validation Results

Table 2-22 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-22—CY 2020 Performance Improvement Project Validation Results for SelectHealth (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
	Design Total	**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
	Implementation Total	**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

SelectHealth progressed to reporting Remeasurement 3 data in CY 2020. For Remeasurement 3, the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday was 33.3 percent. This rate is 1.7 percentage points lower than the Remeasurement 2 rate; however, SelectHealth maintained a statistically significant increase ($p = 0.0014$) of 6.6 percentage points over the baseline rate.

SelectHealth was able to sustain statistically significant improvement over the baseline rate for two remeasurement periods. It should be noted that there was a change in the HEDIS 2018 *Immunizations for Adolescents (IMA)* measure numerator specifications (i.e., a two-dose HPV vaccination series was added instead of a three-dose series). This change may impact the comparability of Remeasurement 2 and Remeasurement 3 data to the baseline rate.

Table 2-23 displays data for SelectHealth's PIP.

Table 2-23—PIP—*HPV Vaccine Prior to 13th Birthday for Female Medicaid Members*
SelectHealth

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Sustained Improvement
The percentage of 13-year-old female Medicaid members who had 2 doses of human papillomavirus (HPV) vaccine prior to their 13th birthday	N: 257 D: 961	26.7%	N: 308 D: 1,157	26.6%	N: 371 D: 1,060	35.0%*	N: 353 D: 1,060	33.3%*	*Achieved*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator

SelectHealth—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

SelectHealth designed a scientifically sound project and reported and analyzed its Remeasurement 3 data accurately. SelectHealth conducted appropriate QI processes to identify and prioritize barriers; implemented interventions that were logically linked to the barriers; and was successful in achieving a statistically significant, sustained improvement in the study indicator rate over the baseline. Additionally, SelectHealth's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. SelectHealth's PIP aims to improve HPV vaccination rates in its female adolescent Medicaid population. By increasing the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

HSAG recommends the following:

- Since SelectHealth has demonstrated sustained improvement in this PIP, the health plan should consult with UDOH on next steps.
- Considering the changes to the HEDIS specifications, if SelectHealth decides to continue with the current PIP topic, it should redetermine the baseline measurement period to allow for comparability of remeasurement data to the baseline.

- SelectHealth must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that SelectHealth's HEDIS compliance auditor found SelectHealth's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. SelectHealth contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of SelectHealth's FAR revealed that SelectHealth's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results.

Performance Measure Outcomes

Table 2-24 shows SelectHealth's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-24—SelectHealth HEDIS 2020 Results

HEDIS Measure	SelectHealth 2020 Rate	2020 NCQA Quality Compass Average
Antidepressant Medication Management		
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**50.88%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	94.84%	90.72%
Breast Cancer Screening		
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**50.02%**	58.35%
Cervical Cancer Screening		
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**57.66%**	60.13%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one	73.41%	70.28%

HEDIS Measure	SelectHealth 2020 Rate	2020 NCQA Quality Compass Average
chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)		
Chlamydia Screening in Women		
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**38.01%**	58.04%
Comprehensive Diabetes Care		
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	91.67%	88.22%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	65.36%	57.11%
Controlling High Blood Pressure		
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	76.12%	60.75%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	86.93%	80.40%
Prenatal and Postpartum Care		
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	79.56%	75.22%
Use of Imaging Studies for Low Back Pain		
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	74.76%	74.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	90.46%	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	**65.36%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**67.00%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

SelectHealth—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection (URI)*
- *Child Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Testing and Eye Exam (Retinal) Performed*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 1*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

Opportunities for Improvement and Recommendations

SelectHealth fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Antidepressant Medication Management*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

SelectHealth exceeded the 2020 NCQA Quality Compass average for only nine of the 15 applicable measure rates (60.00 percent), indicating several opportunities for improvement. SelectHealth could focus its improvement efforts on medication management; breast cancer, cervical cancer, and chlamydia preventive screenings for women; and well-child visits for infants and young children.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

SelectHealth—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed SelectHealth's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access

requirements. SelectHealth's sample of credentialed providers included physician assistants, a licensed professional counselor, licensed social workers, a physical therapist, a psychologist, an orthopedist, and a nurse practitioner. HSAG reviewed a full sample of 10 records for both the grievance and appeals record reviews. SelectHealth submitted a sample of four service authorization denial records for review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records SelectHealth submitted and through conducting a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

Overall, HSAG found that SelectHealth demonstrated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that SelectHealth's searchable online provider directory included all required information. HSAG noted that the searchable online directory contained information about whether providers had participated in cultural competency training and whether providers' offices had accommodations for members with physical disabilities.

Based on a review of provider agreements in CY 2018 and CY 2019, HSAG had found that provider agreements lacked provisions that the provider agrees to make available for audit, evaluation, or inspection—by the State, CMS, the U.S. Department of Health and Human Services (HHS) inspector general, and the comptroller general (or designees)—its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to Medicaid members and pertaining to any aspect of services and activities performed or amounts payable under the Contractor's contract with the State. For the CY 2020 review, SelectHealth submitted evidence that its provider agreements included associated regulatory language as defined in 42 CFR §438.230(c).

HSAG found that for each credentialing file reviewed, SelectHealth obtained an application, verified licensure and education, and conducted searches of federal exclusion databases prior to appointment. HSAG found that in all prior authorization denial records SelectHealth demonstrated timely determinations. In one of the files HSAG reviewed, SelectHealth demonstrated appropriate and timely use of an extension.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that SelectHealth's provider directories (print and electronic) did not include the provider's website URL and did not indicate whether the provider had completed cultural competency training or if the office had accommodations for members with physical disabilities. In CY 2020 HSAG found that the searchable directory continued to lack provider URLs and the portable document format (PDF) directory lacked cultural competency information about providers as well as URLs. HSAG suggested that SelectHealth develop a procedure to resolve this long-standing issue.

During review of the service authorization denial records, HSAG found that SelectHealth sent the same extension letter to both the member and the provider, which requested additional information and did not clarify medical terminology in the member letter. In addition, the member was not informed of the right to grieve the extension. HSAG suggests that SelectHealth establish a process to review letters that are sent to members to ensure clarity and appropriate readability grade level.

HSAG reviewed the appeal records and found that two acknowledgement letters were not sent in a timely manner and that two resolution letters were not written at an easy-to-understand grade level (i.e., a sixth-grade level to the extent possible). In addition, HSAG found that one appeal was not assigned to a reviewer in a timely manner and therefore did not meet timely resolution requirements. HSAG suggested that SelectHealth examine its appeal response procedures to improve the timeliness and quality experience for its members.

During the grievances record review, HSAG also found that SelectHealth did not send three grievance acknowledgement letters to members in a timely manner. HSAG reviewed notes in the system and letters to the member and found that members who called in a grievance were offered an opportunity to file a "formal" grievance. If they chose not to, then SelectHealth did not perform a follow-up or investigation and closed the case. Federal regulations state that the Medicaid managed care plan must accept grievances orally or in writing, according to 42 CFR §438.402(c)(3)(i). SelectHealth must accept a grievance regardless of how the member submits it and may not put an additional burden on the member to follow up in writing. SelectHealth must consider the initial verbal expression of dissatisfaction the grievance. HSAG noted that SelectHealth may have confused the process for filing a grievance orally with the process for filing an appeal orally. HSAG noted that it was likely that SelectHealth missed many grievances and consequently did not investigate their associated quality of service issues during the period under review. Within the files reviewed, HSAG found evidence of further confusion between grievances and appeals, as some members were offered the opportunity to file an appeal following the review of a quality of service issue. In addition, HSAG removed one appeal file from the grievance record review that SelectHealth had misidentified as a grievance. HSAG strongly recommends that SelectHealth's management team review 42 CFR §438 Subpart F–Grievance and Appeal System and retrain staff on grievance and appeal identification and processing.

VALIDATION OF NETWORK ADEQUACY

Table 2-25 displays the match percentage for provider information between the data submitted by SelectHealth and all ACOs and the online provider directory. Table 2-26 reflects the percentage of providers who have the service listed as available on SelectHealth's online directory as compared to all ACOs.

Table 2-25—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth and All ACOs

Provider Information	SelectHealth			All ACOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	190	99.5%	0.5%	958	99.2%	0.8%
Provider Middle Name	190	91.1%	8.9%	958	97.7%	2.3%
Provider Last Name	190	99.5%	0.5%	958	99.8%	0.2%
Provider Address 1	190	75.3%	24.7%	958	90.5%	9.5%
Provider Address 2	190	81.1%	18.9%	958	90.3%	9.7%
Provider City	190	83.7%	16.3%	958	93.8%	6.2%
Provider State	190	98.9%	1.1%	958	99.5%	0.5%
Provider Zip Code	190	83.7%	16.3%	958	93.8%	6.2%
Provider County	190	0.0%	100.0%	958	0.7%	99.3%
Provider Specialty*	190	94.7%	5.3%	958	89.6%	10.4%
Provider Accepting New Patients	190	8.4%	91.6%	958	73.7%	26.3%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-26—Percentage of Provider Service Information Available in Online Directory for SelectHealth and All ACOs

Available Services Information	SelectHealth			All ACOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	190	71.1%	28.9%	958	47.5%	52.5%
Non-English Language Speaking Provider	190	92.1%	7.9%	958	97.6%	2.4%
Provider Accommodates Physical Disabilities	190	90.0%	10.0%	958	44.9%	55.1%
Provider Completed Cultural Competency Training	190	92.1%	7.9%	958	37.3%	62.7%
Provider URL	190	34.7%	65.3%	958	19.9%	80.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-27 displays the number and percent of provider categories wherein SelectHealth met the time/distance standards at the statewide level.

Table 2-27—Compliance With Time/Distance Standards by Provider Domain—SelectHealth

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Specialists—Pediatric	17	3	17.6%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	3	50.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	1	100.0%
Behavioral Health—Pediatric	1	1	100.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

SelectHealth—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While SelectHealth's PDV indicated that only 53.7 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched the submitted data for the majority of providers found online. Additionally, over 90 percent of the sampled providers found in the online directory included service information on cultural competency, physical disability accommodation, and whether the provider speaks non-English languages.

Geographic network distribution analysis indicated that SelectHealth met 96.6 percent of the time/distance standards in the frontier counties and 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, Ancillary Facilities, Behavioral Health—Adult, and Behavioral Health—Pediatric provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth's online provider directory is critical for members to have timely access to appropriate health care providers. 41.2 percent of the sampled providers were

not found in the SelectHealth's online provider directory. Additionally, 5.1 percent of the provider locations were not found in the directory. Even among providers found online, SelectHealth had a lower match rate for Provider Address 1 (75.3 percent) and providers accepting new patients (8.4 percent) compared to the other ACOs. HSAG recommends that SelectHealth frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth met the time/distance standards for 39 of the 58 (67.2 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-28. While failure to meet some of the standards might result from lack of providers, SelectHealth should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth and the inability to identify the providers in the data using the standard definitions.

Table 2-28—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
PCP—Pediatric	PCP—Midlevel - Pediatric
Specialists—Pediatric	Allergy & Immunology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Oncology/Hematology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

Health Choice

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Health Choice submitted its new clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness.*

Validation Results

Table 2-29 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-29—PIP—*Follow-Up After Hospitalization for Mental Illness*
Health Choice

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Implementation Total		**Not Assessed**		
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Health Choice had not progressed to reporting data in this validation cycle.

Health Choice—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Health Choice designed a scientifically sound project. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Additionally, Health Choice's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Health Choice must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.
- Health Choice must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Health Choice's Utah Medicaid Integrated Care (UMIC) line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have the CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Health Choice—Quality, Timeliness, and Access to Care—Compliance Reviews

Health Choice's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards.

For the CY 2020 compliance monitoring activities, HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Health Choice's sample of credentialed providers included four nurse practitioners, a physical therapist, an audiologist, two primary care physicians, an ophthalmologist, and a physician assistant. HSAG reviewed a full sample of 10 prior authorization denial records. Health Choice submitted a sample of one appeal record and two grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Health Choice submitted and through conducting a virtual, web-based review consisting of interviews with key Health Choice staff members.

Strengths

Health Choice provided evidence of a utilization management (UM) program that operated effectively to process authorization requests and decisions in a timely manner, ensure consistent authorization decision-making processes, and uphold nationally recognized clinical practice guidelines (CPGs).

Health Choice described two major software implementations within the UM department: 1) updated InterQual criteria sets, and 2) enhancements to the CareRadius platform that improved the overall layout and speed of the system and added survey tools, including a discharge survey that automatically

tasked the transition of care (TOC) team with following up with the member, potentially positively impacting the quality and access to care.

Health Choice provided HSAG with evidence that during the period under review, Health Choice ensured that covered services were made available and accessible to members in a timely manner. Within its provider manual and provider agreements, Health Choice described medically necessary covered services that participating providers furnish. Health Choice provided its Network Monitoring policy which described methods for monitoring the size and sufficiency of the network. Health Choice demonstrated analysis of time and distance standards through its GeoAccess reports, which were run every six months. In addition, Health Choice network services representatives were assigned counties to maintain provider counts, oversee coverage issues, and actively recruit providers where access disparities may exist.

Health Choice described an effective "Safety Net" care management structure and mechanisms to coordinate between teams and ensure member care. These systems included software such as CareRadius, Med/MC for claims data, and a national community resource database. Health Choice provided an example of staff members using the national community resource database to support a member's transition out of state by connecting the member to local resources in the member's new place of residence. Health Choice outlined plans to partner with the Department of Public Health and develop disease management programs for diabetes, asthma, and congestive heart failure.

Health Choice had policies and procedures that described the organization's commitment to promoting and protecting member rights. Within the procedures, Health Choice identified several mechanisms to ensure that staff and providers took into account member rights. Mechanisms included annual staff training on member rights, member and provider newsletters, provider agreements, onboarding processes for new employees and newly contracted providers, and monitoring member complaints.

Health Choice's Compliance Plan and Fraud, Waste, and Abuse (FWA) policy addressed a code of conduct, designation of a compliance officer and compliance committee, compliance training for employees and some providers, effective lines of communication and reporting, and dedicated staff with processes for investigation of potential FWA. The provider manual informed providers of Health Choice's mechanisms to screen for, prevent, and report FWA and provided a link to the Office of Inspector General (OIG) website for more information. Health Choice's compliance program activities and FWA monitoring were interrelated. Health Choice staff members described provisions for reporting potential FWA to the State; suspension of payments to providers for allegation of fraud; and reporting to the State any overpayments identified and recovered, member circumstances affecting member eligibility (including death and change of residence), and termination of provider agreements.

Health Choice's Quality Assessment and Performance Improvement (QAPI) program involved a matrixed partnership including clinical services, medical directors, and overarching guidance through recent NCQA accreditation. Health Choice provided evidence through policies, procedures, and supporting interviews that substantiated compliance with the QAPI program's ability to assess performance and engage in improvement activities.

Health Choice's Quality staff members described a pattern variation analysis that explored differences in providers, members, and other data characteristics. These analyses helped Health Choice identify high and low performers in the provider network. Health Choice collaborated with high performers to gain insights regarding best practices. When low performers were identified, Health Choice was able to provide additional training and support. For example, reports indicated low breast cancer screening rates; upon further investigation, Health Choice was able to identify an underserved immigrant population accessing services at federally qualified health centers (FQHCs). Health Choice provided additional translation support at these locations and increased member education efforts to build understanding regarding the importance of breast cancer screenings.

Opportunities for Improvement and Recommendations

Health Choice refers to the outdated term "notice of action" (NOA) in multiple documents, which is the previous terminology for NABD. HSAG strongly suggests that all related documentation be updated to include the current terminology, NABD, to align with State and federal guidelines as well as reduce confusion.

Pertaining to coverage and authorization of services, Health Choice's definition of "medical necessity" was not inclusive of the required criteria, potentially negatively affecting the quality of and access to care.

Two of the 10 denial records included benefit determination and reasons that were not clearly described. Health Choice explained that this was due to a staff member's writing error. In both instances the staff member wrote a determination explanation that was inconsistent with the actual service requested (i.e., back pain versus neck pain). Additionally, Health Choice did not include appeal information in the NABD letters. HSAG found some instances wherein a clinical term was included at the beginning of the letter and the corresponding acronym appeared at the bottom of the letter; however, the two were not clearly linked, potentially negatively impacting the quality of service and access to care. HSAG suggests that Health Choice implement a process to review NABD letters prior to sending them to the member.

The cultural competency training Health Choice developed for its providers to explain how to promote the benefits of health care services lacked information about health care attitudes, beliefs, and practices that affect access to health care services. HSAG recommends strengthening the cultural competency training.

Health Choice's Member Rights and Responsibilities policy did not include that the member will receive information on treatment alternatives. In addition, HSAG evaluated Health Choice's website and several documents available on the website (i.e., the provider directory, member handbook, and drug formulary) for accessibility and found many errors indicating barriers to accessibility for members with visual impairments. In addition, the website did not have a notification that electronic information is available to members in paper form, without charge, upon request, and provided within five business days from the request.

Health Choice's provider directories did not contain the provider's website URL; an indicator to identify whether a provider has completed cultural competency training; or whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. Health Choice's provider directories also did not include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services (including written translation, oral interpretation, and the toll-free and TTY/TDD customer service number) and availability of materials in alternative formats.

During the appeal record review, HSAG found that in one file a registered nurse (RN) (rather than a pharmacist or an individual with an appropriate pharmacy background) reviewed the decision to deny a pharmaceutical request. This file was out of compliance with timeliness requirements for processing the appeal and for sending an extension notice in a timely manner. In addition, the extension letter did not inform the member of the right to file a grievance about the extension or to go directly to a State fair hearing due to Health Choice failing to adhere to timeliness requirements. For another record that resulted in Health Choice issuing an extension, Health Choice did not provide evidence to show how the delay was in the member's interest. In this case the delay was due to an internal error, and Health Choice should have provided an expedited resolution as soon as it became aware of the delay. HSAG strongly suggests that senior leadership review these discrepancies and ensure that appropriate systems are in place for members to receive a timely notification of appeal resolutions.

Within its policies, Health Choice stated that standard oral member appeals must be followed by a written letter or completed Member Appeal Form "within five business days from the date of the oral appeal." Health Choice cannot put an artificial time limit or constraint on a member to follow an oral appeal with a written appeal. In addition, if a member needs assistance with completing a written appeal following the oral request, Health Choice must provide assistance according to 42 CFR §438.406(a)(1).

Health Choice's written provider agreement did not specify that CMS, the HHS inspector general, and the comptroller general (or designees) will have availability to audit, evaluate, or inspect its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic services.

Upon review of Health Choice's provider manual and provider agreement, HSAG discovered that neither contained the required information about the grievance and appeal processes and the State fair hearing system.

VALIDATION OF NETWORK ADEQUACY

Table 2-30 displays the match percentage for provider information between the data submitted by Health Choice and all MCOs (excluding HOME) and the online provider directory. Table 2-31 reflects the percentage of providers who have the service listed as available on Health Choice's online directory as compared to all MCOs (excluding HOME).

Table 2-30—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Health Choice and All MCOs

Provider Information	Health Choice			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	152	99.3%	0.7%	809	98.6%	1.4%
Provider Middle Name	152	99.3%	0.7%	809	94.7%	5.3%
Provider Last Name	152	99.3%	0.7%	809	99.5%	0.5%
Provider Address 1	152	87.5%	12.5%	809	91.1%	8.9%
Provider Address 2	152	90.1%	9.9%	809	91.7%	8.3%
Provider City	152	90.8%	9.2%	809	94.4%	5.6%
Provider State	152	97.4%	2.6%	809	99.4%	0.6%
Provider Zip Code	152	89.5%	10.5%	809	92.5%	7.5%
Provider County	152	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	152	65.1%	34.9%	809	91.6%	8.4%
Provider Accepting New Patients	152	85.5%	14.5%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-31—Percentage of Provider Service Information Available in Online Directory for Health Choice and All MCOs

Available Services Information	Health Choice				All MCOs (excluding HOME)			
	Total	Percentage Shown	Percentage Not Shown	Percentage Pending	Total	Percentage Shown	Percentage Not Shown	Percentage Pending
Any Practice Limitations*	152	19.1%	80.3%	0.7%	809	65.8%	34.1%	0.1%
Non-English Language Speaking Provider	152	99.3%	0.7%	0.0%	809	91.6%	8.4%	0.0%
Provider Accommodates Physical Disabilities	152	0.7%	98.7%	0.7%	809	43.8%	56.1%	0.1%
Provider Completed Cultural Competency Training	152	0.7%	98.7%	0.7%	809	41.8%	58.1%	0.1%
Provider URL	152	0.0%	100.0%	0.0%	809	14.1%	85.9%	0.0%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-32 displays the number and percent of provider categories wherein Health Choice met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-32—Compliance With Time/Distance Standards by Provider Domain—Health Choice

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)
PCP—Adult	2	1	50.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	3	3	100.0%
Behavioral Health—Facilities	4	1	25.0%

Health Choice—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While 54.2 percent of the sampled providers could not be found in the online directory, Health Choice was the only MCO which had an option for members to be able to request a paper form of the provider directory. Additionally, Health Choice noted that the most recent update to the website and paper directory was in October 2020.

Geographic network distribution analysis indicated that Health Choice met time/distance standards for 86.4 percent of all provider categories and 100 percent of the standards for PNC/Women's Health Providers, Specialists—Adult, Additional Physical Health—Providers, Hospitals, Ancillary—Facilities, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Health Choice's online provider directory is critical for members to have timely access to appropriate health care providers. Health Choice's PDV indicated that only 42.2 percent of the sampled providers were found in the health plan's online provider directory. Additionally, Health Choice had a substantially lower match rate for Provider Specialty (65.1 percent) compared to the other MCOs, and county information was not present for any of the sampled records. HSAG recommends that Health Choice frequently update its online provider directory with the

required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Health Choice include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Health Choice should also assess including information on provider URL and additional provider services such as cultural competency training status and physical disability accommodation.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Health Choice should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, all MCOs encountered challenges in meeting the time/distance standards for Additional Physical Health—Facilities and Behavioral Health—Facilities provider domains. The provider categories that did not meet the standards are listed in Table 2-33. Additionally, Health Choice did not report any Mammography facilities or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Health Choice should continue to assess areas of inadequacy to identify providers who chose not to contract with Health Choice and the inability to identify the providers in the data using the standard definitions.

Table 2-33—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
PCP—Adult	PCP—Medical—Adult

Healthy Outcomes Medical Excellence (HOME)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, HOME continued its PIP topic: *Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus.*

Validation Results

Table 2-34 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-34—CY 2020 Performance Improvement Project Validation Results for HOME (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

The purpose of this PIP is to decrease the HbA1c level in the identified pre-diabetic study cohort (i.e., an HbA1c between 5.7 to 6.4) to an HbA1c level less than 5.7. For the baseline, HOME identified the study cohort members based on their most recent HbA1c reading during CY 2017. A total of 103 pre-diabetic members were identified in the study cohort. Since all members included in the study are pre-diabetic, the rate for the study indicator during baseline was 0.0 percent. For Remeasurement 1, HOME reported that three members were dropped from the study cohort due to disenrollment; therefore, the Remeasurement 1 denominator for the cohort was 100. During CY 2018, the most recent HbA1c reading for 43 members in the study cohort was less than 5.7. For Remeasurement 2, HOME reported that 15 additional members were dropped from the study cohort due to disenrollment; therefore, the study denominator for the cohort was 85. During CY 2019, the most recent HbA1c reading for 36 members was less than 5.7. Even though the Remeasurement 2 rate was 0.7 percentage points below the Remeasurement 1 rate, it represented a statistically significant improvement over the baseline.

Table 2-35 displays data for HOME's *Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus* PIP.

Table 2-35—PIP—*Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus*

HOME

Study Indicator	Baseline Period 01/01/2017–12/31/2017		Remeasurement 1 01/01/2018–12/31/2018		Remeasurement 2 01/01/2019–12/31/2019		Sustained Improvement
Percentage of HOME enrollees in the identified pre-diabetic study cohort, who had a most recent HbA1c < 5.7 in the measurement period.	N: 0 D: 103	0.0%	N: 43 D: 100	43.0%*	N: 36 N: 85	42.3 %*	*Yes*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator

HOME—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HOME designed a scientifically sound PIP. The technical design of the PIP was sufficient to measure outcomes, and the PIP's solid design allowed for the successful progression to the next stage of the PIP process. HOME conducted appropriate QI processes to identify barriers and implemented interventions that were logically linked to the barriers. HOME sustained a statistically significant increase in the study indicator rate over the baseline for two consecutive remeasurement periods. HOME's study topic addressed CMS' requirements related to outcomes, specifically, the quality and timeliness of, and access to care and services. HOME's PIP aims to decrease the HbA1c level in the identified pre-diabetic study cohort (i.e., an HbA1c level between 5.7 to 6.4) to an HbA1c level less than 5.7.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- HOME has demonstrated sustained improvement in this PIP. The health plan should consult with UDOH on the next steps for this PIP.
- HOME must continue to revisit the causal/barrier analysis and QI processes at least annually to reevaluate barriers and develop new interventions as needed.
- HOME must build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that HOME's HEDIS compliance auditor found HOME's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. HOME contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of HOME's FAR revealed that HOME's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV results

Performance Measure Outcomes

Table 2-36 presents HOME's reporting year (RY) 2020 performance measure results.

Table 2-36—HOME RY 2020 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	50.00%
Follow-Up Within 30 Days	97.37%

HOME—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

HOME demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. HOME also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for HOME related to PMV; however, HOME may want to consider focusing on improving follow-up care post hospital discharge.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

HOME—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance follow-up review, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, service authorization denials, and appeals for alignment with the quality, timeliness, and access domains. HSAG reviewed a full sample of 10 initial credentialing

files for the period under review. HOME provided a sample of six prior authorization denial records, nine appeal records, and one grievance record for the period under review.

HSAG determined findings based on a desk review of the documents HOME submitted and through conducting a virtual, web-based review consisting of interviews with key HOME staff members.

Strengths

Overall findings for HOME indicated improvement from CY 2019 to CY 2020. Concerning member information, in CY 2018, HSAG had found that HOME had not advised members that information on its website is available in paper form without charge upon request and would be provided within five business days. During the CY 2019 interview, HSAG determined that this was not corrected. For the CY 2020 review, HSAG found that HOME included a statement on its website indicating that information on its website is available in paper form without charge, upon request, and would be provided within five business days.

HSAG found full compliance with HOME's credentialing records and found that four of the six prior authorization denial records included all required information and were sent in a timely manner. HSAG also found full compliance with eight of the nine appeals files, as HOME had included all required information in the acknowledgements and resolutions to the members and had sent them in a timely manner. HSAG reviewed HOME's one grievance file and found that HOME had met all grievance processing requirements.

Opportunities for Improvement and Recommendations

In HOME's prior authorization denial files HSAG found that two records in the submission did not include a NABD letter to the member. The final correspondence HSAG identified in each of the two files was a letter to the durable medical equipment (DME) supplier requesting additional information. In one case, HSAG found that the letter date was also listed as the denial date in the member's medical record, without any notice going to the member. HSAG suggests that HOME review the denial response process to ensure that all members receive a NABD notification, and specifically assess the process wherein DME is denied. HSAG also found that one appeals record was missing the acknowledgement and resolution letters to the member.

HSAG noted that one grievance over a five-month period is an unusually small amount. HSAG suggested that HOME review its grievance collection policies and procedures to ensure that HOME is tracking and appropriately documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-37 displays the match percentage for provider information between the data submitted by HOME and the online provider directory. Table 2-38 reflects the percentage of providers who have the service listed as available on HOME's online directory.

Table 2-37—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for HOME

Provider Information	Total	Match Percentage	Unmatched Percentage
Provider First Name	62	98.4%	1.6%
Provider Middle Name	62	64.5%	35.5%
Provider Last Name	62	98.4%	1.6%
Provider Address 1	62	35.5%	64.5%
Provider Address 2	62	75.8%	24.2%
Provider City	62	67.7%	32.3%
Provider State	62	90.3%	9.7%
Provider Zip Code	62	48.4%	51.6%
Provider County	62	0.0%	100.0%
Provider Specialty*	62	80.6%	19.4%
Provider Accepting New Patients	62	8.1%	91.9%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-38—Percentage of Provider Service Information Available in Online Directory for HOME

Available Services Information	Total	Percentage Shown	Percentage Not Shown	Percentage Pending
Any Practice Limitations*	62	4.8%	95.2%	0.0%
Non-English Language Speaking Provider	62	90.3%	9.7%	0.0%
Provider Accommodates Physical Disabilities	62	0.0%	98.4%	1.6%
Provider Completed Cultural Competency Training	62	0.0%	100.0%	0.0%
Provider URL	62	38.7%	61.3%	0.0%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-39 displays the number and percent of provider categories wherein HOME met the time/distance standards at the statewide level.

Table 2-39—Compliance With Time/Distance Standards by Provider Domain—HOME

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Adult	2	2	100.0%
PCP—Pediatric	2	1	50.0%

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PNC/Women's Health Providers	2	1	50.0%
Specialists—Adult	17	16	94.1%
Specialists—Pediatric	17	0	0.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	1	33.3%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	4	0	0.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

HOME—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Geographic network distribution analysis indicated that HOME met time/distance standards for 86.2 percent and 84.6 percent of all provider categories in frontier and urban counties, respectively. Additionally, HOME met 100 percent of the standards for PCP—Adult, Additional Physical Health—Providers, and Hospitals provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in HOME's online provider directory is critical for members to have timely access to appropriate health care providers. HOME's PDV indicated that only 17.0 percent of the sampled providers were found in the health plan's online provider directory. The match percentage for address fields were low for the providers found on HOME's online directory. Information on physical disability accommodation and cultural competency training was also not included in HOME's online directory. HSAG recommends that HOME frequently update its online provider directory with the required, accurate provider information and fix the issues related to search options. HSAG also recommends that HOME have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. HOME should continue to assess the accuracy of the category assigned to each provider in the submitted data for

accurate network adequacy results. The provider categories that did not meet the standards are listed in Table 2-40. HOME did not report any pediatric specialty providers in the data for Allergy & Immunology, Pediatric; Ophthalmology, Pediatric; or Orthopedic Surgery, Pediatric categories. Additionally, HOME did not report any Outpatient Infusion/Chemotherapy facilities in the provider data. HOME did not meet any time/distance standards at the statewide level for the pediatric specialty providers and behavioral health facilities. While failure to meet some of the standards might result from lack of providers, HOME should continue to assess areas of inadequacy to identify providers who chose not to contract with HOME and the inability to identify the providers in the data using the standard definitions.

Table 2-40—Provider Categories That Failed to Meet Time/Distance Standards—HOME*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Medical
Specialists—Adult	Infectious Disease
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Healthy U submitted a new clinical PIP topic: *Improving Adults' Access to Preventive/Ambulatory Care Services*.

Validation Results

Healthy U submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-41—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U had not progressed to reporting data in this validation cycle.

Healthy U—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Healthy U designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The study topic selected by Healthy U addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and, access to care and services. The PIP submitted by Healthy U aims to increase the percentage of adult members receiving annual ambulatory or preventive care visits with a physician.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Healthy U's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U—Quality, Timeliness, and Access to Care—Compliance Reviews

Healthy U's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included two doctors of osteopathic medicine, a licensed social worker, an advance practice RN specializing in gerontology, radiologists, a neurologist, a marriage and family therapist, an orthopedic surgeon, a behavioral analyst, and a physical therapist. Healthy U submitted a sample of two prior authorization denial records, two appeal records, and three grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Healthy U described a matrixed UM structure that collaborated with medical management, operations, and other teams frequently. Workflows for pre-service, post-service, and TOC teams were well outlined and upheld requirements. Healthy U used Epic software throughout the organization, which ensured cohesive processes across teams to receive and process authorizations. The Drug Utilization Review Board maintained a diverse clinical membership in line with federal requirements and conducted annual oversight to review and update clinical standards, positively impacting Healthy U's quality of care. Healthy U used InterQual consistently to make UM decisions and operated under well-documented policies and procedures to ensure timely initial and continuing authorizations. Furthermore, Healthy U conducted extensive interrater reliability (IRR) testing throughout the year. This training was further supported by a monthly physician meeting known as the "Review Roundup" where trends and learning opportunities were discussed.

Healthy U maintained and monitored a network of providers sufficient to provide access to covered health services for members, including those with limited English proficiency or physical or mental disabilities. Healthy U had mechanisms to ensure that all covered services were available and accessible to members in a timely manner.

Healthy U showcased a diverse care management program that included adult, pediatric, mom and baby, and other specialty subpopulations. The Care Management department clearly demonstrated engagement in data-driven decision making. Staff described a risk stratification methodology used to identify members who may need additional care management supports. Based on recent coronavirus disease 2019 (COVID-19) changes to health care operations, Healthy U worked to transition providers to telemedicine platforms. One example included the asthma care management program moving to an "e-Asthma" approach which allowed members and providers to remain in contact virtually. Through the e-Asthma program, providers were able to identify ongoing supports needed, such as deploying high efficiency particulate air (HEPA) filters to members' houses.

Healthy U maintained policies and procedures that clearly delineated processes for members to file appeals and grievances, and for Healthy U staff members to review and process member grievance and appeal request submissions. Healthy U described the procedures for accepting and reviewing grievances and appeals. The process described aligned with Healthy U's policies.

Healthy U's submission of supporting documentation and evidence of access standards included policies, procedures, the provider manual, sample provider agreements, sample credentialing applications, the Compliance Plan, the FWA Compliance Plan, annual credentialing reviews, provider-specific communications, and a credentialing review worksheet. HSAG reviewed all submissions and found that most of the documents substantiated compliance with provider selection, credentialing, and compliance program requirements.

Healthy U presented a robust QAPI program that included collaboration between various departments and levels of leadership. Healthy U maintained an enterprise data warehouse (EDW) that integrated referrals and admit, discharge, and transfer (ADT) feeds, and provided staff members the ability to gain insights regarding specific member populations.

Additionally, the Quality team mentioned it was currently laying groundwork with stakeholders to eventually implement value-based payments. Healthy U also discussed plans to launch text messaging and email capabilities in March 2021.

Furthermore, Healthy U submitted detailed workflows and desktop procedures regarding the claims processing system. These documents outlined quality assurance measures taken to maintain accuracy, including auditing 3 percent of internal claims and 15 percent of claims that did not auto-adjudicate. Healthy U targeted 99 percent financial accuracy and 97 percent processing accuracy, and staff members attested to consistently meeting these goals.

Opportunities for Improvement and Recommendations

Upon desk review, HSAG found that multiple documents referred to notices of action (NOAs), which does not reflect current contract terminology. HSAG recommends that Healthy U update all related documents to reflect the current NABD terminology to align with State and federal guidelines and reduce confusion. Healthy U's Clinical Practice Guidelines policy and UM Program Description both included definitions of "medically necessary services"; however, these definitions did not include all required criteria, which could negatively impact the quality of services.

Healthy U documented and described a process for consulting with providers during the authorization review period. However, Healthy U also engaged in a denial reconsiderations process which did not adhere to State and federal denial and appeal guidelines. The Peer-to-Peer (P2P) Review Request Form and associated process were described as being used after the denial letter is mailed to the member. It is the intent of the State and federal regulations that after the NABD has been mailed, any additional actions and decisions then fall under the appeal process. Furthermore, the denial reconsiderations process did not include additional member notices. It is the intent of the State and federal regulations that the member be informed regarding denial and appeal decisions. Also related to provider consultation, the Pharmacy Authorization policy stated that "incomplete requests or requests received without all necessary supporting documentation may be denied for lack of documentation." While Healthy U's policy stated that expedited authorization decisions must be determined no later than 72 hours after receipt of the request, the NABD letters incorrectly stated three business days. One denial record review sample included clinical language that was not easy to understand (e.g., "rectal adenocarcinoma," "neoadjuvant," and "ganglion impar neurolysis"), negatively impacting the access domain.

Although Healthy U submitted a sample of three grievances for review, HSAG determined that two of the grievances were indeed appeals. Hence, Healthy U reported that it filed one grievance during this time period. HSAG recommends that Healthy U conduct an analysis of it processes, including those of call center staff, to ensure that all grievances and appeals are classified and accounted for appropriately so that Healthy U can track and trend them and initiate QI interventions as warranted. Further, a pharmacist overturned a "grievance" involving a pharmacy denial over the phone, demonstrating that Healthy U did not follow appeal procedures. Notes stated that the pharmacist overturned the denial because the medication was "very low cost," even though "the provider had not submitted the required information and the quantity requested was above suggested amounts." HSAG suggests that Heathy U evaluate this specific incident to determine the root cause of the issue.

While Healthy U defined "grievance" appropriately in policies and procedures, it was evident that customer service staff members were unable to delineate the difference between a grievance and an appeal. Healthy U submitted a sample of three grievances for HSAG to review as part of a sample of records. Upon review, HSAG determined that two of the grievances were actually appeals (a call requesting that Healthy U overturn a pharmacy denial and physical therapy denial). In one case the member called to dispute a denied request for authorization of medication. The customer service

representative contacted a pharmacist to review the denial. According to comments Healthy U provided from a note taken during the call, the pharmacist overturned the denial; and "although the provider had not submitted the required information and the quantity requested was above suggested amounts," the pharmacist overturned the denial because the medication was "very low cost." Healthy U staff did not follow the process for reviewing a denial. Healthy U must ensure that staff follow its process for resolving appeals for every appeal and that staff members are trained appropriately in the policies and processes.

HSAG noted that one grievance (the adjusted sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Healthy U review its grievance collection policies and procedures to ensure it is accounting for all member-submitted grievances, including those resolved quickly or that require little or no investigation.

Healthy U refers subcontractors to the provider manual for information about grievance and appeal processes and the State fair hearing system at the time they enter into a contract. HSAG reviewed the provider manual and identified that the information provided was not clear and did not accurately describe the grievance and appeal processes and the State fair hearing system. For example, Healthy U's provider directory included language that written appeals must follow oral appeals within five business days or the member's appeal will be closed. HSAG also observed that some terms were not consistent with UDOH contract language and federal regulations. For example, the provider manual referred to the adverse decision of a preservice authorization as a "notice of action."

Healthy U did not have a written policy and procedure that addressed conducting checks on employees and other individuals and entities to ensure that it does not employ an individual or entity excluded from participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.

HSAG reviewed three of Healthy U's delegation agreements, none of which incorporated language regarding the right of the State, CMS, the HHS inspector general, the comptroller general, or their designee to audit, evaluate, and inspect aspects pertaining to the services and activities performed or determination of amounts payable under Healthy U's contract with the State.

VALIDATION OF NETWORK ADEQUACY

Table 2-42 displays the match percentage for provider information between the data submitted by Healthy U and all MCOs (excluding HOME) and the online provider directory. Table 2-43 reflects the percentage of providers who have the service listed as available on Healthy U's online directory as compared to all MCOs (excluding HOME).

Table 2-42—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All MCOs

Provider Information	Healthy U			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	200	100.0%	0.0%	809	98.6%	1.4%
Provider Middle Name	200	96.5%	3.5%	809	94.7%	5.3%
Provider Last Name	200	99.5%	0.5%	809	99.5%	0.5%
Provider Address 1	200	97.0%	3.0%	809	91.1%	8.9%
Provider Address 2	200	90.5%	9.5%	809	91.7%	8.3%
Provider City	200	98.0%	2.0%	809	94.4%	5.6%
Provider State	200	100.0%	0.0%	809	99.4%	0.6%
Provider Zip Code	200	96.5%	3.5%	809	92.5%	7.5%
Provider County	200	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	200	99.0%	1.0%	809	91.6%	8.4%
Provider Accepting New Patients	200	100.0%	0.0%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-43—Percentage of Provider Service Information Available in Online Directory for Healthy U and All MCOs

Available Services Information	Healthy U			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	200	59.0%	41.0%	809	65.8%	34.1%
Non-English Language Speaking Provider	200	91.0%	9.0%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	200	41.0%	59.0%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	200	93.5%	6.5%	809	41.8%	58.1%
Provider URL	200	30.5%	69.5%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-44 displays the number and percent of provider categories wherein Healthy U met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-44—Compliance With Time/Distance Standards by Provider Domain—Healthy U

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	7	100.0%
Additional Physical Health—Facilities	6	5	83.3%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	2	66.7%
Behavioral Health—Facilities	4	3	75.0%

Healthy U—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While 44.8 percent of the sampled providers could not be found in the online directory, Healthy U's match rates for all required provider fields except Provider Address 2 and Provider County exceeded 95 percent. Additionally, 100 percent of the sampled providers had a match on Provider First Name, Provider State, and whether the provider accepted new patients, and 93.5 percent of the provider records online included service information on cultural competency training.

Geographic network distribution analysis indicated that Healthy U met the most time/distance standards (90.9 percent) statewide among the MCOs and met 100 percent of the standards for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Additional Physical Health—Providers, and Hospitals provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Healthy U's PDV indicated that only 53.3 percent of the sampled providers were found in the health plan's online provider directory. Only 41 percent of the sampled providers found in the online directory had information on physical disability accommodation, and 30.5 percent of the providers had a provider URL. HSAG recommends that Healthy U frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that Healthy U have an option

for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U met the time/distance standards for 40 of the 44 (90.9 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-45. All MCOs encountered challenges in meeting the time/distance standards for Additional Physical Health—Facilities and Behavioral Health—Facilities provider domains. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

Table 2-45—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	General Hospitals with a Psychiatric Unit

Molina

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020 validation, Molina submitted a new clinical PIP topic: *Follow-Up After Hospitalization for Mental Illness*.

Validation Results

Molina submitted the Design stage of the PIP for this year's validation. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-46—CY 2020 Performance Improvement Project Validation Results for Molina (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (7/7)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Molina had not progressed to reporting data in this validation cycle.

Molina—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Molina designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The PIP topic selected by Molina addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Molina must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Molina's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Molina—Quality, Timeliness, and Access to Care—Compliance Reviews

Molina's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Molina's sample of credentialed providers included nurse practitioners, physician assistants, a dermatologist, a podiatrist, a physical therapist, a marriage and family therapist, and a licensed social worker. HSAG reviewed a sample of 10 prior authorization denial records and 10 grievance records. Molina submitted a full sample of seven appeal records.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Molina submitted and through conducting a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

Molina maintained policies that detailed an effective UM program which included a standardized IRR process which was conducted annually and followed the NCQA 8/30 sampling approach. In addition, Molina described that it conducted a monthly review of local RN authorizations.

A strength associated with the access and quality domains was Molina's extensive policies and procedures that described how Molina delivers and coordinates care for its member populations. Initial screening and comprehensive assessments were embedded in Molina's documentation system. Members identified as having care management needs as a result of the initial screening were referred to a nurse for the diagnosis-based comprehensive assessment(s). Molina used a stratification algorithm to determine case management and care planning activities. Members in need of coordination due to TOCs were referred to a separate team for TOC management.

Pertaining to the quality domain of care, Molina had adequate policies that addressed privacy requirements in 45 CFR parts 160 and 164. Policies and procedures addressed release of information for sharing records, disclosure requirements, access limitations, minimum access necessary, and technical and physical access safeguards.

Molina had policies and procedures that clearly articulated Molina's intent to respect member rights and to ensure that staff members and providers protect member rights. Molina used the member handbook and member newsletters on its website to help members understand the Medicaid program and benefits available. Molina provided evidence of adequate processes for ensuring member materials are readily accessible (compliant with Section 508 of Section 504 of the Rehabilitation Act). Member materials such as the member handbook and the Guide to Accessing Quality Health Care were written in a manner that could be easily understood and were available in Utah's prevalent alternative language and alternative formats. Molina also provided evidence of having a process for language interpretation services. The provider directory search page provided options for members to change the view to achieve readily accessible (508 compliant) results, positively impacting members' access to care.

Molina provided policies and procedures as evidence of a comprehensive compliance program to detect and prevent FWA. During the interview Molina described processes for routine internal monitoring and auditing of compliance risks, which aligned with policies and met requirements. Molina also had processes in place to conduct random sampling of members to ensure that services represented as being provided were actually provided to members.

Within its Compliance Training policy, Molina stated that it would train employees on Molina's Compliance Plan, Code of Conduct, and Anti-Fraud Plan, and that training would be conducted within 60 days from the date of hire and annually thereafter. Molina's staff members affirmed this policy during the interview. Molina maintained a centralized toll-free hotline and Internet-based reporting system available 24 hours a day, seven days a week to enable employees, members, providers, vendors, subcontractors, and related entities to report instances of suspected noncompliance, violations of State or federal law, and violations of government or company policies and procedures.

Opportunities for Improvement and Recommendations

Based on HSAG's record review, Molina processed all denials in a timely manner, despite noted turnover during early 2020. However, HSAG found the following issues with the denials, potentially negatively impacting the quality, timeliness, and access domains of care.

HSAG identified inconsistencies linked to the corporate UM process. Denial records included four instances wherein services were denied due to lack of information; however, HSAG did not see evidence of a documented consultation with the provider to seek additional information. Molina's policies outlined three outreach attempts as part of the UM procedure; however, Molina did not uphold this process consistently in practice. Molina must ensure staff at both the local and corporate levels are following UM policies and procedures and engaging in provider outreach, when appropriate.

Furthermore, Molina should use extensions to gather additional information from providers when in the member's best interest.

- Molina did not always list the reason for the NABD in language that was easy to read.
- Molina included a requirement that members needed to submit a written appeal within five days following an oral request for an appeal.
- Molina indicated that expedited appeals may take three calendar days to resolve instead of the current 72-hour time frame.
- Molina did not have language clarifying that the member, health care provider, or authorized representative may submit a request for an expedited appeal.

Molina conducted a network adequacy analysis for all provider types outlined within the State contract, except behavioral health. The network adequacy report used standards less strict than those outlined in the State contract to measure time and distance adequacy for Washington County. The network adequacy report indicated that Washington, Davis, and Weber counties did not have any pharmacy providers, Utah County had one pharmacy provider, and Salt Lake County had only three pharmacy providers. Molina must ensure that its behavioral health and pharmacy provider networks and the providers in Washington County meet the State time and distance standards.

Molina provided evidence that it considered some of the required elements in establishing and maintaining its network; however, Molina did not present sufficient evidence to address all required elements, including:

- The anticipated Medicaid enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area.
- The number of network providers accepting/not accepting new Medicaid members.
- The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, or other technology solutions.

Molina's policies and procedures described a process of making three phone attempts to reach newly enrolled members, then mailing a hard copy assessment to any member not successfully reached by phone. During the on-site interview, Molina's team leader for the team responsible for this process confirmed the process for phone call attempts; however, the team leader stated that Molina does not send any written communication to the members following the three phone attempts. HSAG recommends that Molina develop a mechanism to improve its process and ensure that Molina's policies and procedures are consistent with its operational practices. Doing so may increase the number of members who receive an initial screening within 90 days of enrollment to identify any ongoing special conditions that require a course of treatment or regular care monitoring.

Molina received most grievances through phone calls, and member services addressed the grievances. HSAG noted a general lack of clarity in the way the call center documented acknowledgements and resolutions in the records and recommends that Molina develop and train call center staff to ensure that members are informed of their rights and are aware of the grievance process.

Molina provided the member handbook and other critical member materials via the website. The member welcome letter informed members where to find the handbook. While Molina provided material describing a process to ensure 508 compliance of the website, results of HSAG's testing using the WAVE Web Accessibility Evaluation Tool revealed that the Medicaid Integrated Care landing page and the Member Resources page showed 53 and 55 errors, respectively. Molina must refine its procedures to better ensure 508 compliance of its website to ensure that members successfully obtain required member materials. Molina did not provide evidence of how it informs members that they may request information about physician incentive plans. Molina must develop a process to make physician incentive plans available to members upon request.

Molina's policies did not include the complete State and federal definitions of "adverse benefit determination," "appeal," and "grievance." Molina's Member Grievance and Medical Appeals policy incorrectly described a NABD as "a determination that the enrollee disagrees with" and used the term "aggrieved person" when describing the appeal process. Further, processes indicated that a grievance could result in an appeal or State fair hearing, when only a NABD can lead to an appeal. HSAG also noticed the general lack of clarity between these definitions in policy and in practice. HSAG found one sample record wherein Molina had incorrectly routed an appeal to be processed as a grievance. Lastly, HSAG noted that the terms "NABD," "grievance," and "appeal" were used interchangeably in the member handbook. Molina must update its internal policies and procedures to include the complete and accurate federal definitions of "NABD" and "grievance." Furthermore, HSAG recommends working with UDOH to clarify these definitions in the member handbook to further support the quality of services Molina provides and access to care.

HSAG found that in two of the appeal samples, members were encouraged to withdraw their appeals due to a delay in Molina obtaining the signed appeal letter following an oral appeal, which could potentially negatively impact access to care. Instead of explaining the extension process and exercising this option, Molina instead encouraged members to "withdraw" the appeal and resubmit. Staff members indicated the withdrawal process was common and an existing report showed withdrawn appeals. This report indicated that a total of four appeals were withdrawn and only one case wherein the member followed up and received an overturned outcome. Notably, one of the withdrawn requests was for a surgery. In an instance identified within the grievance records, staff should have offered an appeal; however, staff members incorrectly routed the issue through the grievance system. HSAG recommends that Molina's leadership update its policies and procedures to clarify that staff members must assist members through all reasonable means to complete grievances and appeals. Molina should clarify policies and procedures to include extensions when appropriate and remove references to "withdrawal" and "resubmission" processes thereby decreasing barriers for members' access to exercising the right to appeal and potentially to receiving services.

Molina's procedural documentation incorrectly stated that an appeal needed to be filed in writing within five days of an oral appeal, or within 30 days, and the provider manual listed the time frame for filing an appeal as 180 days. HSAG recommends that Molina ensure documents reflect that a member has 60 days from the NABD to file an appeal, to improve timely access to service.

Molina submitted a sample extension template letter that did not include notification of the member's right to grieve the extension. Molina should update policies, procedures, and templates to include this language.

VALIDATION OF NETWORK ADEQUACY

Table 2-47 displays the match percentage for provider information between the data submitted by Molina and all MCOs (excluding HOME) and the online provider directory. Table 2-48 reflects the percentage of providers who have the service listed as available on Molina's online directory as compared to all MCOs (excluding HOME).

Table 2-47—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina and All MCOs

Provider Information	Molina			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	259	96.5%	3.5%	809	98.6%	1.4%
Provider Middle Name	259	97.3%	2.7%	809	94.7%	5.3%
Provider Last Name	259	100.0%	0.0%	809	99.5%	0.5%
Provider Address 1	259	92.3%	7.7%	809	91.1%	8.9%
Provider Address 2	259	95.0%	5.0%	809	91.7%	8.3%
Provider City	259	95.4%	4.6%	809	94.4%	5.6%
Provider State	259	100.0%	0.0%	809	99.4%	0.6%
Provider Zip Code	259	93.8%	6.2%	809	92.5%	7.5%
Provider County	259	0.0%	100.0%	809	0.2%	99.8%
Provider Specialty*	259	100.0%	0.0%	809	91.6%	8.4%
Provider Accepting New Patients	259	81.1%	18.9%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-48—Percentage of Provider Service Information Available in Online Directory for Molina and All MCOs

Available Services Information	Molina			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	259	97.3%	2.7%	809	65.8%	34.1%
Non-English Language Speaking Provider	259	99.6%	0.4%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	259	51.0%	49.0%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	259	0.4%	99.6%	809	41.8%	58.1%
Provider URL	259	0.0%	100.0%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-49 displays the number and percent of provider categories wherein Molina met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-49—Compliance With Time/Distance Standards by Provider Domain—Molina

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	4	66.7%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	3	3	100.0%
Behavioral Health—Facilities	4	3	75.0%

Molina—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Molina's PDV indicated that 69.1 percent of the sampled providers were found in the health plan's online provider directory. Apart from provider information related to Provider County and Provider Accepting New Patients fields, Molina's match rate between submitted data and the online directory information exceeded 90 percent for all provider fields. Additionally, Molina's website noted that the most recent update to the paper directory was in October 2020 when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina met 88.6 percent of the statewide time/distance standards and met 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, and Behavioral Health—Adult provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training, physical disability accommodation, and provider URL, since less than 2 percent of sampled providers found online included information about these services.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina met the time/distance standards for 39 of the 44 (88.6 percent) provider categories. The provider categories that did not meet the standards are listed in Table 2-50. Additionally, Molina did not report any Mammography facilities or Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina and the inability to identify the providers in the data using the standard definitions.

Table 2-50—Provider Categories That Failed to Meet Time/Distance Standards—Molina

Provider Domain	Provider Category
Additional Physical Health—Facilities	Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
Behavioral Health—Facilities	Behavioral Health Hospital

SelectHealth

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth submitted its clinical PIP topic: *7–Day Follow–Up After Hospitalization for Mental Illness for Medicaid Integration Members.*

Validation Results

Table 2-51 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met.*

Table 2-51—CY 2020 Performance Improvement Project Validation Results for SelectHealth (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (7/7)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

SelectHealth had not progressed to reporting data in this validation cycle.

SelectHealth—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

SelectHealth designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. The PIP topic selected by SelectHealth addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- SelectHealth must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- SelectHealth must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

SelectHealth's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. Therefore, it did not have CY 2019 data required to calculate or report performance measures in CY 2020.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

SelectHealth—Quality, Timeliness, and Access to Care—Compliance Reviews

SelectHealth's UMIC line of business, providing both physical health and behavioral health services to Medicaid expansion members, initiated operations in January 2020. As such, HSAG conducted a full review of all standards. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. SelectHealth's sample of credentialed providers included a psychiatrist, nurses, a physician assistant, licensed social workers, psychologists, and a certified counselor. HSAG reviewed a sample of 10 prior authorization denial records and a sample of 10 appeal records. SelectHealth submitted a sample of two grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records SelectHealth submitted and through conducting a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

SelectHealth's policies, procedures, submitted evidence, and interviews all supported a detailed UM process. SelectHealth staffed and structured its UM department in a way that resulted in systematic, timely reviews of authorization requests. SelectHealth further supported its UM department via a software platform that allowed staff members to store and disseminate information. The denial record review confirmed that SelectHealth mailed NABD letters in a timely manner, engaged medical professionals in a consistent review of documentation when needed, and made support staff available over weekends to ensure it met turnaround times for expedited requests and outpatient drug authorizations. A diverse UM department membership aligned with federal requirements, and staff participated in both the Drug Utilization Review Board and pharmacy and therapeutics committees. These committees were active and made timely decisions regarding formulary changes.

SelectHealth provided evidence that it delivers and coordinates care for its UMIC population. SelectHealth had embedded initial screening and comprehensive assessments in its care management documentation system (CareRadius). SelectHealth provided a Collaborative Care Program description that described levels of care management based on a predictive modeling program used to determine outreach efforts to minimize care gaps and determine care planning goals. SelectHealth staff members described best practices for ensuring members were connected with care managers and a PCP. These included allowing existing providers to serve UMIC members for up to 90 days following enrollment, using a vendor to outreach to members with care gaps, and recently developing a program (at the time of the virtual audit) designed to reach out to members to ensure they know how to choose a PCP and encouraging them to do so.

SelectHealth used a vendor, Eliza, to place initial automated calls to members. SelectHealth staff members reported that the Eliza system made six attempts to reach members. Staff members also reported that if a member were identified as needing care management services based on care gaps and the assigned care manager was unable to reach the member, SelectHealth would send a letter encouraging the member to contact the care manager.

SelectHealth had adequate policies that addressed privacy requirements in 45 CFR parts 160 and 164. Policies and procedures addressed release of information for sharing records, disclosure requirements, access limitations, minimum access necessary, and technical and physical access safeguards.

SelectHealth had a designated team and policies and procedures for addressing grievances and appeal requests. SelectHealth's documentation system captured all the required elements, including the credentials of the decision maker, and allowed staff to ensure that decision makers had not been involved in the original denial decision and had the appropriate clinical expertise. SelectHealth had completed all appeals HSAG reviewed during the virtual audit and had sent notice to the members according to the required time frames.

During the period under review, SelectHealth maintained policies that guided the processes for building and maintaining its provider network. During the interview, SelectHealth's medical staff and provider data director described the processes for initial credentialing and recredentialing that aligned with SelectHealth's policies and were compliant with federal regulations and State contract requirements. HSAG reviewed a sample of credentialing records and found full compliance with requirements, including evidence that SelectHealth obtained and reviewed the application for appointment, verified licensure and education, and conducted searches against federal exclusion lists prior to appointment for each provider file reviewed.

SelectHealth presented extensive evidence through policy, procedures, interviews, and live demonstration during the virtual audit which supported a comprehensive QAPI program. SelectHealth monitored service utilization, member outcomes, satisfaction, and key performance measures through various interconnected software and reporting platforms. SelectHealth discussed sharing timely data with providers via dashboards aimed to support the medical home model. SelectHealth used these dashboards to engage low-performing providers in improvement efforts, congratulate high-performing

providers, and analyze gaps in care where additional outreach was needed. Staff members described that data sharing "goes both ways," meaning SelectHealth was both sending and receiving key information through secure data exchanges to develop a comprehensive view of the UMIC population. Additionally, SelectHealth was in the beginning phases of implementing behavioral health performance measures and was actively working with UDOH to gather a more complete view of pharmacy data.

Opportunities for Improvement and Recommendations

Within the denial records, HSAG identified five instances wherein a member received a verbal denial regarding an out-of-network (OON) provider. In conjunction with other findings regarding network adequacy and member information related to the provider directory, this finding suggests that SelectHealth should analyze its network and outreach providers to join the integrated health plan.

SelectHealth described a mechanism to extend authorization decision timelines to obtain additional provider information; however, HSAG found SelectHealth's outreach during the standard 14-calendar-day time frame to be minimal. In one record review, SelectHealth made only one outreach attempt prior to the extension, and SelectHealth sent the denial decision letter as its second provider contact. Staff members stated that SelectHealth outreached to providers to request documents within 24 hours prior to the time frame expiring. If SelectHealth did not receive the requested documentation within 24 hours, it would immediately issue an extension. HSAG recommends that SelectHealth enhance its policies and procedures to use the standard authorization time frame more effectively prior to issuing extensions.

Through its record review, HSAG also noted five instances wherein a member requested OON providers, but SelectHealth's advocate team mislabeled these requests as denials. Based on the prevalence of these instances, HSAG recommends that SelectHealth assess the existing provider network and develop a process of recruiting these OON providers, when suitable.

Although SelectHealth sent all observed denials to members in a timely manner, its Preauthorization Notification Standards policy incorrectly described the urgent authorization timeline as three days instead of 72 hours. Additionally, while staff correctly described the time frames for sending denials, the Preauthorization Notification Standards policy described a process of "stopping the clock" when discussing extensions, which could negatively impact the timely access to care.

Most denial letters were easy to read at the sixth-grade reading level; however, three samples did include clinical terminology without common-language explanations. HSAG encourages SelectHealth to consider a method, such as an editorial review prior to the release of critical member letters, to ensure that member letters are easy to understand and meet language requirements outlined in 42 CFR §438.10(c).

Although SelectHealth's grievance and appeals policies correctly defined the term "grievance," its operational practices were such that not all grievances seemed to be captured and tracked as grievances, potentially impacting the quality of services. In addition, documentation in the grievance

files HSAG reviewed indicated that members are "offered" the opportunity to file a grievance or a "formal grievance." Requiring members to complete a second step after expressing dissatisfaction may discourage members from continuing to discuss issues or may prevent subsequent phone calls to grieve. Further, while policies and procedures accurately included provisions for acknowledging grievances, SelectHealth's process impeded members from receiving acknowledgment that they had filed a grievance (i.e., placed a call expressing dissatisfaction). The process of offering the grievance filing indicated that SelectHealth did not consider the initial call of complaint the grievance or acknowledge it as such. In addition, the documentation in the grievance records did not include evidence that the member was contacted either verbally or in writing to provide resolution. HSAG suggests that senior grievance and appeal leadership develop a process to ensure that, at the point the member expresses dissatisfaction, SelectHealth staff members log and track the contact and treat it as a grievance, including documentation of acknowledgement and resolution.

HSAG's review of attachments to the appeal resolution letters sent to the members identified many errors, including incorrect information regarding the continuation of benefits. The attachment did not notify members that they may have to pay for any continued services if the denial is upheld and did not clarify that although the request for continued services must be made withing 10 days of the NABD or before the effective date of the termination or reduction of services, the appeal may still be submitted up to 60 days from the date of the NABD. Further, while SelectHealth submitted policies outlining the process for extensions of the appeal time frame, the policy and record review did not provide evidence that SelectHealth had operationalized a process for notifying the member of the right to grieve the extension.

Member satisfaction survey results included low scores in terms of members "reaching their personalized goals." HSAG encourages SelectHealth to continue working with members to ensure they are engaged with understanding their individualized treatment goals.

Pertaining to the access and timeliness of care, HSAG reviewed the NAV report SelectHealth submitted and found that the network for Washington County was not evaluated against the time and distance standards set forth in the Utah contract. In addition, SelectHealth did not consider pharmacy providers when evaluating the network. SelectHealth did not show evidence that it provided family planning services or monitored them for sufficiency. During the interview, staff members discussed the availability of family planning providers, but SelectHealth reported that it did not monitor the network for timely access to these providers during the review period. While the Access and Availability Guidance document SelectHealth supplied outlined standards for timely access, SelectHealth did not have specific provisions in the document to take corrective action when a provider or provider's office failed to comply.

SelectHealth did not have a policy that described the process for ensuring that members receive notice of any significant change in the required informational materials at least 30 days prior to the change. In addition, staff were unable to articulate the process SelectHealth uses to inform members of significant changes. HSAG suggests that SelectHealth develop a mechanism to provide members

written notice of any significant change in the information required in §438.10(g) at least 30 days before the intended effective date of the change.

SelectHealth submitted its Medicaid Compliance & FWA Workplan, which did not include language with specific procedures for disclosing prohibited affiliations, ownership, and excess payments. The Medicaid Agreement Addendum included an overarching statement indicating that if SelectHealth becomes insolvent or bankrupt, members are not liable for any of SelectHealth's debts. However, the statement did not include the additional language required in 42 CFR §438.106. Further, SelectHealth's written delegation agreements did not include all required language.

VALIDATION OF NETWORK ADEQUACY

Table 2-52 displays the match percentage for provider information between the data submitted by SelectHealth and all MCOs (excluding HOME) and the online provider directory. Table 2-53 reflects the percentage of providers who have the service listed as available on SelectHealth's online directory as compared to all MCOs (excluding HOME).

Table 2-52—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth and All MCOs

Provider Information	SelectHealth			All MCOs (excluding HOME)		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	198	99.5%	0.5%	809	98.6%	1.4%
Provider Middle Name	198	85.9%	14.1%	809	94.7%	5.3%
Provider Last Name	198	99.0%	1.0%	809	99.5%	0.5%
Provider Address 1	198	86.4%	13.6%	809	91.1%	8.9%
Provider Address 2	198	89.9%	10.1%	809	91.7%	8.3%
Provider City	198	92.4%	7.6%	809	94.4%	5.6%
Provider State	198	99.5%	0.5%	809	99.4%	0.6%
Provider Zip Code	198	88.9%	11.1%	809	92.5%	7.5%
Provider County	198	1.0%	99.0%	809	0.2%	99.8%
Provider Specialty*	198	93.4%	6.6%	809	91.6%	8.4%
Provider Accepting New Patients	198	26.8%	73.2%	809	73.3%	26.7%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-53—Percentage of Provider Service Information Available in Online Directory for SelectHealth and All MCOs

Available Services Information	SelectHealth			All MCOs (excluding HOME)		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	198	67.2%	32.8%	809	65.8%	34.1%
Non-English Language Speaking Provider	198	75.8%	24.2%	809	91.6%	8.4%
Provider Accommodates Physical Disabilities	198	70.2%	29.8%	809	43.8%	56.1%
Provider Completed Cultural Competency Training	198	75.3%	24.7%	809	41.8%	58.1%
Provider URL	198	26.8%	73.2%	809	14.1%	85.9%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age

Table 2-54 displays the number and percent of provider categories wherein SelectHealth met the time/distance standards at the statewide level. All MCOs (except HOME) only operate in urban areas.

Table 2-54—Compliance With Time/Distance Standards by Provider Domain—SelectHealth

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
PCP—Adult	2	2	100.0%
PNC/Women's Health Providers	2	2	100.0%
Specialists—Adult	17	17	100.0%
Additional Physical Health—Providers	7	6	85.7%
Additional Physical Health—Facilities	6	3	50.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	3	2	66.7%
Behavioral Health—Facilities	4	2	50.0%

SelectHealth—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While SelectHealth's PDV indicated that only 54.5 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched with the submitted

data for the majority of the providers found online. Additionally, the health plan had the highest percentage of sampled providers found in the online directory who included service information on physical disability accommodation (70.2 percent).

Geographic network distribution analysis indicated that SelectHealth met 84.1 percent of the time/distance standards and met 100 percent of the standards statewide for PCP—Adult, PNC/Women's Health Providers, Specialists—Adult, Hospitals, and Ancillary—Facilities provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth's online provider directory is critical for members to have timely access to appropriate health care providers. 40.2 percent of the sampled providers were not found in SelectHealth's online provider directory. Additionally, 5.2 percent of the provider locations were not found in the directory. Even among providers found online, SelectHealth had a lower match rate for providers accepting new patients (26.8 percent) compared to the other MCOs. HSAG recommends that SelectHealth frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

The CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth met the time/distance standards for 37 of the 44 (84.1 percent) provider categories. The provider categories that did not meet the standards are listed Table 2-55. While failure to meet some of the standards might result from lack of providers, SelectHealth should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth and the inability to identify the providers in the data using the standard definitions.

Table 2-55—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Mammography; Outpatient Infusion/Chemotherapy
Additional Physical Health—Providers	Diagnostic Radiology
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit

Medicaid PIHP and PAHP PMHPs Providing Mental Health and/or Substance Use Disorder Services

Bear River Mental Health Services (Bear River)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Bear River submitted its PIP topic: *Suicide Prevention.*

Validation Results

Table 2-56 summarizes the validation findings for each stage validated for CY 2020. Overall, 95 percent of all applicable evaluation elements received a score of *Met.*

Table 2-56—CY 2020 Performance Improvement Project Validation Results for Bear River (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
Implementation Total		**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**95% (19/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Bear River progressed to reporting Remeasurement 4 results for the two study indicators.

The baseline rate for the percentage of eligible members who received the Columbia-Suicide Severity Rating Scale (C-SSRS) screening was 7.9 percent, which increased to 27.6 percent for Remeasurement 1, 54.1 percent for Remeasurement 2, and 55.9 percent for Remeasurement 3. For Remeasurement 4, the Study Indicator 1 rate of 52.7 percent decreased from the Remeasurement 3 rate by 3.2 percentage points; however, Bear River sustained the statistically significant increase ($p < 0.0001$) of 44.8 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 36.2 percent, which increased to 77.6 percent for Remeasurement 1 and then decreased to 59.5 percent for Remeasurement 2, following by an increase to 83.5 percent for Remeasurement 3. For Remeasurement 4, the Study Indicator 2 rate of 86.7 percent was 3.2 percentage points above the Remeasurement 3 rate and sustained the statistically significant increase ($p < 0.0001$) of 50.5 percentage points over the baseline.

Bear River was able to sustain statistically significant improvement over the baseline for four consecutive measurement periods for both study indicators.

Table 2-57 displays data for Bear River's *Suicide Prevention* PIP.

Table 2-57—PIP—*Suicide Prevention*
Bear River

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Remeasurement 4 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 218 D: 2,746	7.9%	N: 820 D: 2,966	27.6%*	N: 1,440 D: 2,660	54.1%*	N: 1,857 D: 3,323	55.9%*	N: 1,450 D: 2,751	52.7%*	*Yes*
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 38 D: 105	36.2%	N: 342 D: 441	77.6%*	N: 261 D: 439	59.5%*	N: 222 D: 266	83.5%*	N: 346 D: 399	86.7%*	*Yes*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator

Bear River—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Bear River designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Bear River reported and analyzed its Remeasurement 4 data accurately. Bear River conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers, and had a positive impact on the study indicator outcomes. Additionally, Bear River's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Bear River's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk. By increasing the percentage of members who received a C-SSRS screening during a face-to-face outpatient visit and the percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. Bear River was able to sustain improvement for three consecutive measurement periods for both study indicators.

HSAG recommends the following:

- Bear River has demonstrated sustained improvement in this PIP for four consecutive remeasurement periods. The health plan should consider a new PIP topic for next year's submission in consultation with UDOH.
- Bear River must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Bear River should build on its momentum of improvement to ensure it continues to sustain the improvement achieved.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-58 presents Bear River's measurement year (MY) 2020 performance measure results.

Table 2-58—Bear River MY 2020 *FUH* Results

Indicator	Bear River Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	60.16%	52.33%
Follow-Up Within 30 Days	69.92%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Bear River—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Bear River demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Bear River also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Bear River provided HSAG a detailed case listing of the numerator and denominator cases. There was an additional case listed, and during PSV it was identified that the case was a result of retroactive eligibility. Consequently, HSAG recommends that in the future, Bear River submit the case listing at the same time they submit the State's custom rate template.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Bear River—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Bear River's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Bear River's sample of credentialed providers included a certified mental health counselor and two licensed social workers. HSAG reviewed a full sample of 10 grievance records. Bear River reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Bear River submitted and through conducting a virtual, web-based review consisting of interviews with key Bear River staff members.

Strengths

In CY 2020 Bear River submitted a revised NABD template letter which indicated a corrected time frame (120 days from the appeal resolution) for a member to file for a State fair hearing, potentially positively impacting the quality and timeliness of care. In CY 2019, HSAG had reviewed Bear River's Medicaid provider directory and found that it was not up to date with Bear River's current Medicaid provider list (created October 2018). In addition, the provider directory only included a blanket statement for providers' linguistic capabilities. Following the review, Bear River developed a mechanism to ensure that the information included in the paper provider directory is updated at least monthly, that electronic provider directories are updated no later than 30 calendar days after Bear River receives updated provider information, and that these directories include linguistic capabilities and languages (including American Sign Language) offered by each provider or provider's office. Bear River submitted a link to its online provider directory which included a current list of providers and their linguistic capabilities.

For both CY 2018 and 2019, HSAG had found that Bear River did not have a method to ensure members received the services for which providers were billing. For the CY 2020 compliance review, Bear River submitted a spreadsheet that demonstrated its method to query a sample of members

monthly to determine whether they received services that network providers or employed providers represented as having been delivered. HSAG reviewed the spreadsheet and found compliance with the requirement.

HSAG reviewed a sample of initial credentialing files and found that Bear River had obtained an application, verified education and licensure, and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing records.

HSAG reviewed a sample of grievances and found that each grievance was acknowledged immediately and resolved within the allotted 90-day time frame, and that each resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement as a result of the follow-up compliance review.

VALIDATION OF NETWORK ADEQUACY

Table 2-59 displays the match percentage for provider information between the data submitted by Bear River and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-59—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Bear River and All PMHPs

Provider Information	Bear River			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	32	93.8%	6.3%	364	97.3%	2.7%
Provider Middle Name	32	84.4%	15.6%	364	85.7%	14.3%
Provider Last Name	32	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	32	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	32	100.0%	0.0%	364	93.7%	6.3%
Provider City	32	100.0%	0.0%	364	95.6%	4.4%
Provider State	32	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	32	96.9%	3.1%	364	97.5%	2.5%
Provider County	32	62.5%	37.5%	364	24.5%	75.5%

Table 2-60 displays the number and percent of provider categories wherein Bear River met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-60—Compliance With Time/Distance Standards by Urbanicity—Bear River

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Bear River	9	2	22.2%	2	22.2%	0	0.0%

Bear River—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Bear River's PDV indicated that 100 percent of the sampled providers were found in the health plan's online provider directory. Additionally, the health plan had 100 percent match percentages for Provider Last Name and all address fields except ZIP Code and Provider County. Bear River also included a last updated date on the provider online directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Bear River's online provider directory is critical for members to have timely access to appropriate health care providers. Bear River should continue to frequently update its online provider directory with the required, accurate provider information. HSAG recommends that Bear River have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Bear River should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Bear River did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-61. While failure to meet some of the standards might result from lack of providers, Bear River should continue to assess areas of inadequacy to identify providers who chose

not to contract with Bear River and the inability to identify the providers in the data using the standard definitions.

Table 2-61—Provider Categories That Failed to Meet Time/Distance Standards—Bear River*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Central Utah Counseling Center (Central)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Central submitted its new clinical PIP topic: *Inpatient Readmission Rates*.

Validation Results

Table 2-62 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-62—CY 2020 Performance Improvement Project Validation Results for Central (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (4/4)**	**0% (0/4)**	**0% (0/4)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (12/12)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (7/7)**		
Validation Status		***Met***		

Indicator Outcomes

Central had not progressed to reporting baseline data during this validation cycle.

Central—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Central designed a scientifically sound project and implemented system interventions that were related to barriers identified through QI processes and have the potential to drive improvement toward the desired outcomes. Central's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Central's PIP aims to improve processes and outcomes of members' mental health care and to decrease readmission to inpatient psychiatric hospitals within 12 months of discharge.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Central must ensure that it follows the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.

- Central must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Central must have a process in place for evaluating each PIP intervention and its impact on the study indicator and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-63 presents Central's MY 2020 performance measure results.

Table 2-63—Central MY 2020 *FUH* Results

Indicator	Central Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**42.00%**	52.33%
Follow-Up Within 30 Days	78.00%	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

Central—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Central demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Central also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information. Central implemented conditional formatting with its spreadsheet, which assisted Central staff in identifying which members were to be included in the rate calculation.

Opportunities for Improvement and Recommendations

Central's rates for members hospitalized for mental illness who received a follow-up visit within seven days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Central focus on improvement efforts designed to ensure that members receive a Central-furnished service within seven days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Central—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations. As such, for the CY 2020 review, HSAG did not conduct a review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Central's sample of credentialed providers included a certified mental health counselor, a case manager, and a social worker. Central submitted a sample of one grievance record for the period under review. Central reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Central submitted and through conducting a virtual, web-based review consisting of interviews with key Central staff members.

Strengths

During the period under review, Central conducted initial credentialing for three new providers. The providers included a social worker, a skills group aide, and a therapist. HSAG reviewed the personnel files for each provider. HSAG found that Central had collected an application, verified licensure and education (as appropriate), and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing files reviewed.

During the period under review, Central reported receiving one grievance. The grievance came from a member who called to complain about being treated unfairly. Central used an internal form to document the grievance. The form included all required information. Central resolved the grievance with the member in a timely manner.

Opportunities for Improvement and Recommendations

HSAG noted that one grievance (the full sample of reported grievances) over a five-month period is an unusually small quantity. HSAG suggests that Central review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-64 displays the match percentage for provider information between the data submitted by Central and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-64—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Central and All PMHPs

Provider Information	Central			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	19	89.5%	10.5%	364	97.3%	2.7%
Provider Middle Name	19	89.5%	10.5%	364	85.7%	14.3%
Provider Last Name	19	94.7%	5.3%	364	98.9%	1.1%
Provider Address 1	19	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	19	42.1%	57.9%	364	93.7%	6.3%
Provider City	19	100.0%	0.0%	364	95.6%	4.4%
Provider State	19	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	19	100.0%	0.0%	364	97.5%	2.5%
Provider County	19	0.0%	100.0%	364	24.5%	75.5%

Table 2-65 displays the number and percent of provider categories wherein Central met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-65—Compliance With Time/Distance Standards by Urbanicity—Central

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Central	9	2	22.2%	2	22.2%	0	0.0%

Central—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While Central's PDV indicated that only 67.9 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan had a 100 percent match between submitted data and the online provider directory for Provider Address 1, City, State, and Zip Code fields.

Opportunities for Improvement and Recommendations

Accurate provider information in Central's online provider directory is critical for members to have timely access to appropriate health care providers. In CY 2020, 25 percent of the sampled providers could not be found in the online directory, and an additional 7.1 percent of the provider locations could not be found in the health plan's online directory. Central should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Central include the last updated date on its provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Central should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Central did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-66. While failure to meet some of the standards might result from lack of providers, Central should continue to assess areas of inadequacy to identify providers who chose not to contract with Central and the inability to identify the providers in the data using the standard definitions.

Table 2-66—Provider Categories That Failed to Meet Time/Distance Standards—Central*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Davis Behavioral Health (Davis)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Davis submitted its new clinical PIP topic: *Access to Care.* The PIP submitted by Davis aims to increase access to care by improving the timeliness of substance use treatment from the date of initial contact by the member for treatment to the first two clinical appointments offered to the member.

Validation Results

Table 2-67 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-67—CY 2020 Performance Improvement Project Validation Results for Davis (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (15/15)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (8/8)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Davis progressed to reporting baseline results. The baseline rate for the percentage of members who had an initial appointment scheduled within seven calendar days from the first contact was 29.4 percent. The baseline rate for the percentage of members who had a second appointment scheduled within 14 calendar days from treatment admission was 86.3 percent.

Table 2-68 displays data for Davis's *Access to Care* PIP.

Table 2-68—PIP—*Access to Care*
Davis

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
1. Percentage of initial appointments scheduled within 7 calendar days from first contact.	N: 126 D: 428	29.4%	*Not Assessed*
2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	N: 195 D: 226	86.3%	*Not Assessed*

N–Numerator D–Denominator

Davis—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Davis designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Davis reported baseline data accurately, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Davis's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Davis must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Davis must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Davis must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-69 presents Davis's MY 2020 performance measure results.

Table 2-69—Davis MY 2020 *FUH* Results

Indicator	Davis Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	70.15%	52.33%
Follow-Up Within 30 Days	82.84%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Davis—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Davis demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Davis also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Although HSAG did not identify any specific opportunities for improvement or recommendations for Davis, and Davis's *FUH* rates were above the statewide PMHP average, continued opportunities to improve rates exist.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Davis—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Davis's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Davis's sample of credentialed providers included two nurses, a certified mental health counselor, a social work intern, a physician prescriber, a health service technician, and four licensed social workers. Davis reported 11 grievances for the period under review; however, Davis later determined that two of the grievances were not from Medicaid members. HSAG reviewed the nine remaining Medicaid member grievance records. Davis reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Davis submitted and through conducting a virtual, web-based review consisting of interviews with key Davis staff members.

Strengths

HSAG reviewed a full sample of 10 initial credentialing files and found that for all files, Davis provided evidence that applicants' names were searched against the federal exclusion database prior to hire.

Of the nine grievance records reviewed, HSAG found that Davis had acknowledged and resolved all grievances in a timely manner. HSAG found full compliance with Davis's grievance submission.

In CY 2019, HSAG reviewed Davis's online provider directory for its employed providers and found that the directory only included a list of the provider names and professional designations. In CY 2020, Davis provided evidence that it had updated the provider directory for its contracted and employed providers to include all required demographic information concerning its network providers.

Opportunities for Improvement and Recommendations

Pertaining to the credentialing record review, HSAG found that for the clinical mental health counselor, Davis did not verify the provider's education and licensure until after the provider was hired. HSAG recommends that Davis conduct a periodic review of its credentialing records to ensure that all requirements are met.

VALIDATION OF NETWORK ADEQUACY

Table 2-70 displays the match percentage for provider information between the data submitted by Davis and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-70—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Davis and All PMHPs

Provider Information	Davis			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	83	96.4%	3.6%	364	97.3%	2.7%
Provider Middle Name	83	98.8%	1.2%	364	85.7%	14.3%
Provider Last Name	83	97.6%	2.4%	364	98.9%	1.1%
Provider Address 1	83	83.1%	16.9%	364	92.9%	7.1%
Provider Address 2	83	97.6%	2.4%	364	93.7%	6.3%
Provider City	83	98.8%	1.2%	364	95.6%	4.4%
Provider State	83	98.8%	1.2%	364	99.7%	0.3%
Provider Zip Code	83	97.6%	2.4%	364	97.5%	2.5%
Provider County	83	45.8%	54.2%	364	24.5%	75.5%

Table 2-71 displays the number and percent of provider categories wherein Davis met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-71—Compliance With Time/Distance Standards by Urbanicity—Davis

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Davis	9	6	66.7%	0	0.0%	3	33.3%

Davis—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While Davis's PDV indicated that 83.8 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rate between submitted data and the online provider directory for all fields exceeded 90 percent except for Provider Address 1 and Provider County.

Opportunities for Improvement and Recommendations

Accurate provider information in Davis's online provider directory is critical for members to have timely access to appropriate health care providers. In CY 2020, 13.1 percent of the sampled providers could not be found in the online directory, and an additional 3 percent of the provider locations could not be found in the health plan's online directory. Davis should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Davis include the last updated date on its provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Davis should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Davis did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements for members in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the

standards are listed in Table 2-72. While failure to meet some of the standards might result from lack of providers, Davis should continue to assess areas of inadequacy to identify providers who chose not to contract with Davis and the inability to identify the providers in the data using the standard definitions.

Table 2-72—Provider Categories That Failed to Meet Time/Distance Standards—Davis*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Four Corners Community Behavioral Health (Four Corners)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Four Corners submitted its new clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*. The PIP submitted by Four Corners aims to improve processes and outcomes to ensure members with an opioid use disorder (OUD) are getting the support and outreach needed to maintain engagement and participation in treatment.

Validation Results

Table 2-73 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-73—CY 2020 Performance Improvement Project Validation Results for Four Corners (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Implementation Total		**Not Assessed**		
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Four Corners had not progressed to reporting data in this validation cycle.

Four Corners—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Four Corners designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Four Corners' study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Four Corners must ensure that it follows the approved PIP methodology to calculate and report baseline data accurately in next year's annual submission.

- To impact the Remeasurement 1 study indicator rate, Four Corners should complete a causal/barrier analysis to identify barriers to desired outcomes and implement interventions to address those barriers in a timely manner. Interventions implemented late in the Remeasurement 1 study period will not have enough time to impact the study indicator rate.
- Four Corners must document the process and steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- Four Corners must implement active, innovative improvement strategies with the potential to directly impact study indicator outcomes.
- Four Corners must have a process in place for evaluating each PIP intervention and its impact on the study indicators and allow continual refinement of improvement strategies. The evaluation process should be ongoing and cyclical. Intervention-specific evaluation results should guide next steps of each intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-74 presents Four Corners' MY 2020 performance measure results.

Table 2-74—Four Corners MY 2020 *FUH* Results

Indicator	Four Corners Rate*	Statewide PMHP Average**
Follow-Up Within 7 Days	**37.50%**	52.33%
Follow-Up Within 30 Days	**50.00%**	67.11%

*Anything with a small denominator is likely to be subject to wild swings in performance and interpretations should be made with caution.
**Statewide Average excludes HOME which falls into the MCO section above.
Rates in **red** font indicate the rate fell below the statewide PMHP average.

Four Corners—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Four Corners demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Four Corners also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Four Corners' rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Four Corners focus on improvement efforts designed to ensure that members receive a Four Corners-furnished service within seven days and within 30 days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Four Corners—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Four Corners' CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Four Corners' sample of credentialed providers included a licensed practical nurse and a peer support specialist. Four Corners reported four grievances for the period under review. Four Corners reported that it did not have any prior authorization denials or appeals during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Four Corners submitted and through conducting a virtual, web-based review consisting of interviews with key Four Corners staff members.

Strengths

In CY 2018, upon review of the member handbook and other written member information, HSAG found that Four Corners did not include taglines in large print (18 point) and prevalent non-English languages. In CY 2019, HSAG identified the taglines but noted that they were not in large print (18-point) font. For CY 2020, Four Corners updated its member handbook to include the taglines in 18-point font.

During the prior compliance monitoring reviews, HSAG found that Four Corners did not have a provider directory in written or electronic form. In CY 2020, HSAG found that Four Corners maintained a comprehensive provider list on its website, which included all required elements.

HSAG reviewed a sample of initial credentialing files and found that Four Corners had collected an application, verified education and licensure, and checked the providers against federal exclusion lists prior to hire. HSAG found full compliance with the credentialing records.

Four Corners submitted four grievances representing the full sample for the period under review. HSAG reviewed the grievances and found that Four Corners acknowledged and resolved each grievance within the allotted time frame and included the required information in the resolution letter.

Opportunities for Improvement and Recommendations

Pertaining to the grievance record review, HSAG suggests that Four Corners consider a way to document the grievance acknowledgement more prominently in the grievance file. HSAG suggests that Four Corners consider whether it is capturing all grievances, as four is not many for a five-month period.

VALIDATION OF NETWORK ADEQUACY

Table 2-75 displays the match percentage for provider information between the data submitted by Four Corners and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-75—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Four Corners and All PMHPs

Provider Information	Four Corners			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	22	95.5%	4.5%	364	97.3%	2.7%
Provider Middle Name	22	68.2%	31.8%	364	85.7%	14.3%
Provider Last Name	22	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	22	95.5%	4.5%	364	92.9%	7.1%
Provider Address 2	22	95.5%	4.5%	364	93.7%	6.3%
Provider City	22	100.0%	0.0%	364	95.6%	4.4%
Provider State	22	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	22	100.0%	0.0%	364	97.5%	2.5%
Provider County	22	13.6%	86.4%	364	24.5%	75.5%

Table 2-76 displays the number and percent of provider categories wherein Four Corners met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-76—Compliance With Time/Distance Standards by Urbanicity—Four Corners

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Four Corners	9	3	33.3%	3	33.3%	0	0.0%

Four Corners—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While Four Corners' PDV indicated that 88 percent of the sampled providers were found in the health plan's online provider directory, the health plan's website clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rates between submitted data and the online provider directory for all fields exceeded 95 percent except for Provider Middle Name and Provider County.

Opportunities for Improvement and Recommendations

Accurate provider information in Four Corners' online provider directory is critical for members to have timely access to appropriate health care providers. Four Corners should continue to frequently update its online provider directory with the required, accurate provider information. HSAG also recommends that Four Corners include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Based on HSAG's feedback from CY 2019 compliance reviews, Four Corners responded that the provider directory has been updated to include whether the providers will accept new members, and the cultural and linguistic capabilities offered by the provider or provider's office. However, these fields were not assessed in the CY 2020 PDV for the PMHPs.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Four Corners should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Four Corners did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements for members in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-77. While failure to meet some of the standards might

result from lack of providers, Four Corners should continue to assess areas of inadequacy to identify providers who chose not to contract with Four Corners and the inability to identify the providers in the data using the standard definitions.

Table 2-77—Provider Categories That Failed to Meet Time/Distance Standards—Four Corners*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical - Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Healthy U

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Healthy U submitted its new clinical PIP topic, *Improving Follow-up After Hospitalization for Mental Illness*, for its Summit County PMHP members.

Validation Results

Table 2-78 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements validated received a score of *Met*.

Table 2-78—CY 2020 Performance Improvement Project Validation Results for Healthy U (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	*Not Assessed*		
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**Not Assessed**		

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (8/8)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (5/5)**		
Validation Status		***Met***		

Indicator Outcomes

Healthy U had not progressed to reporting baseline data during this validation cycle.

Healthy U—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Healthy U designed a scientifically sound project. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Healthy U's PIP topic addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to care and services and aims to reduce the risk of negative outcomes by increasing timely follow-up care following a hospitalization for mental illness.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Healthy U must conduct a causal/barrier analysis to identify and prioritize barriers and develop appropriate interventions.

- Healthy U must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

Healthy U's PMHP program began providing services to members in September 2019 and did not have any members who met the discharge criteria for the *FUH-UT* measure during the measurement period due to enrollment specifications. However, the PMHP demonstrated the IS and processes necessary to collect, calculate, and report complete and accurate results that would lead to an "R" audit designation even though Healthy U did not report any rates (i.e., denominator or numerator).

Healthy U—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Healthy U demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Healthy U also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Healthy U.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Healthy U—Quality, Timeliness, and Access to Care—Compliance Reviews

Healthy U's behavioral health line of business, providing coverage in Summit County, initiated operations in September 2019. As such, HSAG conducted a full review of all standards. For the CY 2020 compliance monitoring activities, HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Healthy U's sample of credentialed providers included a licensed social worker, advance practice RNs, physicians, a behavioral analyst, and a marriage and family therapist. Healthy U submitted a full sample inclusive of one prior authorization denial record and reported that it did not have any appeals or grievances for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Healthy U submitted and through conducting a virtual, web-based review consisting of interviews with key Healthy U staff members.

Strengths

Healthy U described a matrixed UM structure that collaborated with medical management, operations, and other teams frequently. Workflows for pre-service, post-service, and TOC teams were well outlined and upheld requirements. Healthy U used Epic software throughout the organization, which ensured cohesive processes across teams to receive and process authorizations. Healthy U used InterQual consistently to make UM decisions and operated under well-documented policies and procedures to ensure timely initial and continuing authorizations. Furthermore, Healthy U conducted extensive IRR testing throughout the year. This training was further supported by a monthly physician meeting known as the "Review Roundup" where trends and learning opportunities are discussed.

Healthy U maintained and monitored a network of providers sufficient to provide access to covered health services for members, including those with limited English proficiency or physical or mental disabilities. Healthy U had mechanisms to ensure that all covered services were available and accessible to members in a timely manner.

Healthy U showcased a diverse care management program that included adult, pediatric, mom and baby, and other specialty subpopulations. The Care Management department clearly demonstrated engagement in data-driven decision making. Staff described a risk stratification methodology used to identify members who may need additional care management supports. Despite an overall influx of members, Healthy U reported that wait times to see a therapist decreased from weeks to days since implementation of the PMHP line of business.

Healthy U maintained policies and procedures that clearly delineated processes for members to file appeals and grievances, and for Healthy U staff members to review and process member grievance and appeal request submissions. Healthy U described the procedures for accepting and reviewing grievances and appeals. The process described aligned with Healthy U's policies.

Healthy U's submission of supporting documentation and evidence included policies, procedures, provider manual, sample provider agreements, sample credentialing applications, Compliance Plan and FWA Compliance Plan, annual credentialing reviews, different provider letters, and a credentialing review worksheet. HSAG reviewed all submissions and found that most of the documents substantiated compliance with provider selection, credentialing, and compliance program requirements.

Healthy U presented a robust QAPI program that included collaboration between various departments and levels of leadership. Healthy U maintained an EDW that integrated referrals and ADT feeds, and provided staff members the ability to gain insights regarding specific populations.

Additionally, the Quality team mentioned it was currently laying groundwork with stakeholders to eventually implement value-based payments. Healthy U also discussed plans to launch text messaging and email capabilities in March 2021.

Furthermore, Healthy U submitted detailed workflows and desktop procedures regarding the claims processing system. These documents outlined quality assurance measures taken to maintain accuracy, including auditing 3 percent of internal claims and 15 percent of claims that did not auto-adjudicate. Healthy U targeted 99 percent financial accuracy and 97 percent processing accuracy, and staff members attested to consistently meeting these goals.

Opportunities for Improvement and Recommendations

Upon desk review, HSAG found that multiple documents referred to NOAs, which does not reflect current contract terminology. HSAG recommends that Healthy U update all related documents to reflect the current NABD terminology to align with State and federal guidelines and reduce confusion. Healthy U's Clinical Practice Guidelines policy and UM Program Description both included definitions of "medically necessary services"; however, these definitions did not include all required criteria, negatively affecting the quality domain.

Healthy U documented and described a process for consulting with providers during the authorization review period. However, Healthy U also engaged in a denial reconsiderations process which did not adhere to State and federal denial and appeal guidelines. The Peer-to-Peer (P2P) Review Request Form and associated process were described as being used after the denial letter is mailed to the member. It is the intent of federal regulations that after the NABD has been mailed, any additional actions and decisions then fall under the appeal process. Furthermore, the denial reconsiderations process did not include additional member notices. It is the intent of federal regulations that the member be informed regarding denial and appeal decisions. Also related to provider consultation, the Pharmacy Authorization policy stated that "incomplete requests or requests received without all necessary supporting documentation may be denied for lack of documentation." While Healthy U's policy stated that expedited authorization decisions must be determined no later than 72 hours after receipt of the request, the NABD letters incorrectly stated three business days.

Within its provider manual and Appeals policy, Healthy U stated that the member must follow an oral appeal request with a written, signed appeal (unless the request is for expedited resolution); however, the provider manual also included a time frame for when written appeals must follow oral appeals (within five business days) or the member's appeal "will be closed." HSAG suggested that Healthy U remove the five-day time frame from the provider manual.

Healthy U refers subcontractors to the provider manual for information about grievance and appeal processes and the State fair hearing system at the time they enter into a contract. HSAG reviewed the provider manual and identified that the information provided was not clear and did not accurately describe the grievance and appeal processes and the State fair hearing system. HSAG also observed

that some terms were not consistent with UDOH contract language. For example, the provider manual referred to the adverse decision of a preservice authorization as a "notice of action."

Healthy U did not have a written policy and procedure that addressed conducting checks on employees and other individuals and entities to ensure that it does not employ individuals or entities excluded from participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act.

HSAG reviewed three of Healthy U's delegation agreements, none of which incorporated language regarding the right of the State, CMS, the HHS inspector general, the comptroller general, or their designee to audit, evaluate, and inspect aspects pertaining to the services and activities performed or determination of amounts payable under Healthy U's contract with the State.

VALIDATION OF NETWORK ADEQUACY

Table 2-79 displays the match percentage for provider information between the data submitted by Healthy U and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-79—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Healthy U and All PMHPs

Provider Information	Healthy U			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	4	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	4	100.0%	0.0%	364	85.7%	14.3%
Provider Last Name	4	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	4	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	4	100.0%	0.0%	364	93.7%	6.3%
Provider City	4	100.0%	0.0%	364	95.6%	4.4%
Provider State	4	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	4	100.0%	0.0%	364	97.5%	2.5%
Provider County	4	0.0%	100.0%	364	24.5%	75.5%

Table 2-80 displays the number and percent of provider categories wherein Healthy U met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-80—Compliance With Time/Distance Standards by Urbanicity—Healthy U

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Healthy U	9	3	33.3%	4	44.4%	0	0.0%

Healthy U—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Healthy U's online provider directory noted that updates to the directories occur five days per week, excluding weekends, holidays, or interruptions due to upgrades, system maintenance, or unplanned outages.

Opportunities for Improvement and Recommendations

Accurate provider information in Healthy U's online provider directory is critical for members to have timely access to appropriate health care providers. Only four of the sampled 59 providers (6.8 percent) were found on Healthy U's online provider directory. Healthy U should evaluate its submitted provider data and the online provider directory to identify areas of discrepancy. The health plan should also provide an option for its members to request a paper form of the provider directory and include an email address or toll-free number for members to report errors.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Healthy U should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Healthy U did not meet the time/distance standards for any provider categories. However, it should be noted that to meet the standard statewide, the PMHPs had to meet the requirements in urban, rural, and frontier areas and most PMHPs operate regionally. The provider categories that did not meet the standards are listed in Table 2-81. While failure to meet some of the standards might result from lack of providers, Healthy U should continue to assess areas of inadequacy to identify providers who chose not to contract with Healthy U and the inability to identify the providers in the data using the standard definitions.

Table 2-81—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Northeastern Counseling Center (Northeastern)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Northeastern submitted its new clinical PIP topic: *Inpatient Post Discharge Engagement and Suicide Intervention*. Northeastern aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions for members discharged from an inpatient hospital stay.

Validation Results

Table 2-82 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-82—CY 2020 Performance Improvement Project Validation Results for Northeastern (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (9/9)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Northeastern progressed to reporting baseline data. The PIP includes four performance indicators.

- The baseline rate for the percentage of discharges wherein members receiving a formal covered service or a documented Caring Contact within one to three business days post-discharge was 60 percent.
- The baseline rate for the percentage of inpatient discharges wherein members received a personalized safety plan one to seven days post-discharge was 23.1 percent.
- The baseline rate for the percentage of inpatient discharges wherein members received a C-SSRS one to seven days post-discharge was 26.9 percent.
- The baseline rate for the percentage of inpatient discharges wherein members received a formal covered service or a documented Caring Contact 31 to 60 days post-discharge was 53.3 percent.

Table 2-83 displays data for Northeastern's *Inpatient Post Discharge Engagement and Suicide Intervention* PIP.

Table 2-83—PIP—*Inpatient Post Discharge Engagement and Suicide Intervention*
Northeastern

Study Indicator Results			
Study Indicators	**Baseline (01/01/2019–12/31/2019)**		**Sustained Improvement**
1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge.	N: 18 D: 30	60.0%	*Not Assessed*
2. Percentage of inpatient discharges where members received a personalized Safety Plan 1–7 days post discharge with or through Northeastern Counseling.	N: 6 D: 26	23.1%	*Not Assessed*
3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post discharge.	N: 7 D: 26	26.9%	*Not Assessed*
4. Percentage of inpatient discharges where members received a formal covered service or a documented "Caring Contact" (i.e., documented "outreach") 31 to 60 days post discharge.	N: 16 D: 30	53.3%	*Not Assessed*

N–Numerator D–Denominator

Northeastern—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Northeastern designed a scientifically sound PIP and conducted appropriate QI processes to identify and prioritize barriers, and to implement interventions that were logically linked to the barriers and have the potential to impact the study indicator outcomes. Northeastern's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Northeastern must report the measurement periods consistently throughout the submission.

- Northeastern must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Northeastern must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-84 presents Northeastern's MY 2020 performance measure results.

Table 2-84—Northeastern MY 2020 *FUH* Results

Indicator	Northeastern Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	63.33%	52.33%
Follow-Up Within 30 Days	73.33%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Northeastern—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Northeastern demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Northeastern also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Northeastern based on *FUH* rates exceeding the Statewide PMHP Average; however, opportunities exists for Northeastern to continue to focus improvement efforts on increasing *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Northeastern—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations for

Northeastern. As such, for the CY 2020 review, HSAG did not conduct a follow-up review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Northeastern's sample of credentialed providers included a case manager and four social workers. Northeastern submitted a sample consisting of five grievance records for the period under review. Northeastern reported that it did not have any prior authorization denials and that it had one appeal during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Northeastern submitted and through conducting a virtual, web-based review consisting of interviews with key Northeastern staff members.

Strengths

HSAG reviewed the five credentialing files and found that all providers completed an application prior to hire. Three of the files pertained to social work students, and one file involved a case manager. HSAG found that Northeastern had searched all providers against the federal exclusion databases and had completed all credentialing activities prior to hire. HSAG found full compliance with these files.

For the appeal record reviewed, the member had submitted the appeal following a retrospective claim denial, not related to a denial of service prior authorization. Northeastern responded to the appeal in a timely manner. HSAG found full compliance with the appeal requirements.

HSAG reviewed the five grievances and found that the acknowledgement and resolutions were timely and included all required elements. HSAG found full compliance with the requirements.

Opportunities for Improvement and Recommendations

HSAG noted that five grievances (the full sample of reported grievances) over a five-month period was a small quantity. HSAG suggests that Northeastern review its grievance collection policies and procedures to ensure it is properly tracking and documenting all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-85 displays the match percentage for provider information between the data submitted by Northeastern and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-85—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Northeastern and All PMHPs

Provider Information	Northeastern			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	20	95.0%	5.0%	364	97.3%	2.7%
Provider Middle Name	20	55.0%	45.0%	364	85.7%	14.3%
Provider Last Name	20	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	20	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	20	95.0%	5.0%	364	93.7%	6.3%
Provider City	20	100.0%	0.0%	364	95.6%	4.4%
Provider State	20	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	20	100.0%	0.0%	364	97.5%	2.5%
Provider County	20	0.0%	100.0%	364	24.5%	75.5%

Table 2-86 displays the number and percent of provider categories wherein Northeastern met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-86—Compliance With Time/Distance Standards by Urbanicity—Northeastern

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Northeastern	9	2	22.2%	0	0.0%	0	0.0%

Northeastern—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Northeastern's online provider directory clearly displayed an option to request a paper form of the provider directory. Additionally, the health plan's match rate between submitted data and the online

provider directory for all fields met or exceeded 95 percent except for Provider Middle Name and Provider County for the sampled providers who were found in the online directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Northeastern's online provider directory is critical for members to have timely access to appropriate health care providers. Over 48 percent of the sampled providers could not be found in Northeastern's online directory. Northeastern should evaluate its submitted provider data and the online provider directory to identify areas of discrepancy. HSAG recommends that Northeastern report the last updated date on its online provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Northeastern should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Northeastern only met the time/distance standards for two of the provider categories in the frontier areas and none in the rural or urban areas. The provider categories that did not meet the standards are listed in Table 2-87. While failure to meet some of the standards might result from lack of providers, Northeastern should continue to assess areas of inadequacy to identify providers who chose not to contract with Northeastern and the inability to identify the providers in the data using the standard definitions.

Table 2-87—Provider Categories That Failed to Meet Time/Distance Standards—Northeastern*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist - Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Salt Lake County Division of Mental Health (Salt Lake)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Salt Lake submitted its PIP topic: *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County.* Salt Lake aims to improve behavioral health outcomes by increasing member engagement and retention in OUD treatment by providing medication-assisted treatment (MAT) services.

Validation Results

Table 2-88 summarizes the validation findings for each stage validated for CY 2020. Overall, 87 percent of all applicable evaluation elements received a score of *Met.*

Table 2-88—CY 2020 Performance Improvement Project's Validation Results for Salt Lake County (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	50% (1/2)	50% (1/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	67% (2/3)	33% (1/3)	0% (0/3)
Design Total		**78% (7/9)**	**22% (2/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total		**100% (6/6)**	**0% (0/6)**	**0% (0/6)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**87% (13/15)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**75% (6/8)**		
Validation Status		***Partially Met***		

Indicator Outcomes

Salt Lake reported baseline data during this validation cycle. The baseline rate for the percentage of members diagnosed with an OUD, who initiated substance use disorder (SUD) treatment, and who may have received MAT services was 75.0 percent. The baseline rate for the percentage of members who received MAT services and remained in treatment longer than six months was 28.4 percent.

Table 2-89 displays data for Salt Lake's PIP.

Table 2-89—PIP—*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*
Salt Lake

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services.	N: 66 D: 88	75.0%	*Not Assessed*
2. Percentage of members who received MAT services and remained in treatment longer than 6 months.	N: 25 D: 88	28.4%	*Not Assessed*

N–Numerator D–Denominator

Salt Lake—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Salt Lake reported baseline data accurately according to the documented study design, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Salt Lake's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Salt Lake's PIP aims to improve behavioral health outcomes by increasing member engagement and retention in OUD treatment by providing MAT services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 75 percent of critical evaluation elements and 87 percent of overall evaluation elements across all activities completed and validated. Salt Lake has opportunities for improvement to accurately define the study indicators and the data collection process for Study Indicator 2.

As the PIP progresses, HSAG recommends the following:

- Salt Lake should clarify whether Study Indicator 1 is focused on OUD members receiving MAT services or screening/evaluation for MAT services. In addition, the health plan should not use "may have" terminology in describing Study Indicator 1.
- Salt Lake should provide a clear, step-by-step narrative regarding the data collection process for Study Indicator 2.
- Salt Lake must update the narrative interpretation of data to discuss changes in the study indicator rates over the baseline and include statistical testing results.
- Salt Lake must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Two of the three interventions address barriers toward study indicator data collection. Salt Lake must ensure that in addition to improving data collection, the PIP interventions address barriers toward improving member care.
- Salt Lake must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-90 presents Salt Lake's MY 2020 performance measure results.

Table 2-90—Salt Lake MY 2020 *FUH* Results

Indicator	Salt Lake Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**41.23%**	52.33%
Follow-Up Within 30 Days	**59.58%**	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

Salt Lake—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Salt Lake demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Salt Lake also had appropriate processes to receive and process claims and encounters.

Opportunities for Improvement and Recommendations

Salt Lake's rates for members hospitalized for mental illness who received a follow-up visit within seven days and 30 days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Salt Lake focus on improvement efforts designed to ensure that members receive a Salt Lake-furnished service within seven days and 30 days following discharge from a hospitalization.

HSAG also recommends that Salt Lake County provide additional oversight of Optum's operations and provide additional training to Optum's staff to ensure the rate calculation reflects the directive and definitions provided by UDOH.

In addition, HSAG recommends additional code or supplemental documentation to better define the creation of key variables that support rate production. This will facilitate source code review in the future and ensure Salt Lake develops source code in alignment with measure specifications. HSAG also recommends extracting additional information from myAvatar as it relates to performance indicators, specifically adding the discharge date to provide clarification for calculation of rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Salt Lake—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations for Salt Lake. As such, for the CY 2020 review, HSAG did not conduct a follow-up review of federal regulations or State contract requirements.

HSAG did, however, request and review a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Salt Lake's sample of credentialed providers included a psychologist and six social workers. HSAG reviewed a sample of 10 prior authorization denial records and 10 appeal records. Salt Lake reported having three grievances during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Salt Lake submitted and through conducting a virtual, web-based review consisting of interviews with key Salt Lake staff members.

Strengths

Salt Lake submitted initial credentialing files for the period under review that were detailed and well-organized. HSAG found that, for each provider file reviewed, Salt Lake had collected an application, verified licensure and education, and checked the providers against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing files reviewed.

HSAG reviewed the prior authorization denial files and found that most files pertained to members seeking additional inpatient days after a set of previously approved days had expired. In some cases, the inpatient days were denied following prior authorization, and in other cases, Salt Lake denied claims that were submitted after a hospitalization that was not pre-approved. Salt Lake reviewed and made a decision about prior authorizations for hospital stays within hours of receipt and immediately followed up with the requesting provider by telephone. Salt Lake sent its NABD letter to the member and the provider after the decision was made. The NABD letters contained all required information. HSAG found full compliance with the denial files reviewed.

HSAG reviewed a sample of 10 appeals of retroactive claims denials. Salt Lake upheld most denial decisions; however, a few were overturned in whole or in part. HSAG reviewed the appeal resolution letters and found that all required information had been included. Salt Lake clearly indicated in the resolution letter to the member that the member was not responsible for payment, as applicable. Salt Lake sent all appeal resolution letters in a timely manner. HSAG found full compliance with the appeal records reviewed.

HSAG reviewed the grievance records and found that each grievance was acknowledged and resolved within the allotted time frame of 90 days, and that the resolution letter included the required information.

Opportunities for Improvement and Recommendations

HSAG noted that three grievances over a five-month period is an unusually small amount. Salt Lake noted that it has conducted ongoing training with staff to ensure that member-generated concerns of all levels are entered into the complaints database and investigated, even those that are resolved during the initial telephone contact. HSAG suggests that Salt Lake continue its ongoing review to ensure that all grievances are captured and documented.

VALIDATION OF NETWORK ADEQUACY

Table 2-91 displays the match percentage for provider information between the data submitted by Salt Lake and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-91—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Salt Lake and All PMHPs

Provider Information	Salt Lake			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	79	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	79	82.3%	17.7%	364	85.7%	14.3%
Provider Last Name	79	98.7%	1.3%	364	98.9%	1.1%
Provider Address 1	79	89.9%	10.1%	364	92.9%	7.1%
Provider Address 2	79	91.1%	8.9%	364	93.7%	6.3%
Provider City	79	81.0%	19.0%	364	95.6%	4.4%
Provider State	79	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	79	96.2%	3.8%	364	97.5%	2.5%
Provider County	79	6.3%	93.7%	364	24.5%	75.5%

Table 2-92 displays the number and percent of provider categories wherein Salt Lake met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-92—Compliance With Time/Distance Standards by Urbanicity—Salt Lake

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Salt Lake	9	3	33.3%	2	22.2%	8	88.9%

Salt Lake—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Geographic network adequacy analysis indicated that Salt Lake met the urban time/distance standard for eight of the nine provider categories.

Opportunities for Improvement and Recommendations

Accurate provider information in Salt Lake's online provider directory is critical for members to have timely access to appropriate health care providers. The CY 2020 PDV indicated that 66.5 percent of the sampled providers could not be found in Salt Lake's online directory and the provider locations could not be found in the online directory for an additional 9 percent of the sampled providers. Salt Lake should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Salt Lake report the last updated date on its online provider directory and include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Salt Lake should also provide an option for members to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Salt Lake should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Salt Lake only met the time/distance standards for three of the provider categories in the frontier areas and two in the rural areas. The provider categories that did not meet the standards are listed in Table 2-93. While failure to meet some of the standards might result from lack of providers, Salt Lake should continue to assess areas of inadequacy to identify providers who chose not to contract with Salt Lake and the inability to identify the providers in the data using the standard definitions.

Table 2-93—Provider Categories That Failed to Meet Time/Distance Standards—Salt Lake*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical - Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Southwest Behavioral Health Center (Southwest)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Southwest submitted its new PIP topic: *Outcome Questionnaire (OQ) Project*. Southwest aims to improve behavior therapy by increasing the number of OQ reviews with members during psychotherapy sessions. According to the PIP documentation, the OQ reviews help in treatment planning by predicting those members who need special attention to prevent treatment failure and maximize treatment effectiveness.

Validation Results

Table 2-94 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-94—CY 2020 Performance Improvement Project Validation Results for Southwest (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (9/9)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Southwest reported baseline data. For the baseline measurement period, Southwest reported that 15.1 percent of the psychotherapy sessions included an OQ review with the member at the time of service.

Table 2-95 displays data for Southwest's PIP.

Table 2-95—PIP—*Outcome Questionnaire Project*
Southwest

Study Indicator	Baseline Period 07/01/2018 to 06/30/2019		Sustained Improvement
The percentage of psychotherapy sessions during which the OQ is reviewed with a member who is age 18 or older at the time of service.	N: 990 D: 6,547	15.1%	*Not Assessed*

N–Numerator D–Denominator

Southwest—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Southwest designed a scientifically sound PIP, reported accurate data, and implemented a provider intervention that was related to barriers identified through appropriate QI processes. Southwest's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Southwest's PIP aims to improve member behavior therapy outcomes by increasing the number of OQ reviews with members during psychotherapy sessions.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

- As the PIP progresses, HSAG recommends the following:
- Southwest must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Southwest must develop an evaluation methodology to determine the effectiveness of the implemented intervention and report evaluation results. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-96 presents Southwest's MY 2020 performance measure results

Table 2-96—Southwest MY 2020 *FUH* Results

Indicator	Southwest Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	59.84%	52.33%
Follow-Up Within 30 Days	71.65%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Southwest—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Southwest demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Southwest also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Southwest based on *FUH* rates above the Statewide PMHP Average; however, continued opportunities exist to focus improvement efforts on increasing *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Southwest—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Southwest's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Southwest's sample of credentialed providers included several case managers, a nurse, a mobile crisis outreach worker, and two therapists. Southwest submitted a sample of seven grievance records for the period under review. Southwest reported that it did not have any prior authorization denials or appeals for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Southwest submitted and through conducting a virtual, web-based review consisting of interviews with key Southwest staff members.

Strengths

HSAG reviewed the grievance records and found that Southwest had acknowledged and resolved them within the allotted time frame and had included the required information in the resolution letter. HSAG found full compliance with Southwest's grievance submission.

In CY 2019, HSAG found that Southwest stated within its provider directory, "All internal staff at Southwest Behavioral Health are required to complete Cultural Competency trainings. Subcontracted providers do not have a contract requirement to complete training"; however, the provider directory did not delineate which providers are employed and which are contracted. In response to this finding,

Southwest included a column in its provider directory listing which providers are with the group "Southwest Behavioral Health," impacting the quality and access domains.

Opportunities for Improvement and Recommendations

HSAG reviewed a sample of initial credentialing files and found that Southwest had collected an application from four of the 10 providers after the hire date. HSAG also found that Southwest had not checked seven of the 10 providers against federal exclusion databases prior to hire. HSAG found that Southwest had not verified education and licensure for two of the three licensed providers prior to hire. HSAG suggests that Southwest leadership review all credentialing files for completeness and evaluate the processes in place to ensure consistency of credentialing processes.

During the interview, HSAG recommended that Southwest develop a method to more clearly document the acknowledgement that occurs during a verbal grievance.

In CY 2019, HSAG had found that Southwest did not note the languages (including American Sign Language) the providers or providers' offices offered, as required, within its provider directory, but the directory did state that interpreters are available. This finding remained in CY 2020. HSAG suggests that Southwest indicate the languages (including American Sign Language) each provider or provider's office offers in its provider directory.

VALIDATION OF NETWORK ADEQUACY

Table 2-97 displays the match percentage for provider information between the data submitted by Southwest and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-97—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Southwest and All PMHPs

Provider Information	Southwest			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	29	100.0%	0.0%	364	97.3%	2.7%
Provider Middle Name	29	79.3%	20.7%	364	85.7%	14.3%
Provider Last Name	29	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	29	89.7%	10.3%	364	92.9%	7.1%
Provider Address 2	29	96.6%	3.4%	364	93.7%	6.3%
Provider City	29	100.0%	0.0%	364	95.6%	4.4%

Provider Information	Southwest			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider State	29	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	29	89.7%	10.3%	364	97.5%	2.5%
Provider County	29	0.0%	100.0%	364	24.5%	75.5%

Table 2-98 displays the number and percent of provider categories wherein Southwest met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-98—Compliance With Time/Distance Standards by Urbanicity—Southwest

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Southwest	9	4	44.4%	4	44.4%	0	0.0%

Southwest—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Southwest's online provider directory included a last update date for provider information in the online provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Southwest's online provider directory is critical for members to have timely access to appropriate health care providers. Only 22.8 percent of the sampled providers could be found in Southwest's online directory. Southwest should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Southwest include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website. Southwest should also provide an option for members to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Southwest should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Southwest only met the time/distance standards for four of the nine provider categories in the frontier and rural areas. The provider categories that did not meet the standards are listed in Table 2-99. While failure to meet some of the standards might result from lack of providers, Southwest should continue to assess areas of inadequacy to identify providers who chose not to contract with Southwest and the inability to identify the providers in the data using the standard definitions.

Table 2-99—Provider Categories That Failed to Meet Time/Distance Standards—Southwest*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Utah County Department of Drug and Alcohol Prevention and Treatment

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Utah County continued its PIP topic: *Suicide Prevention*

Validation Results

Table 2-100 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-100—CY 2018 Performance Improvement Project's Validation Results for Utah County (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**100% (2/2)**	**0% (0/2)**	**0% (0/2)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (19/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (10/10)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Utah County reported Remeasurement 2 results. The baseline rate for the percentage of eligible members who received the C-SSRS screening was 30.0 percent. For Remeasurement 2, the Study Indicator 1 rate of 43.5 percent demonstrated a statistically significant increase ($p = 0.0001$) of 13.5 percentage points over the baseline.

The baseline rate for the percentage of members who required and received a same-day safety plan was 0.0 percent. For Remeasurement 2, the Study Indicator 2 rate of 30.8 percent exceeded the Remeasurement 1 rate by 4.7 percentage points and demonstrated a statistically significant increase ($p = 0.0001$) of 30.8 percentage points over the baseline.

The PIP was not evaluated for sustained improvement because only one study indicator demonstrated statistically significant improvement over the baseline during Remeasurement 1.

Table 2-101 displays data for Utah County's PIP.

Table 2-101—PIP—*Suicide Prevention*
Utah County

Study Indicator	Baseline Period 01/01/2017–12/31/2017		Remeasurement 1 01/01/2018–12/31/2018		Remeasurement 2 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 149 D: 497	30%	N: 172 D: 573	30%	N: 164 D: 377	43.5%*	*Not Assessed*
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 0 D: 51	0.0%	N: 12 D: 46	26.1%*	N: 8 D: 26	30.8%*	*Not Assessed*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator NA-Not Applicable

Utah County—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Utah County designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Utah County reported and analyzed its Remeasurement 2 data accurately. Utah County conducted appropriate QI processes to identify and prioritize barriers, and implemented interventions that were logically linked to the barriers and had a positive impact on the outcomes. Utah County's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Utah County's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

CY 2020 was the last year for Utah County's PIP. HSAG recommends that Utah County continue to build on its momentum of improvement and apply any lessons learned and knowledge gained through the QI processes applied during this PIP.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-102 shows Utah County's MY 2020 results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Utah County's rates were materially biased and assessed as Not Reportable by the HSAG auditor.

Table 2-102—Utah County MY 2020 *IET* Results

Indicator	Utah County 2020 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Initiation of AOD Treatment—Total—Total	**NR**
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Engagement of AOD Treatment—Total—Total	**NR**

NR—Not Reportable

Utah County—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

While Utah County demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy and had appropriate processes to receive and process claims and encounters, HSAG's auditor identified several measure pre-production and reporting errors.

Opportunities for Improvement and Recommendations

HSAG identified several pre-production steps that negatively affected the production of the performance measures. HSAG identified an error in Utah County's source code associated with the length of time used to evaluate continuous enrollment. Utah County subsequently resubmitted data correcting that error, and HSAG approved the source code. Additionally, during the PSV section of the

virtual site visit, HSAG identified three critical errors. The errors included both data validation errors (i.e., discrepancies between Credible and the measure source file) and event categorization errors (i.e., compliance status of selected dates of service and AOD diagnoses categorization). Following the virtual site visit, HSAG identified several follow-up items to address the measure pre-production and reporting errors. Utah County staff members reviewed, modified, and resubmitted performance measure rates and clarification surrounding HSAG's findings. Upon review, HSAG determined that the responses were insufficient to support the accuracy of the revised rates or confidence in the limiting of potential bias in the rates. Additionally, final rate review revealed ongoing data aggregation errors.

HSAG recommended that Utah County review and update both its source code and measure calculation steps. Specifically, source code should be reviewed to ensure that diagnoses are pulled and assigned to members accurately based on the qualifying index event. Additionally, the selection of the index episode start date should be updated to reflect the discharge date if the qualifying index event is an inpatient stay. At the time of the CY 2020 PMV, measure calculation processes relied on the use of pivot tables that may not account for errors contained within the source data. Additional data cleaning and validation may be necessary to ensure appropriate counting of numerator and denominator elements.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

Utah County Department of Drug and Alcohol Prevention and Treatment—Quality, Timeliness, and Access to Care—Compliance Reviews

Effective April 2020, Utah County discontinued activities as a PAHP directly contracted with UDOH. Utah County is now a subcontractor providing services under Wasatch Behavioral Health, which was already operating as a PMHP in the area. As such, HSAG's compliance monitoring activities for Utah County for CY 2020 consisted of a review of Utah County's CY 2019 CAP. HSAG did not review any additional administrative credentialing, denial, grievance, or appeals records.

Strengths

Based on HSAG findings in the CY 2018 and CY 2019 compliance reviews, in CY 2020 Utah County developed policies, procedures, and a mechanism to detect over- and underutilization and ensure consistent application of any criteria used to make authorization decisions. Utah County also updated its NABD letter to include appropriate time frames for requesting an appeal if continuing benefits during an appeal or State fair hearing.

In 2020, Utah County also addressed findings that the provider directory was found to be incomplete and posted the updated directory on its website in a machine-readable format.

In its 2020 CAP, Utah County described a new policy and mechanism for sending a letter to members asking if they had received the actual service that is documented on a certain date chosen during peer reviews. Utah County also began developing processes to evaluate the effectiveness of reporting QAPI data.

Opportunities for Improvement and Recommendations

HSAG did not identify any ongoing opportunities for improvement for Utah County.

VALIDATION OF NETWORK ADEQUACY

Utah County's contract with UDOH ended prior to the start of NAV activities; therefore, Utah County was not included in this EQR-related activity in CY 2020.

Valley Behavioral Health (Valley)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Valley submitted its PIP topic: *Suicide Prevention*.

Validation Results

Table 2-103 summarizes the validation findings for each stage validated for CY 2020. Overall, 81 percent of all applicable evaluation elements received a score of *Met.*

Table 2-103—CY 2019 Performance Improvement Project Validation Results for Valley (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	67% (2/3)	33% (1/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	67% (4/6)	33% (2/6)	0% (0/6)
Implementation Total		**67% (6/9)**	**33% (3/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	0% (0/1)	100% (1/1)	0% (0/1)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes Total		67% (2/3)	33% (1/3)	0% (0/3)
Percentage Score of Applicable Evaluation Elements *Met*		81% (17/21)		
Percentage Score of Applicable Critical Evaluation Elements *Met*		83% (10/12)		
Validation Status		*Partially Met*		

Indicator Outcomes

For CY 2020, Valley progressed to reporting Remeasurement 3 results.

For Summit County, the baseline rate for the percentage of eligible members who received the C-SSRS screening was 45.5 percent. For Remeasurement 3, the Study Indicator 1 rate of 85.4 percent demonstrated a statistically significant increase ($p < 0.0001$) of 39.9 percentage points over the baseline.

For Summit County, the baseline rate for the percentage of members who required and received a same-day safety plan was 90.5 percent. For Remeasurement 2, the Study Indicator 2 rate of 89.9 percent decreased from the Remeasurement 1 rate of 100 percent and did not represent statistically significant improvement over the revised baseline (CY 2017) results. Note that since the denominator population for this study indicator is very small, the percentage point change in results should be interpreted with caution.

For Tooele County, the baseline rate for the percentage of members who received the C-SSRS screening was 39.8 percent. For Remeasurement 3, the Study Indicator 1 rate of 96.8 percent demonstrated a statistically significant increase ($p < 0.0001$) of 57.0 percentage points over the baseline.

For Tooele County, the baseline rate for the percentage of members who required and received a same-day plan was 63.2 percent. For Remeasurement 3, the Study Indicator 2 rate of 86.9 percent decreased from the Remeasurement 2 rate by 0.9 percentage points; however, this rate demonstrated a statistically significant increase ($p < 0.0001$) of 23.7 percentage points over the baseline.

Valley was able to sustain a statistically significant improvement that was achieved at Remeasurement 1 for the subsequent measurement period for Study Indicator 1 in both counties and for Study Indicator 2 in Tooele County; however, for Study Indicator 2 in Summit County, the health plan was not able to sustain a statistically significant improvement.

Table 2-104 displays data for Valley's PIP.

Table 2-104—PIP—*Suicide Prevention*
Valley

Study Indicator	Baseline Period^ 01/01/2016–12/31/2016		Remeasurement 1 01/01/2017–12/31/2017		Remeasurement 2 01/01/2018–12/31/2018		Remeasurement 3 01/01/2019–12/31/2019		Sustained Improvement
Summit County									
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 80 D: 176	45.5%	N: 183 D: 217	84.3%*	N: 168 D: 200	84.0%*	N: 146 D: 171	85.4%*	*Yes*
Study Indicator	**Baseline Period^ 01/01/2017–12/31/2017**		**Remeasurement 1 01/01/2018–12/31/2018**		**Remeasurement 2 01/01/2019–12/31/2019**				**Sustained Improvement**
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 19 D: 21	90.5%	N: 16 D: 16	100%	N: 8 D: 9	89.9%	N: D:		*No*
Study Indicator	**Baseline Period^ 01/01/2016–12/31/2016**		**Remeasurement 1 01/01/2017–12/31/2017**		**Remeasurement 2 01/01/2018–12/31/2018**		**Remeasurement 3 01/01/2019–12/31/2019**		**Sustained Improvement**
Tooele County									
1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit.	N: 335 D: 841	39.8%	N: 616 D: 980	62.9%*	N: 674 D: 947	71.2%*	N: 1,038 D: 1,072	96.8%*	*Yes*
2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	N: 43 D: 68	63.2%	N: 95 D: 107	88.8%*	N: 108 D: 123	87.8%*	N: 139 D: 160	86.9%*	*Yes*

*Indicates statistically significant improvement over the Remeasurement 1 rate. N–Numerator D–Denominator

^Due to concerns regarding a true comparison of study indicator rates with CY 2015 data as the baseline, CY 2016 was reassigned as the new baseline measurement period for Study Indicator 1 for both counties and Study Indicator 2 for Toole County. For Summit County, Study Indicator 2, the health plan reassigned CY 2017 as the new baseline measurement period.

Valley—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Valley designed a scientifically sound PIP, and the technical design of the PIP was sufficient to measure outcomes. Valley reported accurate data and conducted appropriate QI processes to identify and prioritize barriers. Valley implemented interventions that were logically linked to the barriers and had a positive impact on the outcomes. Valley's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Valley's PIP aims to improve processes and outcomes of members' mental health care, to improve detection of suicidal risk, and to provide appropriate interventions based on level of risk.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 83 percent of critical evaluation elements and 81 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the narrative interpretation of results and evaluation of interventions for effectiveness.

CY 2020 was the last year for Valley's PIP. HSAG recommends that Valley continue to build on its momentum of improvement and apply any lessons learned and knowledge gained through the QI processes applied during this PIP.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-105 presents Valley's MY 2020 performance measure results.

Table 2-105—Valley MY 2020 *FUH* Results

Indicator	Valley Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	64.71%	52.33%
Follow-Up Within 30 Days	82.35%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Valley—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Valley demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data

completeness and accuracy. Valley also had appropriate processes to receive and process claims and encounters.

Opportunities for Improvement and Recommendations

Although Valley established and demonstrated robust data systems for collecting, extracting, and validating performance measure data, HSAG identified some pre-production steps that initially affected the production of performance measure rates. During the virtual site visit, HSAG conducted PSV on a random sample of members and identified critical errors in several of the records. The errors included data validation errors affecting the inclusion and exclusion of members from both the denominator and numerator, thereby impacting overall rates.

Following the virtual site visit, HSAG provided guidance and follow-up requests to Valley for review. Analytic staff members reviewed the list of items, assessed the code, and implemented appropriate fixes to correct the identification of the eligible population and numerator compliance. In addition to addressing unintended restrictions, code was updated to incorporate claims and encounter data. HSAG reviewed both the updated code and measure source file and confirmed correction of all outstanding data issues.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Valley—Quality, Timeliness, and Access to Care—Compliance Reviews

Effective October 2020, Valley suspended activities as a PMHP in Utah. As such, HSAG's compliance monitoring activities for CY 2020 consisted of a review of Valley's CY 2019 CAP.

Strengths

Valley indicated in its CY 2020 CAP that it will implement a mechanism to ensure that the information included in the paper provider directory is updated at least monthly and that electronic provider directories are updated no later than 30 calendar days after Valley receives updated provider information.

During the CY 2018 review, HSAG reviewed Valley's Client Complaint System policy (dated February 2016), which described Valley's client grievance processes, and the Client Appeal System (dated September 2013), which addressed the appeals and State fair hearing processes. During the on-site interview, HSAG noted that the processes described by staff members were inconsistent with written policies. Staff members commented that the policies were old and outdated. For the CY 2019 review, Valley noted that the policy was being revised and was not yet available. For CY 2020, Valley indicated in its CAP that the policies and procedures governing its grievance and appeal systems had been updated. Valley also indicated that training on the revised policies was to occur in January 2020.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG evaluated the accessibility of Valley's website and the PDFs on its website and identified 48 accessibility and 96 contrast errors. For the CY 2019 follow-up review, HSAG again evaluated Valley's website using the WAVE Web Accessibility Evaluation Tool and identified 47 accessibility and 72 contrast errors. For the CY 2019 review, Valley stated that it had not yet taken measures to address this issue and intended to overhaul the website in November 2019. For the CY 2020 CAP, Valley did not provide sufficient evidence that it would evaluate the website and make corrections to ensure that the format and content are readily accessible. Additionally, Valley did not indicate that it would provide language on the website informing members that the information on the website is available in paper form without charge upon request, and that the information would be provided within five business days.

In CY 2018, HSAG found that Valley did not have a provider directory in written or electronic form for members. For the CY 2019 review, Valley provided HSAG with Community Partners Lists for Tooele County and Summit County as evidence of compliance. These lists included community resources and stakeholders, but not providers. For its CY 2020 CAP, Valley indicated that is does not contract with physicians. HSAG noted that Valley's provider directory should include the required demographic details of both employed and contracted providers and be made available in a format that is readily accessible.

VALIDATION OF NETWORK ADEQUACY

None of the providers sampled during the PDV were located in the health plan's online directory.

Table 2-106 displays the number and percent of provider categories wherein Valley met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-106—Compliance With Time/Distance Standards by Urbanicity—Valley

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Valley	9	2	22.2%	0	0.0%	0	0.0%

Valley—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

In 2020 PDV, HSAG identified that Valley had an option for members to request a paper form of the provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Valley's online provider directory is critical for members to have timely access to appropriate health care providers. In the CY 2020 PDV, none of the providers in the submitted data were found in Valley's online provider directory. In CY 2019 compliance reviews, HSAG had identified that Valley's provider directory lacked much of the required information about Valley's providers and was not updated as frequently as required. Valley should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Valley include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Valley should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Valley only met the time/distance standards for two of the provider categories in frontier areas and none in rural or urban areas. The provider categories that did not meet the standards are listed in Table 2-107. While failure to meet some of the standards might result from lack of providers, Valley should continue to assess areas of inadequacy to identify providers who chose not to contract with Valley and the inability to identify the providers in the data using the standard definitions.

Table 2-107—Provider Categories That Failed to Meet Time/Distance Standards—Valley*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Wasatch Behavioral Health (Wasatch)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Wasatch submitted its PIP topic: *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ [Youth Outcomes Questionnaire] Outcome Measures*. Wasatch aims to improve behavioral therapy by increasing the administration of the Clinical Support Tool (CST) in conjunction with Y/OQ instruments during outpatient individual psychotherapy. According to the PIP documentation, the appropriate use of CSTs will improve treatment outcomes and decrease the frequency of deterioration for the most at-risk members.

Validation Results

Table 2-108 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met.*

Table 2-108—CY 2020 Performance Improvement Project Validation Results for Wasatch (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation Total		**100% (7/7)**	**0% (0/7)**	**0% (0/7)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (8/8)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Wasatch reported baseline data.

The baseline rate for the percentage of Y/OQ signal cases wherein the CST was administered within the four-month window (including two calendar months before the signal month, the signal month, and one calendar month after the signal month) was 6.2 percent.

Table 2-109 displays data for Wasatch's PIP.

Table 2-109—PIP—*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*
Wasatch

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2019–12/31/2019)**		**Sustained Improvement**
The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	N: 292 D: 4,700	6.2%	*Not Assessed*

N–Numerator D–Denominator

Wasatch—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Wasatch designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes. Wasatch reported baseline data accurately, used appropriate QI processes, and implemented interventions that have the potential to drive improvement toward the desired outcomes. Additionally, Wasatch's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Wasatch must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Wasatch must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-110 presents Wasatch's MY 2020 performance measure results.

Table 2-110—Wasatch MY 2020 *FUH* Results

Indicator	Wasatch Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	61.37%	52.33%
Follow-Up Within 30 Days	78.97%	67.11%

*Statewide Average excludes HOME which falls into the MCO section above.

Wasatch—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Wasatch demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Wasatch also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement or recommendations for Wasatch based on *FUH* measure rates exceeding the Statewide PMHP Average; however, opportunities continue to exist for Wasatch to increase *FUH* rates.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Wasatch—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Wasatch's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Wasatch's sample of credentialed providers included social workers, case managers, therapists, human service workers, a peer support specialist, and a clinical mental health counselor. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 grievance records. Wasatch submitted a sample of nine appeal records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Wasatch submitted and through conducting a virtual, web-based review consisting of interviews with key Wasatch staff members.

Strengths

HSAG reviewed the initial credentialing files and found that Wasatch had verified licensure and education, as well as potential exclusions from federal health care programs, prior to hire. HSAG found full compliance with Wasatch's initial credentialing records reviewed.

HSAG reviewed the grievance records and found that Wasatch had documented all required information and resolved the grievances in a timely manner. HSAG found full compliance with the grievance records reviewed.

During the review conducted in CY 2018, HSAG found that Wasatch's provider directory did not contain all required information. In CY 2019, HSAG found that Wasatch's provider directory still lacked some required information. For the CY 2020 review, HSAG found that Wasatch had updated its provider directory to include the missing provider demographics.

In CY 2018, HSAG had found that Wasatch did not have provisions for a method to routinely verify, by sampling or other methods, whether members received services that network providers represented to have been delivered. During the interview conducted in CY 2019, Wasatch staff members discussed methods used to detect potential fraud; however, none of the methods in place involved determining whether members had received services that had been represented as provided. For the CY 2020 review, Wasatch reported that it had developed a method to routinely verify, by sampling or other methods, whether members received services that network providers represented to have been delivered. Wasatch reported that it was surveying 10 to 20 randomly selected members per month.

Opportunities for Improvement and Recommendations

HSAG did not identify any opportunities for improvement as a result of the CY 2020 follow-up compliance review.

VALIDATION OF NETWORK ADEQUACY

None of the providers sampled during the PDV were located in the health plan's online directory.

Table 2-111 displays the number and percent of provider categories wherein Wasatch met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-111—Compliance With Time/Distance Standards by Urbanicity—Wasatch

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Wasatch	9	0	0.0%	0	0.0%	0	0.0%

Wasatch—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Wasatch's online provider directory allowed users to search by provider name, specialty, language spoken, completion of cultural competency training, and department.

Opportunities for Improvement and Recommendations

Accurate provider information in Wasatch's online provider directory is critical for members to have timely access to appropriate health care providers. In the CY 2020 PDV, none of the providers in the submitted data were found in Wasatch's online provider directory. Wasatch should evaluate its submitted provider data and online provider directory to identify areas of discrepancy. HSAG recommends that Wasatch also include an option for members to report errors using an email address or toll-free number which is conspicuously displayed on the website and an option to request a paper form of the provider directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Wasatch should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Wasatch did not meet any of the time/distance standards for any of the provider categories in any of the geographic areas. The health plan's submitted data did not include providers in any category other than Behavioral Therapists (adult and pediatric). The provider categories that did not meet the standards are listed in Table 2-112. While failure to meet some of the standards might result from lack of providers, Wasatch should continue to assess areas of inadequacy to identify providers who chose not to contract with Wasatch and the inability to identify the providers in the data using the standard definitions.

Table 2-112—Provider Categories That Failed to Meet Time/Distance Standards—Wasatch*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Weber Human Services (Weber)

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Weber submitted its clinical PIP topic: *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)*. Weber aims to improve processes and outcomes of members' behavioral health care by increasing member engagement and retention in OUD treatment. The table below lists the two study indicators for this PIP.

Validation Results

Table 2-113 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-113—CY 2020 Performance Improvement Project Validation Results for Weber (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (2/2)	0% (0/2)	0% (0/2)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (2/2)	0% (0/2)	0% (0/2)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	*Not Assessed*		
Implementation Total		**100% (3/3)**	**0% (0/3)**	**0% (03)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (11/11)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (6/6)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Weber progressed to reporting baseline results. The baseline rate for the percentage of members who received at least six case management or peer support services per year was 33.3 percent. The baseline rate for the percentage of members who were discharged and successfully completed the treatment was 21.1 percent.

Table 2-114 displays data for Weber's PIP.

Table 2-114—PIP—*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder Prevention*
Weber

Study Indicator	Baseline Period 01/01/2019–12/31/2019		Sustained Improvement
1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year.	N: 33 D: 99	33.3%	*Not Assessed*
2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	N: 4 D: 19	21.1%	*Not Assessed*

N–Numerator D–Denominator

Weber—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Weber designed a scientifically sound project supported by using key research principles. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process. Weber's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Weber must conduct a causal/barrier analysis, identifying and prioritizing barriers, and develop appropriate evidence-based interventions.
- Weber must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Performance Measure Outcomes

Table 2-115 presents Weber's MY 2020 performance measure results.

Table 2-115—Weber MY 2020 *FUH* Results

Indicator	Weber Rate	Statewide PMHP Average*
Follow-Up Within 7 Days	**49.01%**	52.33%
Follow-Up Within 30 Days	68.38%	67.11%

Rates in **red** font indicate the rate fell below the statewide PMHP average.
*Statewide Average excludes HOME which falls into the MCO section above.

Weber—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Weber demonstrated proficiency in receiving and processing eligibility data and had adequate reconciliation and validation processes in place at each point of eligibility data transfer to ensure data completeness and accuracy. Weber also had appropriate processes to receive and process claims and encounters and had adequate validation processes in place to ensure the data integrity of provider information.

Opportunities for Improvement and Recommendations

Weber's rates for members hospitalized for mental illness who received a follow-up visit within seven days of discharge fell below the statewide PMHP average. Therefore, HSAG recommended that Weber focus on improvement efforts designed to ensure that members receive a Weber-furnished service within seven days following discharge from a hospitalization.

HSAG did not identify any recommendations as a result of the PMV process.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Weber—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Weber's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Weber's sample of credentialed providers included several human service workers, a peer support specialist, a nurse, a retired nurse advocate, and two case managers. HSAG reviewed full samples of 10 prior authorization denials, appeals, and grievance records.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Weber submitted and through conducting a virtual, web-based review consisting of interviews with key Weber staff members.

Strengths

HSAG found that, for all licensed providers reviewed, Weber searched the Utah Division of Occupational and Professional Licensing (DOPL) prior to hire. HSAG also found very detailed grievance records and full compliance with the files reviewed pertaining to quality, access, and timeliness.

In CY 2018 and 2019, HSAG had reviewed Weber's website and found that it did not contain language to notify members that the information on the website is available in paper form without charge upon

request, and that the information would be provided within five business days. In CY 2020, HSAG found that Weber had added a statement to its website notifying members that the information on the website is available in paper form without charge upon request, and that the information would be provided within five business days.

In CY 2018 and 2019, HSAG had found that within its provider directory, Weber did not note the "languages (including American Sign Language) offered by the provider or provider's office" as required, but the directory did state that interpreters are available. For CY 2020, Weber met this requirement by making an overall statement about cultural competency in the directory and added a column indicating the foreign languages available for each provider.

Opportunities for Improvement and Recommendations

For the credentialing review, HSAG found that Weber did not collect an application from one provider and collected the application for another provider after the hire date.

For the prior authorization denial records, HSAG found that for expedited denial requests (continued inpatient care), while Weber did inform the provider of the denial verbally, Weber was not sending the member a NABD letter within 72 hours.

HSAG reviewed the appeal records and noted that most denials were related to denied requests for additional inpatient days after the initial approved days were complete. HSAG noted that two of the 10 files reviewed did not include an acknowledgement letter to the member, and that four of the files did not include a resolution letter to the member. For appeal resolution letters to the member, HSAG suggests that Weber add language informing members that they are not liable for payment (as applicable) to ensure that members are aware of their rights pertaining to balance billing.

VALIDATION OF NETWORK ADEQUACY

Table 2-116 displays the match percentage for provider information between the data submitted by Weber and all PMHPs and the online provider directory. Given the large variability in the PMHP websites, the provider address information was considered a match if the sampled address was listed on the website as a clinic location or a provider address. The PMHP websites were not required to list an address for each individual provider if the sampled provider's address was associated with the PMHP.

Table 2-116—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Weber and All PMHPs

Provider Information	Weber			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	76	98.7%	1.3%	364	97.3%	2.7%
Provider Middle Name	76	89.5%	10.5%	364	85.7%	14.3%

Provider Information	Weber			All PMHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider Last Name	76	100.0%	0.0%	364	98.9%	1.1%
Provider Address 1	76	100.0%	0.0%	364	92.9%	7.1%
Provider Address 2	76	100.0%	0.0%	364	93.7%	6.3%
Provider City	76	100.0%	0.0%	364	95.6%	4.4%
Provider State	76	100.0%	0.0%	364	99.7%	0.3%
Provider Zip Code	76	100.0%	0.0%	364	97.5%	2.5%
Provider County	76	30.3%	69.7%	364	24.5%	75.5%

Table 2-117 displays the number and percent of provider categories wherein Weber met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table.

Table 2-117—Compliance With Time/Distance Standards by Urbanicity—Weber

		Frontier		Rural		Urban	
PMHP	Number of Provider Categories	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Weber	9	0	0.0%	6	66.7%	6	66.7%

Weber—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Weber's PDV indicated that 88.4 percent of the sampled providers were found in the online directory. Additionally, Weber's match rate for all provider fields except Provider First Name, Provider Middle Name, and Provider County information was 100 percent between the submitted data and the online provider directory. The health plan's website also clearly displayed an option to request a paper form of the provider directory.

Opportunities for Improvement and Recommendations

Accurate provider information in Weber's online provider directory is critical for members to have timely access to appropriate health care providers. Weber should ensure that the online provider directory is frequently updated with required, accurate provider information. HSAG recommends that

Weber include the latest update date for provider information on its website and an option for members to report errors in provider information using an email address or toll-free number.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Weber should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Geographic network adequacy results indicate that Weber met six of the nine standards (66.7 percent) in both rural and urban areas. Weber's submitted data for network adequacy did not include any General Hospitals with a Psychiatric Unit or Substance Abuse Facilities. The provider categories that did not meet the standards are listed in Table 2-118. While failure to meet some of the standards might result from lack of providers, Weber should continue to assess areas of inadequacy to identify providers who chose not to contract with Weber and the inability to identify the providers in the data using the standard definitions.

Table 2-118—Provider Categories That Failed to Meet Time/Distance Standards—Weber*

Provider Domain	Provider Category
Behavioral Health—Adult	Behavioral Medical—Adult; Behavioral Therapist—Adult; Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit; Substance Abuse Facility
Behavioral Health—Pediatric	Behavioral Medical—Pediatric; Behavioral Therapist—Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Medicaid PAHPs Providing Dental Services

Premier Access

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Premier submitted its PIP topic: *Improving Dental Sealant Rates in Members Ages 6–9.*

Validation Results

Table 2-119 summarizes the validation findings for each stage validated for CY 2020. Overall, 84 percent of all applicable evaluation elements received a score of *Met*.

Table 2-119—CY 2020 Performance Improvement Project Validation Results for Premier Access (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	67% (4/6)	17% (1/6)	17% (1/6)
Implementation Total		**78% (7/9)**	**11% (1/9)**	**11% (1/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	50% (1/2)	0% (0/2)	50% (1/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		50% (1/2)	0% (0/2)	50% (1/2)
Percentage Score of Applicable Evaluation Elements *Met*		**84% (16/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**80% (8/10)**		
Validation Status		***Not Met***		

Indicator Outcomes

For CY 2020, Premier progressed to reporting Remeasurement 1 results. The baseline rate for members 6 to 9 years of age who received a dental sealant during the baseline measurement was 23.0 percent, which decreased to 21.0 percent during Remeasurement 1.

Table 2-120 displays baseline data for Premier's *Improving Dental Sealant Rates in Members Ages 6–9* PIP.

Table 2-120—PIP—*Improving Dental Sealant Rates in Members Ages 6–9*
Premier

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 01/01/2019–12/31/2019		Sustained Improvement
The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	N: 5,665 D: 24,586	23.0%	N: 4,899 D: 23,333	21.0%	*Not Assessed*

N–Numerator D–Denominator

Premier—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Premier documented a sound PIP design, reported accurate data, and implemented member- and provider-level interventions that were related to barriers identified through QI processes. Premier's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Premier's PIP aims to improve dental sealant rates in children 6 to 9 years old. By increasing the dental sealant rates, Premier intends to prevent the occurrence of dental caries in permanent molars.

Opportunities for Improvement and Recommendations

The PIP received an overall *Not Met* validation status, with a *Met* score for 80 percent of critical evaluation elements and 84 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the documentation of the QI processes, evaluation of interventions, and achievement of improvement in the study indicator outcomes.

As the PIP progresses, HSAG recommends the following:

- Premier must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Premier must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Premier must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicator. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should be documented in the PIP Submission Form and should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Premier's HEDIS compliance auditor found Premier's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Premier contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier's FAR revealed that Premier's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 2-121 shows Premier's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-121—Premier HEDIS 2020 Results

HEDIS Measure	Premier 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	54.02%	43.10%
4–6 Years of Age	68.67%	63.85%
7–10 Years of Age	71.21%	67.17%
11–14 Years of Age	65.01%	62.53%
15–18 Years of Age	58.16%	54.16%
19–20 Years of Age	48.53%	38.26%
Total	64.68%	55.46%

Premier—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit* measure for all performance measure indicator rates.

Opportunities for Improvement and Recommendations

Premier did not have any opportunities for improvement, and HSAG does not have any recommendations for Premier Access.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

Premier—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Premier's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Premier's sample of credentialed providers consisted of a selection of dentists, including general dentists, pediatric dentists, and two oral surgeons. HSAG reviewed a full sample of 10 prior authorization denial records and a full sample of 10 appeal records. Premier submitted a sample of six grievance records for the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Premier submitted and through conducting a virtual, web-based review consisting of interviews with key Premier staff members.

Strengths

In CY 2018 and CY 2019, HSAG had found that Premier's provider directory did not identify which providers had completed cultural competency training. For CY 2020, HSAG found that Premier had included a field in its online provider directory to identify which providers participated in cultural competency training. At the time of the review, Premier had not updated this field for many providers; however, Premier had a process in place to collect this information and was engaged in ongoing efforts to ensure that it queried providers for participation and included the results of the query in the directory.

In CY 2018, HSAG found that Premier's policies, procedures, and member information stated that members may file an appeal orally or in writing and that oral appeals must be followed with a written, signed appeal within five days of an oral appeal. In the preamble to 42 CFR §438, the requirements specifically address that a time limitation for a written response to an oral appeal is not permitted. In response to the requirement, Premier fully removed its requirement for the member to follow an oral request for an appeal with the request in writing. The federal requirements at 42 CFR §438.402 require that an oral request for appeal is followed by a request in writing without time limitation. In CY 2020, HSAG reviewed Premier's revised policy and found that it required members to follow an oral appeal in writing except in the case of expedited appeals.

HSAG reviewed the credentialing records and found that for all providers, Premier collected an application, verified education and licensure, and checked the providers' names against federal exclusions databases prior to hire.

HSAG reviewed Premier's appeal records and found that Premier sent the appeal acknowledgements and resolutions in a timely manner.

HSAG reviewed the grievance records and found that Premier acknowledged and resolved each grievance quickly and within the allotted time frame. HSAG found that the resolution letter to the member was transparent, detailed, and specific to the member's case. Premier included all required information.

Opportunities for Improvement and Recommendations

HSAG reviewed the credentialing records and found that for one provider the credentialing approval date was listed as March 11, 2020, on the credentialing cover sheet; however, Premier depicted two different dates on two different approval letters to the provider. One letter depicted the approval date as January 29, 2020, and the other letter was dated February 24, 2020. Premier conducted the validations and exclusion checks for this provider on February 25, 2020.

HSAG found Premier's NABD letters to be confusing and difficult to follow. The letter template stated in bold font across the top, "This is not a bill. This is a response to your dentist's request for dental treatment for you." A text box in large letters stated, "Notice of Authorization." The letter contained a list of informational bullets; the first bullet listed the authorization dates that the letter is "good for" (even though some or all services listed in the specific letters reviewed may have had a denied status). The letter also contained a table of procedure codes (one line for each procedure for each tooth) and dollar amounts for amount submitted, covered expense, deductible, primary paid, copay, plan payment, patient payment, then status and reason (in code). Following the table, the letter explained the meaning of the procedure codes and reason codes. The status column in the table was the only place in the letter noting that Premier was denying the service. HSAG strongly suggests that Premier work to streamline and simplify its NABD letters and grievance/appeal forms and consider testing them with a member focus group to ensure readability and ease of understanding.

Premier used a hybrid Grievance/Appeal form, sent with the NABDs, for members to request a grievance or appeal. The form stated that "Appeals filed orally must be followed with a written appeal within five business days. The appeal will not be processed if Premier does not receive a written appeal within five business days." In accordance with federal regulations, the member must follow an oral appeal with a written appeal; however, Premier cannot put a time limit on the member to file the appeal in writing. Further clarification on this topic is located in the preamble to the Medicaid managed care regulations (Federal Register, Volume 81, Number 88, published May 6, 2016, page 27,511, third column). When faced with an oral appeal and requesting that the member follow up in writing, HSAG suggests that Premier consider 42 CFR §438.406(a) which requires that Premier provide a member with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Further, the continuation of benefits language in the Grievance/Appeal form stated that for continuation of benefits, an appeal must be filed in 10 days, which is incorrect. A request for continuation must be filed in 10 days; however, the member still retains a 60-day filing time frame in which to file an appeal. HSAG also noted that for one appeal, the same provider that made the denial decision also made the decision to uphold the denial upon appeal.

In the appeal resolution letters, HSAG noted unclear language that the member would not easily understand and situations where appeals and grievances were confused. At the beginning of the Appeal Rights information section, Premier stated, "You have 60 days from the date of a 'Notice of Adverse Benefit Determination letter' to file an Appeal." This language sounds like Premier is referring to a separate letter, as this letter is titled "Notice of Authorization." The letter also stated:

> If you are currently getting treatment and want to continue getting treatment you must ask for an appeal within 10 days from the date this letter was postmarked or delivered to you; OR before the date your dental plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

For dental services, this is confusing given that treatment is usually intermittent and continuation is very rare. Therefore, "getting treatment" is confusing language. Neither the letters nor the Appeals Rights insert included the member's right to free access to all documents or records relevant to the

appeal. In addition, many of the reason code explanations refer to a Salzmann score number, which members may not understand without additional, clarifying information.

For all grievance responses to members, Premier included a blank Grievance/Appeal form with the acknowledgment letter to the member, which is confusing as the grievance had already been filed. For the grievance resolution, Premier included language stating that "If you are not happy with our decision, you can ask for a State Fair Hearing. The attached Your Right to a State Fair Hearing form has information about how to ask for a fair hearing." However, a member does not have any State fair hearing rights following a grievance. HSAG suggested that Premier reference the federal regulations to clearly distinguish grievance processes from appeal processes.

VALIDATION OF NETWORK ADEQUACY

Table 2-122 displays the match percentage for provider information between the data submitted by Premier and all dental PAHPs and the online provider directory. Table 2-123 reflects the percentage of providers who have the service listed as available on Premier's online directory as compared to all dental PAHPs.

Table 2-122—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Premier and All Dental PAHPs

Provider Information	Premier			All Dental PAHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	172	100.0%	0.0%	380	100.0%	0.0%
Provider Middle Name	172	2.3%	97.7%	380	4.5%	95.5%
Provider Last Name	172	100.0%	0.0%	380	100.0%	0.0%
Provider Address 1	172	98.8%	1.2%	380	98.7%	1.3%
Provider Address 2	172	52.9%	47.1%	380	76.8%	23.2%
Provider City	172	100.0%	0.0%	380	100.0%	0.0%
Provider State	172	100.0%	0.0%	380	100.0%	0.0%
Provider Zip Code	172	98.8%	1.2%	380	99.2%	0.8%
Provider County	172	0.6%	99.4%	380	55.0%	45.0%
Provider Specialty*	172	98.3%	1.7%	380	99.2%	0.8%
Provider Accepting New Patients	172	97.1%	2.9%	380	96.6%	3.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-123—Percentage of Provider Service Information Available in Online Directory for Premier and All Dental PAHPs

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	172	100.0%	0.0%	380	59.7%	40.3%
Non-English Language Speaking Provider	172	91.9%	8.1%	380	96.3%	3.7%
Provider Accommodates Physical Disabilities	172	99.4%	0.6%	380	86.8%	13.2%
Provider Completed Cultural Competency Training	172	0.0%	100.0%	380	0.3%	99.7%
Provider URL	172	0.0%	100.0%	380	31.6%	68.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-124 displays the number and percent of provider categories wherein Premier met the time/distance standards at the statewide level.

Table 2-124—Compliance With Time/Distance Standards by Provider Domain—Premier

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Premier—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Premier's online and paper directory are updated every 24 hours according to the health plan's website. The provider directory is available in paper form upon request, and the website also conspicuously displayed an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that Premier met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in Premier's online provider directory is critical for members to have timely access to appropriate health care providers. Only 73.5 percent of the sampled providers were found online, and Provider Middle Name, Provider Address 2, and Provider County were missing for a significant number of sampled providers found in the directory. Additionally, the provider directory did not include information on cultural competency training or provider URL for any of the sampled providers. Since the provider directory is updated every 24 hours, Premier should compare the submitted data and online provider directory to identify areas of discrepancy.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Premier should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

MCNA

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, MCNA submitted its PIP topic: *Annual Dental Visits.*

Validation Results

Table 2-125 summarizes the validation findings for the Design stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-125—CY 2020 Performance Improvement Project Validation Results for MCNA (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (5/5)	0% (0/5)	0% (0/5)
Implementation Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		***Not Assessed***		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (9/9)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, MCNA reported baseline data. The baseline rate for members 1 to 20 years of age who had at least one dental visit during the measurement year was 52.5 percent, and the baseline rate for members ages 21 and over accessing a dentist at least once during the measurement year was 27.4 percent.

Table 2-126 displays the data for MCNA's PIP.

Table 2-126—PIP—*Annual Dental Visits*
MCNA

Study Indicator	Baseline Period (01/01/2019–12/31/2019)		Sustained Improvement
1. The percentage of members ages 1–20 who had at least one dental visit during the measurement year.	N: 30,020 D: 57,218	52.5%	*Not Assessed*
2. The percentage of members ages 21 and older who had at least one dental visit during the measurement year.	N: 5,756 D: 20,980	27.4%	*Not Assessed*

MCNA—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

MCNA documented a sound PIP design, reported accurate data, and implemented member- and provider-level interventions that were related to barriers identified through QI processes. The PIP

study indicators are based on the nationally recognized CMS 416 measure. MCNA's PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of, and access to care and services. MCNA's PIP aims to improve annual dental visit rates for its members. The dental PAHP documented that an annual dental visit can help identify dental health problems early when treatment is likely to be simpler and more affordable. It also helps to prevent many problems from developing by reducing the risk of tooth decay, gum disease, tooth loss, and oropharyngeal cancers.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with *Met* scores for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- MCNA must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- MCNA must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that MNCA's HEDIS compliance auditor found MCNA's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. MCNA contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of MCNA's FAR revealed that MCNA's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 2-127 shows MCNA's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates for the *Annual Dental Visit* measure.

Table 2-127—MCNA HEDIS 2020 Results

HEDIS Measure	MCNA 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	54.52%	43.10%

HEDIS Measure	MCNA 2020 Rate	2020 NCQA Quality Compass Average
4–6 Years of Age	69.75%	63.85%
7–10 Years of Age	72.40%	67.17%
11–14 Years of Age	66.80%	62.53%
15–18 Years of Age	59.41%	54.16%
19–20 Years of Age	44.95%	38.26%
Total	65.74%	55.46%

Strengths

MCNA exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit* measure for all performance measure indicator rates.

Opportunities for Improvement and Recommendations

MCNA did not have any opportunities for improvement, and HSAG does not have any recommendations for MCNA.

ASSESSMENT OF COMPLIANCE WITH MEDICAID MANAGED CARE REGULATIONS

MCNA—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2019 compliance monitoring activities, HSAG conducted a follow-up compliance review for any requirements receiving *Partially Met* or *Not Met* scores during the CY 2018 compliance review for MCNA. As a result of this review, HSAG found full compliance with the Medicaid managed care regulations. As such, for the CY 2020 review, HSAG did not conduct a review of federal regulations or State contract requirements.

HSAG did, however, request a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. MCNA's sample of credentialed providers included several general dentists, a pediatric dentist, and an orthodontist. HSAG reviewed a full sample of 10 prior authorization denial records and 10 appeal records. MCNA reported that eight grievances were filed during the period under review.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records MCNA submitted and through conducting a virtual, web-based review consisting of interviews with key MCNA staff members.

Strengths

HSAG reviewed the initial credentialing sample and found that MCNA had obtained an application, verification of licensure and education, and checked the applicants' names against federal exclusion databases prior to hire. HSAG found full compliance with the credentialing records.

HSAG reviewed the sample of prior authorization denials and found that MCNA sent all other denial decisions in the sample to the member in a timely manner. In addition, HSAG found that the NABD letters included all required information and were well written with an intention to provide ease of understanding.

HSAG reviewed the appeal records and found that MCNA sent acknowledgement and resolution letters in a timely manner. For some files, HSAG found that the members requested an expedited decision and MCNA denied the request, as the member's condition was not life threatening. MCNA sent a letter to the member acknowledging the appeal request but denying the expedition. This letter included the member's right to grieve about the denied expedition request, as required. Within the resolution letters, MCNA provided the member with ample information to clearly explain the reason for not resolving an appeal in the member's favor.

MCNA reported that eight grievances were filed during the period under review. However, MCNA only included seven grievances in the sample it provided to HSAG. HSAG reviewed the records and found that MCNA acknowledged and resolved all seven grievances in a timely manner. HSAG found that the resolution letters included all required information and were well written, detailing the member's grievance, MCNA's actions or investigations, and the resolution.

Opportunities for Improvement and Recommendations

HSAG reviewed the sample of prior authorization denials and found that MCNA sent one denial decision 15 days after the prior authorization request instead of within 14 days, as required.

HSAG reviewed the appeal records and found that most resolution letters contained medical terminology that was more advanced than a sixth-grade reading level, without including an easy-to-understand explanation.

HSAG observed notes for the grievances in several member records in the electronic documentation system that stated, "referred from verbal complaint because the verbal complaint was not able to be resolved on the same day." HSAG noted that none of the grievances MCNA reported were resolved on the same day, meaning that any complaints received and resolved on the same day may not have been included in MCNA's full tally of grievances. HSAG also noted that eight grievances over a five-month period is a relatively small number of grievances. HSAG suggests that MCNA identify and track all grievances, even those resolved in one day, for trending and QI.

VALIDATION OF NETWORK ADEQUACY

Table 2-128 displays the match percentage for provider information between the data submitted by MCNA and all dental PAHPs and the online provider directory. Table 2-129 reflects the percentage of providers who have the service listed as available on MCNA's online directory as compared to all dental PAHPs.

Table 2-128—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for MCNA and All Dental PAHPs

Provider Information	MCNA			All Dental PAHPs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	208	100.0%	0.0%	380	100.0%	0.0%
Provider Middle Name	208	6.3%	93.8%	380	4.5%	95.5%
Provider Last Name	208	100.0%	0.0%	380	100.0%	0.0%
Provider Address 1	208	98.6%	1.4%	380	98.7%	1.3%
Provider Address 2	208	96.6%	3.4%	380	76.8%	23.2%
Provider City	208	100.0%	0.0%	380	100.0%	0.0%
Provider State	208	100.0%	0.0%	380	100.0%	0.0%
Provider Zip Code	208	99.5%	0.5%	380	99.2%	0.8%
Provider County	208	100.0%	0.0%	380	55.0%	45.0%
Provider Specialty*	208	100.0%	0.0%	380	99.2%	0.8%
Provider Accepting New Patients	208	96.2%	3.8%	380	96.6%	3.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-129—Percentage of Provider Service Information Available in Online Directory for MCNA and All Dental PAHPs

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	208	26.4%	73.6%	380	59.7%	40.3%
Non-English Language Speaking Provider	208	100.0%	0.0%	380	96.3%	3.7%
Provider Accommodates Physical Disabilities	208	76.4%	23.6%	380	86.8%	13.2%

Available Services Information	Premier			All Dental PAHPs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	208	0.5%	99.5%	380	0.3%	99.7%
Provider URL	208	57.7%	42.3%	380	31.6%	68.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-130 displays the number and percent of provider categories wherein MCNA met the time/distance standards at the statewide level.

Table 2-130—Compliance With Time/Distance Standards by Provider Domain—MCNA

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

MCNA—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

MCNA's PDV indicated that 93.3 percent of the sampled providers were found in the online provider directory. Additionally, MCNA's match rates between submitted data and the online provider directory for all fields except Provider Middle name exceeded 96 percent. MCNA's website conspicuously displays an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that MCNA met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in MCNA's online provider directory is critical for members to have timely access to appropriate health care providers. Only 4 percent of the sampled providers were not found online, and the location was not found in the directory for an additional 2.7 percent of the sampled providers. HSAG recommends that MCNA update its provider directory to include service information such as practice limitations, cultural competency training, physical disability accommodation, and provider URL for all providers.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. MCNA should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—CHIP

CHIP MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

Molina Healthcare of Utah CHIP

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Molina CHIP submitted a new clinical PIP topic: *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*.

Validation Results

Table 2-131 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-131—CY 2020 Performance Improvement Project's Validation Results for Molina CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI. Review the Data Collection Procedures	100% (4/4)	0% (0/4)	0% (04)
Design Total		**100% (16/16)**	**0% (0/16)**	**0% (0/16)**

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	*Not Assessed*		
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		**Not Assessed**		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (25/25)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (12/12)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, Molina CHIP reported baseline data. For the baseline measurement period, Molina reported that 64.5 percent of children 3 to 17 years of age had evidence of BMI percentile documentation during the measurement year.

Table 2-132 displays data for Molina CHIP's PIP.

Table 2-132—PIP—*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*
Molina CHIP

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2018–12/31/2018)**		**Sustained Improvement**
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN	N: 265 D: 411	64.5%	*Not Assessed*

Study Indicator Results			
Study Indicator	**Baseline Period (01/01/2018–12/31/2018)**		**Sustained Improvement**
and who had evidence of BMI percentile documentation during the measurement year.			

N–Numerator D–Denominator

Molina CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Molina CHIP designed a scientifically sound PIP, conducted appropriate QI processes to identify and prioritize barriers, and implemented interventions that appeared to be logically linked to the barriers. Additionally, Molina CHIP's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. The PIP aims to increase annual BMI screening among its members to increase the likelihood of desired health outcomes through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Molina must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Molina must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with all applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Molina contracted with an external software

vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Molina's FAR revealed that Molina's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations.

Performance Measure Outcomes

Table 2-133 shows Molina's CHIP HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-133—Molina CHIP HEDIS 2020 Results

HEDIS Measure	Molina CHIP 2020Rate	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	92.37%	90.72%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	84.92%	70.28%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	90.74%	80.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	81.51%	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	79.82%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.07%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

Molina CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Molina CHIP exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Child Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

Molina CHIP fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Molina CHIP exceeded the 2020 NCQA Quality Compass average for five of the six applicable measure rates (83.33 percent), indicating an opportunity for improvement. Molina CHIP should require well-child visits for young children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

Molina CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

Molina is one of Utah's Medicaid ACOs. Molina also holds a contract with UDOH to provide managed health care services under CHIP. HSAG's compliance monitoring tools were developed using federal health care regulations at 42 CFR §438, as well as the State CHIP contract requirements. Molina used the same organizational processes and resources used to administer its Medicaid program to carry out processes required by the CHIP program; therefore, findings between Molina's Medicaid and CHIP lines of business were relatively comparable.

For the CY 2020 compliance monitoring activities, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, service authorization denials, and appeals for alignment with the quality, timeliness, and access domains. Molina's sample of initial CHIP credentialing records included a behavioral analyst, an audiologist, a psychiatrist, social worker, surgeon, a gerontologist, an optometrist, a surgeon, a family physician, and a physician assistant. HSAG reviewed a full sample of 10 grievances, 10 prior authorization denials, and 10 appeals for the time period under review.

HSAG determined findings for the CHIP line of business based on a desk review of the documents Molina submitted and through a virtual, web-based review consisting of interviews with key Molina staff members.

Strengths

Overall findings for Molina indicated improvement from CY 2019 to CY 2020, specifically pertaining to access to care. Concerning member information, HSAG found that Molina began using an accessibility product, User1st's uRemediate, which has an application on its website to invert the colors on a page or change to grayscale to help with color contrast. There is also an option to better support the viewer's screen reader.

In CY 2018, HSAG had found that Molina did not have a process in place to verify whether members received services that network providers represented as having been delivered. In CY 2019, HSAG found that new policies regarding this process applied only to the Medicaid line of business and that Molina did not have procedures for its CHIP line of business. For CY 2020, HSAG found that Molina had updated its policy and procedures to ensure the process for sampling members to detect fraudulent billing practices applied to both Medicaid and CHIP.

In CY 2019, at the time of the review, the drug formulary posted on the website in the CHIP dropdown menu did not include drug tiers. For the CY 2020 review, HSAG reviewed the CHIP drug formulary on Molina's website and noted the formulary included a listing of the tier for each medication.

In CY 2020, HSAG found that Molina included within each applicant's credentialing file a signed application, evidence of verification of licensure and education, and evidence that it searched providers against federal exclusion databases prior to appointment. HSAG also found that Molina resolved grievances and sent notice within the required time frames for all grievances reviewed, potentiality positively impacting the timeliness of services.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had reviewed Molina's provider directory content and found that Molina did not include the following information in the provider directory located on its website: website URLs for providers; information concerning whether the provider completed cultural competency training; or whether the provider's office had accommodations for people with physical disabilities, including offices, exam rooms, and equipment. HSAG reviewed Molina's provider directory again in CY 2019 and concluded the same findings. In CY 2020, HSAG found that Molina's online provider directory did not include website URLs for providers or information concerning whether the provider completed cultural competency training, negatively impacting the quality and access domains. HSAG suggested that Molina develop a strategy to ensure its provider directory is complete.

In CY 2018, HSAG found that Molina's appeal process included provisions that the member must complete a written appeal request within five days of the oral request or the member would lose the

right to appeal. For CY 2019, Molina revised its policy to remove the statement that members "lose their right to appeal" but did not remove the artificial time frame of five days: "The written, signed Appeal must be received within five working days from the date of the oral Appeal. If the Aggrieved Person does not follow up with a written, signed Appeal, the Contractor has no further obligation to take action on the Aggrieved Person's Appeal." The Preamble to the Medicaid managed care regulations clarifies this topic wherein CMS states that a time limit cannot be imposed on the member's written response to an oral appeal request. HSAG recommended that Molina's policy stress that Molina will work with the member to provide any assistance needed in filing a written appeal following an oral appeal, to comply with 42 CFR §438.406(a). HSAG suggests that Molina review 42 CFR §438 Subpart F and revise sections of the Appeals Policy, such as Section I. Right to Appeal a Grievance.

HSAG found some confusion within Molina's documents regarding the definitions of "NABD," "notice of action," "grievance," and "appeal." HSAG suggested that Molina remove the outdated term "notice of action" and ensure that the definition for "NABD" aligns with the federal definition. HSAG found that in Molina's CHIP Appeals Procedure stated that members have 30 days to file a State fair hearing, instead of 120 days. Within its policies, Molina stated that there is an option, sometimes, for a member to appeal a grievance, which is inaccurate. HSAG suggested that senior leadership who oversee appeals and grievances thoroughly review policies and procedures to ensure consistency with the federal and State requirements.

In Molina's CHIP prior authorization denial records, HSAG found that the records did not meet the requirements of §438.10, impacting the access, quality, and timeliness domains of care. For example, the attachment, Guidelines for Appealing a Medical Denial, was written using a font smaller than the required 12-point font and included the following incorrect information:

Required members to follow an oral request for an appeal with a written request within five days.

Stated that Molina would process expedited appeals within three business days, instead of 72 hours.

Included outdated language regarding continuation of services.

HSAG noted that Molina referred to all denial letters as "notices of action," which is an obsolete term for CMS. NABD is the current term CMS uses for denials related to 42 CFR §438.

HSAG also found that the NABD letters and appeal resolution letters were often confusing, unclear, or written in language that was above a sixth-grade reading level. HSAG suggests that Molina's leadership review the appeal procedures to ensure compliance with all requirements and incorporate a monitoring system to initiate supervisor review of letters for content and ease of understanding prior to mailing.

HSAG found that internal documentation of grievances lacked some important details, including evidence of a resolution. In addition, HSAG found conflicting acknowledgement/resolution dates between the letter dates and various dates in the electronic documentation system. HSAG suggested that Molina work toward more complete and accurate documentation in its system notes.

VALIDATION OF NETWORK ADEQUACY

Table 2-134 displays the match percentage for provider information between the data submitted by Molina CHIP and all CHIP MCOs and the online provider directory. Table 2-135 reflects the percentage of providers who have the service listed as available in Molina CHIP's online directory as compared to all CHIP MCOs.

Table 2-134—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Molina CHIP and All CHIP MCOs

Provider Information	Molina CHIP			All CHIP MCOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	282	98.9%	1.1%	473	99.4%	0.6%
Provider Middle Name	282	97.2%	2.8%	473	96.2%	3.8%
Provider Last Name	282	100.0%	0.0%	473	99.6%	0.4%
Provider Address 1	282	94.3%	5.7%	473	86.7%	13.3%
Provider Address 2	282	91.5%	8.5%	473	89.0%	11.0%
Provider City	282	97.5%	2.5%	473	93.4%	6.6%
Provider State	282	100.0%	0.0%	473	100.0%	0.0%
Provider Zip Code	282	95.0%	5.0%	473	91.8%	8.2%
Provider County	282	0.7%	99.3%	473	0.6%	99.4%
Provider Specialty*	282	100.0%	0.0%	473	96.4%	3.6%
Provider Accepting New Patients	282	86.2%	13.8%	473	58.6%	41.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-135—Percentage of Provider Service Information Available in Online Directory for Molina CHIP and All CHIP MCOs

Available Services Information	Molina CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	282	87.2%	12.8%	473	84.4%	15.6%
Non-English Language Speaking Provider	282	100.0%	0.0%	473	93.0%	7.0%
Provider Accommodates Physical Disabilities	282	46.8%	53.2%	473	60.9%	39.1%

Available Services Information	Molina CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Provider Completed Cultural Competency Training	282	0.0%	100.0%	473	33.6%	66.4%
Provider URL	282	1.1%	98.9%	473	11.6%	88.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-136 displays the number and percent of provider categories wherein Molina CHIP met the time/distance standards at the statewide level.

Table 2-136—Compliance With Time/Distance Standards by Provider Domain—Molina CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	1	50.0%
Specialists—Pediatric	17	2	11.8%
Additional Physical Health—Providers	6	5	83.3%
Additional Physical Health—Facilities	5	2	40.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	1	50.0%
Behavioral Health—Adult	1	0	0.0%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	3	0	0.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Molina CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Molina CHIP's PDV indicated that 77.5 percent of the sampled providers were found in the health plan's online provider directory. Molina CHIP's match rates between submitted data and the online directory for all provider fields except Provider County and Accepting New Patients exceeded 90 percent. Additionally, the information on the Molina CHIP website noted that the most recent update to the website and paper directory was October 24, 2020, when HSAG reviewed the websites on October 26, 2020.

Geographic network distribution analysis indicated that Molina CHIP met 30 of 41 (73.2 percent) of time/distance standards in the urban counties (74.1 percent) and 100 percent of the standards statewide for the Hospitals provider domain.

Opportunities for Improvement and Recommendations

Accurate provider information in Molina CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. HSAG recommends that Molina CHIP frequently update its online provider directory with the required, accurate provider information and have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website. HSAG also recommends that Molina include provider information on cultural competency training and the provider URL since less than 2 percent of sampled providers included information on these services. Additionally, information on physical disability accommodation was present only in 46.8 percent of the sampled providers found in the online directory.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Molina CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, Molina CHIP met the time/distance standards for 14 of the 41 (34.1 percent) provider categories and struggled to meet standards in rural and frontier counties. Neither of the CHIP MCOs met any standards at the statewide level for Behavioral Health—Adult and Behavioral Health—Facilities provider domains. The provider categories that did not meet the standards are listed in Table 2-137. Additionally, HSAG did not identify any pediatric psychologists in the data for either CHIP MCO. Molina CHIP did not include any pediatric providers for Dermatology or Ophthalmology or any Outpatient Infusion/Chemotherapy facilities in the provider data for any county. While failure to meet some of the standards might result from lack of providers, Molina CHIP should continue to assess areas of inadequacy to identify providers who chose not to contract with Molina CHIP and the inability to identify the providers in the data using the standard definitions.

Table 2-137—Provider Categories That Failed to Meet Time/Distance Standards—Molina CHIP*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Outpatient Infusion/Chemotherapy; Skilled Nursing Facility; Surgical Services (Outpatient or ASC)
Additional Physical Health—Providers	Diagnostic Radiology
Ancillary—Facilities	Pharmacy
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit

Provider Domain	Provider Category
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Midlevel
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Otolaryngology, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

SelectHealth CHIP

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, SelectHealth CHIP submitted its PIP topic: *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday.*

Validation Results

Table 2-138 summarizes the validation findings for each stage validated for CY 2020. Overall, 100 percent of all applicable evaluation elements received a score of *Met*.

Table 2-138—CY 2020 Performance Improvement Project Validation Results for SelectHealth CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
	X. Assess for Sustained Improvement	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**100% (3/3)**	**0% (0/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**100% (20/20)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**100% (11/11)**		
Validation Status		***Met***		

Indicator Outcomes

For CY 2020, SelectHealth CHIP progressed to reporting Remeasurement 3 results. For Remeasurement 3, the study indicator rate of 40.2 percent was 3.1 percentage points higher than the Remeasurement 2 rate and maintained a statistically significant increase ($p = 0.0015$) of 16.8 percentage points over the baseline. SelectHealth CHIP was able to sustain statistically significant improvement over the baseline for two remeasurement periods.

It should be noted that there was a change in HEDIS 2018 *IMA* measure numerator specifications (i.e., a two-dose HPV vaccination series was added instead of a three-dose series). This change may impact the comparability between baseline and Remeasurement 2 data, as well as subsequent remeasurements.

Table 2-139 displays data for SelectHealth CHIP's PIP.

Table 2-139—PIP—*HPV Vaccine Prior to 13th Birthday for Female CHIP Members*
SelectHealth CHIP

Study Indicator	Baseline Period 01/01/2015–12/31/2015		Remeasurement 1 01/01/2016–12/31/2016		Remeasurement 2 01/01/2017–12/31/2017		Remeasurement 3 01/01/2018–12/31/2018		Sustained Improvement
The percentage of 13-year-old female CHIP members who had 2 doses of human papillomavirus (HPV) vaccine prior to their 13th birthday	N: 36 D: 154	23.4%	N: 52 D: 163	31.9%	N: 65 D: 175	37.1%*	N: 72 D: 179	40.2%*	*Achieved*

*Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

SelectHealth CHIP designed a scientifically sound project and reported and analyzed its Remeasurement 3 data accurately. SelectHealth CHIP conducted appropriate QI processes to identify and prioritize barriers, implemented interventions that were logically linked to the barriers and was successful in achievement of a statistically significant, sustained improvement in the study indicator rate over the baseline. The PIP topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. SelectHealth CHIP aims to improve HPV vaccination rates in its female adolescent Medicaid population. By increasing the percentage of 13-year-old female Medicaid members who had two doses of HPV vaccine prior to their 13th birthday, the health plan increases the likelihood of desired health outcomes of its members through providing services that are consistent with current professional, evidence-based knowledge and providing timely care.

Opportunities for Improvement and Recommendations

The PIP received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all activities completed and validated.

As the PIP progresses, HSAG recommends the following:

- Since SelectHealth CHIP has demonstrated sustained improvement in this PIP, the health plan should consult with UDOH on next steps.
- Considering the changes to the HEDIS specifications, if SelectHealth CHIP decides to continue with the current PIP topic, it should redetermine the baseline measurement period to allow for comparability of remeasurement data to the baseline.
- SelectHealth must continue to revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that SelectHealth's HEDIS compliance auditor found SelectHealth's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. SelectHealth contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of SelectHealth's FAR revealed that SelectHealth's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-140 shows SelectHealth CHIP's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-140—SelectHealth CHIP HEDIS 2020Results

HEDIS Measure	SelectHealth CHIP 2020 Rate	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection		
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.07%	90.72%
Childhood Immunization Status		
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	81.33%	70.28%
Immunizations for Adolescents		
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	91.24%	80.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	92.55%	76.92%
Well-Child Visits in the First 15 Months of Life		
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	78.72%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.37%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

SelectHealth CHIP—Assessment With Respect to Quality, Timeliness, and Access to Care—Performance Measures

Strengths

SelectHealth CHIP exceeded the 2020 NCQA Quality Compass average for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Child Immunization Status- Combination 3*
- *Immunizations for Adolescents-Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life*

Opportunities for Improvement and Recommendations

SelectHealth CHIP fell below the 2020 NCQA Quality Compass average for the following measure rates:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

SelectHealth CHIP exceeded the 2020 NCQA Quality Compass average for five of the six applicable measure rates (83.33 percent), indicating an opportunity for improvement. SelectHealth CHIP should focus improvement efforts on ensuring well-child visits for young children.

ASSESSMENT OF COMPLIANCE WITH MANAGED CARE REGULATIONS

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

SelectHealth is one of Utah's Medicaid ACOs. SelectHealth also holds a contract with UDOH to provide managed health care services under CHIP. HSAG's compliance monitoring tools were developed using federal health care regulations at 42 CFR §438, as well as the State CHIP contract requirements. SelectHealth used the same organizational processes and resources used to administer its Medicaid program to carry out processes required by the CHIP program; therefore, findings between SelectHealth's Medicaid and CHIP lines of business were relatively comparable.

For the CY 2020 compliance follow-up review, HSAG reviewed requirements receiving *Partially Met* or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of initial provider credentialing records, member grievances, prior authorization denials, and appeals for alignment with quality, timeliness, and access requirements. The SelectHealth CHIP initial credentialing sample included a marriage and family therapist, nurse practitioners, a counselor, a social worker, a physical therapist, a psychologist, an obstetrician, and a physician assistant. SelectHealth reported having four service authorization denials, one service authorization appeal, and three grievances for its CHIP line of business during the period under review.

HSAG determined findings based on a desk review of the documents SelectHealth submitted and through a virtual, web-based review consisting of interviews with key SelectHealth staff members.

Strengths

Overall findings for SelectHealth indicated improvement from CY 2019 to CY 2020, specifically pertaining to the access domain. Concerning member information, HSAG found that SelectHealth's searchable online provider directory included all required information. HSAG noted that the searchable online directory contained the cultural competency and physical accessibility information which had not been included in the past.

HSAG reviewed SelectHealth's submission for CY 2019 and found that the CHIP handbook included a 90-day time frame instead of a 60-day time frame for filing an appeal. For CY 2020, HSAG reviewed SelectHealth's CHIP member handbook posted on its website and found that the handbook included the correct time frame for member appeals.

Based on a review of provider agreements in CY 2018 and CY 2019, HSAG found that provider agreements lacked provisions that the provider agrees to make available for audit, evaluation, or inspection—by the State, CMS, the HHS inspector general, and the comptroller general (or designees)—its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to Medicaid members and pertaining to any aspect of services and activities performed or amounts payable under the Contractor's contract with the State. For the CY 2020 review, SelectHealth submitted evidence that its provider agreements included the required regulatory language as defined in 42 CFR §438.230(c).

HSAG reviewed initial credentialing files and found that SelectHealth obtained an application, verification of licensure and education, and had searched all providers in the sample against federal exclusion databases prior to appointment. For the CHIP service authorization appeals, HSAG found full compliance with the quality, access, and timeliness requirements.

Opportunities for Improvement and Recommendations

In CY 2018, HSAG had found that SelectHealth's provider directories (print and electronic) did not include the provider's website URL and did not indicate whether the provider had completed cultural competency training or if the office has accommodations for people with physical disabilities. In CY 2020 HSAG found that the searchable directory continued to lack provider URLs and the PDF directory lacked cultural competency information about providers as well as URLs. HSAG suggested that SelectHealth develop a procedure to resolve this ongoing issue.

In the service authorization denial records, HSAG found that SelectHealth sent the same extension letter to both the member and the provider, which requested additional information and did not clarify medical terminology. In addition, the member was not informed of the right to grieve the extension.

HSAG suggested that SelectHealth establish a process to review letters that are sent to members to ensure clarity and compliance with the requirements.

In the appeals review, HSAG found that for two records, SelectHealth did not send the acknowledgement letters in a timely manner. Also, the language in two of the member letters was not written at or below a sixth-grade reading level. In addition, one appeal resolution was not sent within the required time frame of 30 calendar days. HSAG suggested that SelectHealth examine its appeal response procedures to improve the timeliness and quality of experience for its members.

In grievance records and system notes, HSAGs found that members who called in a grievance were offered an opportunity to file a "formal" grievance. If they chose not to, then SelectHealth did not perform a follow-up investigation and closed the case. The federal regulations state that the Medicaid managed care plan must accept grievances orally or in writing, according to 42 CFR §438.402(c)(3)(i). SelectHealth must accept a grievance regardless of how the member submits it and may not put an additional burden on the member to follow up in writing. HSAG discussed during the review that SelectHealth may have confused the process for filing a grievance orally with the process for filing an appeal orally. HSAG noted that it was likely that SelectHealth missed many grievances and consequently did not investigate potential associated quality of service issues during the period under review. Within the files reviewed, HSAG found evidence of further confusion between grievances and appeals, as some members were offered the opportunity to file an appeal following the review of a quality-of-care grievance. In addition, HSAG removed one appeal file from the review that SelectHealth had misidentified as a grievance. HSAG strongly recommends that SelectHealth management review 42 CFR §438 Subpart F–Grievance and Appeal System and retrain staff on grievance and appeal identification and processing.

HSAG also noted that three grievances over a five-month period is an unusually small amount. HSAG suggests that SelectHealth review its grievance collection policies and procedures to ensure that SelectHealth is accounting for all member-submitted grievances, including those resolved quickly or that require little or no investigation.

VALIDATION OF NETWORK ADEQUACY

Table 2-141 displays the match percentage for provider information between the data submitted by SelectHealth CHIP and all CHIP MCOs and the online provider directory. Table 2-142 reflects the percentage of providers who have the service listed as available on SelectHealth CHIP's online directory as compared to all CHIP MCOs.

Table 2-141—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for SelectHealth CHIP and All CHIP MCOs

Provider Information	SelectHealth CHIP			All CHIP MCOs		
	Total	Match Percentage	Unmatched Percentage	Total	Match Percentage	Unmatched Percentage
Provider First Name	191	100.0%	0.0%	473	99.4%	0.6%
Provider Middle Name	191	94.8%	5.2%	473	96.2%	3.8%
Provider Last Name	191	99.0%	1.0%	473	99.6%	0.4%
Provider Address 1	191	75.4%	24.6%	473	86.7%	13.3%
Provider Address 2	191	85.3%	14.7%	473	89.0%	11.0%
Provider City	191	87.4%	12.6%	473	93.4%	6.6%
Provider State	191	100.0%	0.0%	473	100.0%	0.0%
Provider Zip Code	191	86.9%	13.1%	473	91.8%	8.2%
Provider County	191	0.5%	99.5%	473	0.6%	99.4%
Provider Specialty*	191	91.1%	8.9%	473	96.4%	3.6%
Provider Accepting New Patients	191	17.8%	82.2%	473	58.6%	41.4%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-142—Percentage of Provider Service Information Available in Online Directory for SelectHealth CHIP and All CHIP MCOs

Available Services Information	SelectHealth CHIP			All CHIP MCOs		
	Total	Percentage Shown	Percentage Not Shown	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	191	80.1%	19.9%	473	84.4%	15.6%
Non-English Language Speaking Provider	191	82.7%	17.3%	473	93.0%	7.0%
Provider Accommodates Physical Disabilities	191	81.7%	18.3%	473	60.9%	39.1%
Provider Completed Cultural Competency Training	191	83.2%	16.8%	473	33.6%	66.4%
Provider URL	191	27.2%	72.8%	473	11.6%	88.4%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-143 displays the number and percent of provider categories wherein SelectHealth CHIP met the time/distance standards at the statewide level.

Table 2-143—Compliance With Time/Distance Standards by Provider Domain—SelectHealth CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
PCP—Pediatric	2	1	50.0%
PNC/Women's Health Providers	2	1	50.0%
Specialists—Pediatric	17	0	0.0%
Additional Physical Health—Providers	6	3	50.0%
Additional Physical Health—Facilities	5	1	20.0%
Hospitals	1	1	100.0%
Ancillary—Facilities	2	2	100.0%
Behavioral Health—Adult	1	0	0.0%
Behavioral Health—Pediatric	2	1	50.0%
Behavioral Health—Facilities	3	0	0.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

SelectHealth CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

While SelectHealth CHIP's PDV indicated that only 54 percent of the sampled providers were found in the health plan's online provider directory, the provider specialty information matched with the submitted data for 91.1 percent of the providers found online. Additionally, over 80 percent of the sampled providers found in the online directory included service information on cultural competency, physical disability accommodation, practice limitations, and whether the provider speaks non-English languages.

Geographic network distribution analysis indicated that SelectHealth CHIP met 100 percent of the standards statewide for Hospitals and Ancillary—Facilities provider domains.

Opportunities for Improvement and Recommendations

Accurate provider information in SelectHealth CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. 39.8 percent of the sampled providers were not found in SelectHealth CHIP's online provider directory. Additionally, 6.2 percent of the provider locations were not found in the directory. SelectHealth CHIP had a lower match rate for Provider Address 1 (75.4 percent), Provider Address 2 (85.3 percent), and Provider Accepting New Patients (17.8

percent) among providers found online. HSAG recommends that SelectHealth CHIP frequently update its online provider directory with the required, accurate provider information and include the date when the information was last updated. HSAG also recommends that SelectHealth CHIP have an option for members to request a paper form of the provider directory and to report errors using an email address or toll-free number which is conspicuously displayed on the website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. SelectHealth CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results. Statewide, SelectHealth CHIP met the time/distance standards for 10 of the 41 (24.4 percent) provider categories and struggled to meet standards in rural and frontier counties. While neither CHIP MCO met any standards at the statewide level for Behavioral Health—Adult and Behavioral Health—Facilities provider domains, SelectHealth CHIP also did not meet any of the Specialists—Pediatric standards at the statewide level. The provider categories that did not meet the standards are listed in Table 2-144. Additionally, HSAG did not identify any pediatric psychologists in the data for either CHIP MCO. SelectHealth CHIP did not include any providers in any county for Pediatric Physical Medicine, Diagnostic Radiology, Behavioral Therapy Agency/Clinic, or General Hospitals with a Psychiatric Unit provider categories. While failure to meet some of the standards might result from lack of providers, SelectHealth CHIP should continue to assess areas of inadequacy to identify providers who chose not to contract with SelectHealth CHIP and the inability to identify the providers in the data using the standard definitions.

Table 2-144—Provider Categories That Failed to Meet Time/Distance Standards—SelectHealth CHIP*

Provider Domain	Provider Category
Additional Physical Health—Facilities	Laboratory; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Surgical Services (Outpatient or ASC)
Additional Physical Health—Providers	Audiologist; Diagnostic Radiology; Speech Therapist
Behavioral Health—Adult	Substance Abuse Counselor
Behavioral Health—Facilities	Behavioral Health Hospital; Behavioral Therapy Agency/Clinic; General Hospitals with a Psychiatric Unit
Behavioral Health—Pediatric	Behavioral Medical—Pediatric
PCP—Pediatric	PCP—Midlevel—Pediatric
PNC/Women's Health Providers	OBGYN—Midlevel
Specialists—Pediatric	Allergy & Immunology, Pediatric; Cardiology, Pediatric; Dermatology, Pediatric; Endocrinology, Pediatric; Gastroenterology, Pediatric; General Surgery, Pediatric; Infectious Disease, Pediatric; Nephrology, Pediatric; Neurology, Pediatric; Oncology/Hematology, Pediatric; Ophthalmology, Pediatric; Orthopedic Surgery, Pediatric; Otolaryngology, Pediatric; Physical Medicine, Pediatric; Pulmonology, Pediatric; Rheumatology, Pediatric; Urology, Pediatric

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

CHIP PAHP Providing Dental Services

Premier Access—CHIP

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

For CY 2020, Premier CHIP submitted its PIP topic: *Improving Dental Sealant Rates in CHIP Members Ages 6–9.*

Validation Results

Table 2-145 summarizes the validation findings for each stage validated for CY 2020. Overall, 95 percent of all applicable evaluation elements received a score of *Met*.

Table 2-145—CY 2020 Performance Improvement Project Validation Results for Premier CHIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Design	I. Review the Selected Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II. Review the Study Question	100% (1/1)	0% (0/1)	0% (0/1)
	III. Review the Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV. Review the Selected Study Indicators	100% (1/1)	0% (0/1)	0% (0/1)
	V. Review Sampling Methods (if sampling was used)	*Not Applicable*		
	VI. Review the Data Collection Procedures	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	VII. Review the Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	VIII. Assess the Improvement Strategies	83% (5/6)	17% (1/6)	0% (0/6)
Implementation Total		**89% (8/9)**	**11% (1/9)**	**0% (0/9)**

Stage	Activity	Percentage of Applicable Elements*		
		Met	*Partially Met*	*Not Met*
Outcomes	IX. Assess for Real Improvement Achieved	100% (2/2)	0% (0/2)	0% (0/2)
	X. Assess for Sustained Improvement	*Not Assessed*		
Outcomes Total		100% (2/2)	0% (0/2)	0% (0/2)
Percentage Score of Applicable Evaluation Elements *Met*		**95% (18/19)**		
Percentage Score of Applicable Critical Evaluation Elements *Met*		**90% (9/10)**		
Validation Status		***Partially Met***		

Indicator Outcomes

For CY 2020, Premier CHIP progressed to reporting Remeasurement 1 results.

For Remeasurement 1, the study indicator rate demonstrated a statistically significant increase ($p < 0.0001$) of 6.0 percentage points over the baseline, to 21.5 percent. Premier CHIP will be assessed for sustained improvement in the next validation year.

Table 2-146 displays baseline data for Premier CHIP's *Improving Dental Sealant Rates in CHIP Members Ages 6–9* PIP.

Table 2-146—PIP—*Improving Dental Sealant Rates in Members Ages 6–9*
Premier CHIP

Study Indicator	Baseline Period 01/01/2018–12/31/2018		Remeasurement 1 01/01/2019–12/31/2019		Sustained Improvement
The percentage of CHIP members 6–9 years of age who received a dental sealant during the measurement year.	N: 697 D: 4,492	15.5%	N: 913 D: 4,243	21.5%*	*Not Assessed*

* Indicates statistically significant improvement over the baseline. N–Numerator D–Denominator

Premier CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Premier CHIP documented a sound PIP design, reported accurate data, and achieved a statistically significant increase in outcomes. Premier's study topic addressed CMS' requirements related to outcomes—specifically, the quality and timeliness of care and services. Premier's PIP aims to improve dental sealant rates in children 6 to 9 years old. By increasing the dental sealant rates, Premier intends to prevent the occurrence of dental caries in permanent molars.

Opportunities for Improvement and Recommendations

The PIP received an overall *Partially Met* validation status, with a *Met* score for 90 percent of critical evaluation elements and 95 percent of overall evaluation elements across all activities completed and validated. There were opportunities for improvement in the documentation of the QI processes and evaluation of interventions.

As the PIP progresses HSAG recommends the following:

- Premier CHIP must discuss changes in the study rates over the baseline and include statistical testing results in the narrative interpretation of data.
- Premier CHIP must revisit its causal/barrier analysis at least annually to determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- Premier CHIP must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicator. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should be documented in the PIP Submission Form and should guide next steps for each individual intervention.

VALIDATION OF PERFORMANCE MEASURES

Validation Results

HSAG's review of the FAR for HEDIS 2020 based on CY 2019 data showed that Premier's HEDIS compliance auditor found Premier's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Premier contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG's review of Premier's FAR revealed that Premier's HEDIS compliance auditor did not document any specific strengths, opportunities for improvement, or recommendations related to PMV.

Performance Measure Outcomes

Table 2-147 shows Premier CHIP's HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates for the *Annual Dental Visit* measure. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table 2-147—Premier CHIP HEDIS 2020 Results

HEDIS Measure	Premier CHIP 2020 Rate	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	47.69%	43.10%
4–6 Years of Age	**54.44%**	63.85%
7–10 Years of Age	**58.54%**	67.17%
11–14 Years of Age	**57.20%**	62.53%
15–18 Years of Age	**50.77%**	54.16%
19–20 Years of Age	**35.29%**	38.26%
Total	**54.86%**	55.46%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

Premier CHIP—Quality, Timeliness, and Access to Care—Performance Measures

Strengths

Premier CHIP exceeded the 2020 NCQA Quality Compass average for the *Annual Dental Visit—2–3 Years of Age* measure indicator rate.

Opportunities for Improvement and Recommendations

Premier CHIP fell below the 2020 NCQA Quality Compass average for measure indicator rates *4–6, 7–10, 11–14, 15–18, and 19–20 Years of Age* and *the Total* measure indicator rate.

Premier CHIP fell below the 2020 NCQA Quality Compass average for six of the seven (85.71 percent) measure indicator rates. Premier CHIP should focus efforts on providing education about the importance of dental health to the school-age population.

ASSESSMENT OF COMPLIANCE WITH CHIP MANAGED CARE REGULATIONS

Premier CHIP—Quality, Timeliness, and Access to Care—Compliance Reviews

For the CY 2020 compliance monitoring activities, HSAG reviewed Premier's CAP and related interventions and conducted a follow-up compliance review for any requirements receiving *Partially*

Met or *Not Met* scores during the CY 2019 compliance review. HSAG also reviewed a sample of administrative records related to initial provider credentialing, member grievances, service authorization denials, and member appeals for alignment with quality, timeliness, and access requirements. Premier's sample of credentialed providers consisted of a selection of dentists, including general dentists, pediatric dentists, and two oral surgeons. HSAG reviewed a full sample of 10 prior authorization denial records. Premier submitted a sample of two CHIP appeals for the period under review and did not report any grievances.

HSAG determined CY 2020 compliance monitoring findings based on a desk review of the documents and records Premier submitted and through conducting a virtual, web-based review consisting of interviews with key Premier staff members.

Strengths

In CY 2018, HSAG found that Premier's NABD letter inaccurately stated that members had 30 days to file an appeal (instead of 60 days) and that Premier would make expedited decisions within three business days (instead of 72 hours). The letters were missing the member's right to be provided upon request (and free of charge) reasonable access to all documents and records relevant to the adverse benefit determination (medical necessity criteria and information or processes used in setting coverage limits), and the letters did not include information about State fair hearings. Following the CY 2018 review, Premier updated its templates; however, Premier updated the CHIP template to include 90 days instead of 60 days, which was accurate under the previous rule (prior to July 1, 2017). In CY 2020, HSAG reviewed a revised CHIP NABD template letter as part of the desk review and found that Premier had updated this template to indicate that members had 60 days to file an appeal.

In CY 2018 and CY 2019, HSAG found that Premier's provider directory did not identify which providers had completed cultural competency training. For CY 2020, HSAG found that Premier had included a field in its online provider directory to identify which providers participated in cultural competency training. At the time of the review, Premier had not updated this field for many providers; however, Premier had a process in place to collect this information and was engaged in ongoing efforts to ensure that it queried providers for participation and included the results of the query in the directory.

In CY 2018, HSAG found that Premier's policies, procedures, and member information stated that members may file an appeal orally or in writing and that oral appeals must be followed with a written, signed appeal within five days of an oral appeal. In the preamble to 42 CFR §438, the requirements specifically address that a time limitation for a written response to an oral appeal is not permitted. In response to the requirement, Premier fully removed its requirement for the member to follow an oral request for an appeal with the request in writing. The federal requirements at 42 CFR §438.402 require that an oral request for appeal is followed by a request in writing without time limitation. In CY 2020, HSAG reviewed Premier's revised policy and found that it required members to follow an oral appeal in writing except in the case of expedited appeals.

HSAG reviewed the credentialing records and found that for all providers, Premier collected an application, verified education and licensure, and checked the providers' names against federal exclusions lists prior to hire.

HSAG reviewed Premier's appeal records and found that Premier sent the appeal acknowledgements and resolutions in a timely manner. HSAG reviewed the grievance records and found that Premier acknowledged and resolved each grievance quickly and within the allotted time frame. HSAG found that the resolution letter to the member was transparent, detailed, and specific to the member's case. Premier included all required information.

Opportunities for Improvement and Recommendations

HSAG found Premier's NABD letters to be confusing and difficult to follow. The letter template stated in bold font across the top, "This is not a bill. This is a response to your dentist's request for dental treatment for you." A text box in large letters stated, "Notice of Authorization." The letter contained a list of informational bullets; the first bullet listed the authorization dates that the letter is "good for" (even though some or all services listed in the specific letters reviewed may have had a denied status). The letter also contained a table of procedure codes (one line for each procedure for each tooth) and dollar amounts for amount submitted, covered expense, deductible, primary paid, copay, plan payment, patient payment, then status and reason (in code). Following the table, the letter explained the meaning of the procedure codes and reason codes. The status column in the table was the only place in the letter noting that Premier was denying the service. HSAG strongly suggests that Premier work to streamline and simplify its NABD letters and grievance/appeal forms and consider testing them with a member focus group to ensure readability and ease of understanding.

Premier used a hybrid Grievance/Appeal form, sent with the NABDs, for members to request a grievance or appeal. The form stated that "Appeals filed orally must be followed with a written appeal within five business days. The appeal will not be processed if Premier does not receive a written appeal within five business days." In accordance with federal regulations, the member must follow an oral appeal with a written appeal; however, Premier cannot put a time limit on the member to file the appeal in writing. Further clarification on this topic is located in the preamble to the Medicaid managed care regulations (Federal Register, Volume 81, Number 88, published May 6, 2016, page 27,511, third column). When faced with an oral appeal and requesting that the member follow up in writing, HSAG suggests that Premier consider 42 CFR §438.406(a) which requires that Premier provide a member with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. Further, the continuation of benefits language in the Grievance/Appeal form stated that for continuation of benefits, an appeal must be filed in 10 days, which is incorrect. A request for continuation must be filed in 10 days; however, the member still retains a 60-day filing time frame in which to file an appeal. HSAG also noted that for one appeal, the same provider that made the denial decision also made the decision to uphold the denial upon appeal.

In the appeal resolution letters, HSAG noted unclear language that the member would not easily understand and situations where appeals and grievances were confused. At the beginning of the

Appeal Rights information section, Premier stated, "You have 60 days from the date of a 'Notice of Adverse Benefit Determination letter' to file an Appeal." This language sounds like Premier is referring to a separate letter, as this letter is titled "Notice of Authorization." The letter also stated:

> If you are currently getting treatment and want to continue getting treatment you must ask for an appeal within 10 days from the date this letter was postmarked or delivered to you; OR before the date your dental plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

For dental services, this is confusing given that treatment is usually intermittent and continuation is very rare. Therefore, "getting treatment" is confusing language. Neither the letters nor the Appeals Rights insert included the member's right to free access to all documents or records relevant to the appeal. In addition, many of the reason code explanations refer to a Salzmann score number, which members may not understand without additional, clarifying information.

Premier stated that it did not have any grievances for its CHIP line of business during the period under review. This is an unusual finding for a five-month time frame. HSAG suggests that Premier review its processes for identifying and collecting grievances to ensure that it identifies and captures any expressions of dissatisfaction that are resolved quickly as grievances.

VALIDATION OF NETWORK ADEQUACY

Table 2-148 displays the match percentage for provider information between the data submitted by Premier CHIP and the online provider directory. Table 2-149 reflects the percentage of providers who have the service listed as available on Premier CHIP's online directory.

Table 2-148—Percentage of Exact Matches Between the Submitted Provider Data and the Online Directory for Premier CHIP

Provider Information	Total	Match Percentage	Unmatched Percentage
Provider First Name	202	100.0%	0.0%
Provider Middle Name	202	5.0%	95.0%
Provider Last Name	202	100.0%	0.0%
Provider Address 1	202	99.5%	0.5%
Provider Address 2	202	50.0%	50.0%
Provider City	202	99.5%	0.5%
Provider State	202	100.0%	0.0%
Provider Zip Code	202	89.6%	10.4%
Provider County	202	6.4%	93.6%
Provider Specialty*	202	99.0%	1.0%
Provider Accepting New Patients	202	99.0%	1.0%

*For presentation here, Provider Specialty was considered a match if the provider specialty in the submitted provider data was in the same provider category as the provider specialty reported in the online directory. For example, "Midwifery" was listed in provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in provider data and "Neonatology" was listed in the directory.

Table 2-149—Percentage of Provider Service Information Available in Online Directory for Premier CHIP

Available Services Information	Total	Percentage Shown	Percentage Not Shown
Any Practice Limitations*	202	81.7%	18.3%
Non-English Language Speaking Provider	202	95.5%	4.5%
Provider Accommodates Physical Disabilities	202	93.1%	6.9%
Provider Completed Cultural Competency Training	202	0.0%	100.0%
Provider URL	202	5.9%	94.1%

*An example of a practice limitation is the provider only treating patients 1 to 18 years of age.

Table 2-150 displays the number and percent of provider categories wherein Premier CHIP met the time/distance standards at the statewide level.

Table 2-150—Compliance With Time/Distance Standards by Provider Domain—Premier CHIP

Provider Domain	Number of Provider Categories	Count Within Time Distance Standard*	Percent Within Time Distance Standard (%)*
General Dental	2	2	100.0%
Specialist Dental	1	1	100.0%

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Premier CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Premier CHIP's online and paper directories are updated every 24 hours according to the health plan's website. The website also conspicuously displays an email address or toll-free number to use to report errors in the information presented in the provider directory.

Geographic network distribution analysis indicated that Premier CHIP met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

Opportunities for Improvement and Recommendations

Accurate provider information in Premier CHIP's online provider directory is critical for members to have timely access to appropriate health care providers. Only 78.6 percent of the sampled providers were found online, and the Provider Middle Name, Provider Address 2, and Provider County were missing for a significant number of sampled providers found in the directory. Additionally, the provider directory did not include service information on cultural competency training for any provider or URL information for most of the sampled providers. Since the provider directory is updated every 24 hours, Premier CHIP should compare the submitted data and online provider directory to identify areas of

discrepancy. HSAG also recommends that Premier CHIP provide an option for members to request a paper form of the provider directory on its website.

Building on the CY 2019 study, the CY 2020 network adequacy study used a standardized provider crosswalk across all health plans to define provider categories based on provider type, specialty, taxonomy, and credentials. Premier CHIP should continue to assess the accuracy of the category assigned to each provider in the submitted data for accurate network adequacy results.

Appendix A. Objectives and Methodology for External Quality Review by EQR Activity

Objectives of EQR-Related Activities

Validation of Performance Improvement Projects

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that UDOH and key stakeholders can have confidence in the health plans' improvement strategies and that reported improvement in study indicator outcomes is supported by significant change.

Performance Measure Validation

The primary objectives of PMV are to:

- Evaluate the accuracy of the performance measure rates calculated by the health plans.
- Determine the extent to which the specific performance measures calculated by the health plans followed the specifications established for each measure.

Compliance Reviews

Private accreditation organizations, state licensing agencies, Medicaid agencies, and the federal Medicare program all recognize that having standards is only the first step in promoting safe and

effective health care. Making sure that the standards are followed is the second step. The objective of the compliance review activities is to determine the extent to which the health plan complies with the standards set forth at 42 CFR Part 438 and with State contract requirements. In addition, the compliance review process provides meaningful information to UDOH and the health plans regarding:

The quality and timeliness of, and access to, health care furnished by the health plan.

Corrective actions required and interventions needed to improve quality.

Activities needed to enhance and sustain performance and processes.

Validation of Network Adequacy

The purpose of the network capacity and geographic distribution analyses was to determine the geographic distribution of the providers relative to member populations and to assess the capacity of a given provider network.

The goal of the PDV activity was to determine if the information in the health plans' online provider directories found on the respective health plans' websites aligned with the data in the provider file submitted by the health plans. This analysis assessed the accuracy of the provider directories in order to ensure members have adequate and accurate provider demographic and contact information.

Description of Data Obtained

Validation of Performance Improvement Projects

UDOH required each health plan to conduct one PIP during CY 2020. Each health plan chose its own PIP topic. HSAG obtained the data needed to conduct the PIP validations from each health plans' CY 2020 PIP Submission Form. The PIP submission forms submitted provided detailed information about each health plan's PIP as it related to the protocol activities and associated steps HSAG reviewed and evaluated for the CY 2020 validation cycle.

Each section of the PIP submission form includes one of the protocol activities or steps to be undertaken when conducting PIPs. The form presents instructions for documenting information related to each of the protocol activities. The health plans could also attach relevant supporting documentation with the PIP Submission Form. Each health plan completed the form for PIP activities conducted during the measurement year and submitted it to HSAG for validation.

Validation of Performance Measures

Medicaid ACOs, UMIC and CHIP MCOs, and Dental PAHPS

The ACOs, UMIC and CHIP MCOs, and dental PAHPs were required to calculate applicable HEDIS measures following the HEDIS 2020 Technical Specifications, undergo an NCQA HEDIS Compliance Audit[A-1] performed by an NCQA-certified auditor, and report the results of their HEDIS audit to UDOH. These health plans were also required to provide the HEDIS data, final audit reports (FARs), and a copy of the auditor's certification to UDOH. HSAG obtained the HEDIS FARs from UDOH and evaluated the FARs to assess the health plans' compliance with the NCQA HEDIS Compliance Audit standards.

PMHPs and HOME

The 12 PMHPs and HOME were required to calculate and report one measure, *Follow-Up After Hospitalization for Mental Illness (FUH)*, which was a modified version of NCQA's HEDIS 2019 *FUH* measure. The measure was based on claims/encounter data and data from the organization's care management tracking systems. UDOH required the PMHPs and HOME to maintain a data system that allowed for tracking, monitoring, calculating, and reporting this performance measure.

HSAG conducted PMV activities for the 12 PIHP PMHPs and HOME to assess the accuracy of performance measure rates reported and to determine the extent to which the calculated performance rates followed the measure specifications and reporting requirements. HSAG conducted virtual site audits and reviewed these health plans' submitted documentation and performance measure rates.

Substance Use Disorder (SUD) PAHP

The only SUD PAHP, Utah County, was required to calculate and report a state-modified version of the HEDIS 2020 measure, *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*. UDOH identified the measurement period for the *IET* measure as CY 2019 (January 1, 2019, through December 31, 2019). Utah County extracted all data for calculation of the *IET* performance measure from Credible, its electronic health record (EHR).

HSAG conducted PMV activities for Utah County to assess the accuracy of performance measure rates reported and to determine the extent to which the calculated performance measures follow measure specifications and reporting requirements. HSAG conducted a virtual site visit and reviewed Utah County's submitted documentation and performance measure rates.

[A-1] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Assessment of Compliance With Medicaid Managed Care Regulations

During CY 2018, HSAG conducted an assessment of the health plans' compliance with Medicaid managed care regulations and State contract requirements, evaluating all managed care standards under 42 CFR §438 et seq. In CY 2019, HSAG conducted follow-up compliance reviews that included an evaluation of the health plans' corrective action plans (CAPs) to determine the health plans' progress toward achieving full compliance with federal managed care regulations. In CY 2020, HSAG conducted additional follow-up compliance reviews. Also, in CY 2020, HSAG reviewed the health plans' administrative records related to credentialing providers, as requested by UDOH. For the UMIC plans, HSAG conducted a full review of all standards, which included a review of administrative records related to adverse benefit determinations, grievances, appeals, and credentialing.

Documents reviewed during each of the three-year compliance review cycle consisted of the following:

- The monitoring tool with a portion completed by the health plan
- Policies and procedures
- Staff training materials
- Key committee meeting minutes
- Provider and member informational materials
- Sample administrative records related to credentialing

In addition, HSAG obtained data for assessing compliance with regulations through telephonic interviews with key health plan staff members during virtual site reviews.

Validation of Network Adequacy

The CY 2020 NAV analyses and PDV included all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., health care facilities) contracted to provide care as of June 1, 2020, through one of Utah's Medicaid or CHIP managed care health plans.

Medicaid and CHIP Member Data Request

To complete the NAV Analysis, HSAG obtained Medicaid and CHIP member eligibility, enrollment, and demographic information from UDOH. Key data elements requested included unique member identifier, gender, age, health plan in which the member is enrolled, and residential address as of June 1, 2020. Upon receiving the member data files from UDOH, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. HSAG collaborated with UDOH to resolve questions identified during the data review process.

Health Plan Data Request

HSAG submitted a detailed data requirements document to the health plans to request information about providers actively enrolled as June 1, 2020. HSAG supplied the health plans with the provider crosswalk that detailed the methods for classifying each provider category using provider type, specialty, taxonomy, and credentials. The health plans used the provider crosswalk to classify their providers to the appropriate provider categories. Key data elements requested included, but were not limited to, unique provider identifier, enrollment status with the health plans, provider category, provider type, provider specialty, and primary care provider (PCP) indicator.

Methodology and Technical Methods of Data Collection and Analysis

Validation of Performance Improvement Projects

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (cited earlier in this report).[A-2]

HSAG evaluates the following components of the quality improvement (QI) process:

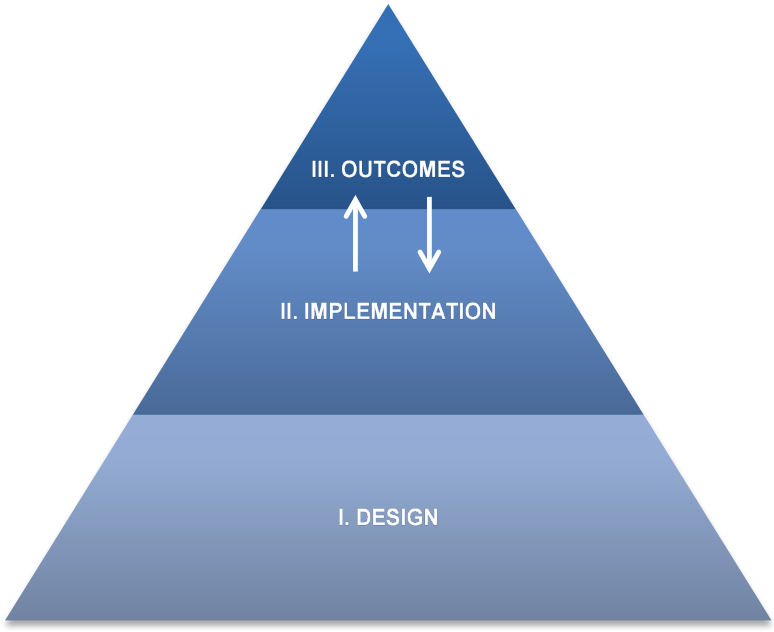
1. Technical structure of the PIP. This step ensures that the MCOs, ACOs, UMIC plans, PMHPs, and PAHPs designed, conducted, and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's validation determines whether the PIP design is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. Implementation of the PIP. Once a PIP is designed, its effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCOs, ACOs, UMIC plans, PMHPs, and PAHPS improved rates through implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

Figure A-1 illustrates the three stages of the PIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study

[A-2] New CMS EQR Protocols were released October 2019 and posted to the CMS website in January 2020. PIP validation activities were already underway at this time; therefore, HSAG used the *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, for conducting PIP validation activities in CY 2020.

topic, question, population, indicators, sampling techniques, and data collection. To implement successful improvement strategies, a methodologically sound study design is necessary.

Figure A-1—PIP Stages



Once the health plan establishes its study design, the PIP process progresses into the Implementation stage. This stage includes data analysis and interventions. During this stage, the health plan evaluates and analyzes its data, identifies barriers to performance, and develops active interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The Outcomes stage is the final stage, which involves the evaluation of real and sustained improvement based on reported results.

Sustained improvement is achieved when outcomes exhibit significant improvement over the baseline and the improvement is sustained with a subsequent measurement period. This stage is the culmination of the previous two stages. If the outcomes do not improve, the health plan investigates the data collected to ensure that the health plan has correctly identified the barriers and implemented appropriate and effective interventions. If it has not, the health plan should revise its interventions and collect additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained improvement is achieved.

HSAG evaluated each PP submitted in CY 2020 using the PIP submission form. In addition, HSAG continued to provide training and technical assistance to the health plans who chose new PIP topics as they began the process of selecting a PIP topic and framing the study design. These health plans submitted the PIP study design for validation in the CY 2020 validation cycle.

Validation of Performance Measures

At the end of the NCQA HEDIS Compliance Audit season, these health plans submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to UDOH. HSAG obtained the data and FARs from UDOH and reviewed and evaluated the FARs to assess health plan compliance with the NCQA HEDIS Compliance Audit standards. The information system (IS) standards are:[A-3]

- IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry.
- IS 2.0—Enrollment Data—Data Capture, Transfer, and Entry.
- IS 3.0—Practitioner Data—Data Capture, Transfer, and Entry.
- IS 4.0—Medical Record Review Processes—Training, Sampling, Abstraction, and Oversight.
- IS 5.0—Supplemental Data—Capture, Transfer, and Entry.
- IS 6.0—Data Preproduction Processing—Transfer, Consolidation, Control Procedures That Support Measure Reporting Integrity
- IS 7.0—Data Integration and Reporting—Accurate Reporting, Control Procedures That Support Measure Reporting Integrity.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation for Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, October 2019 (CMS PMV protocol) cited earlier in this report. The CMS protocol activities for validation of performance measures includes three protocol activities. To conduct validation of performance measures for the PMHPs and HOME, HSAG:

1. Conducted pre-on-site activities including collecting and reviewing relevant documentation and rate review.
    - HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from UDOH for the validation team to review.
    - HSAG prepared a documentation request for the PMHPs, HOME, and the SUD PAHP, which included the Information Systems Capabilities Assessment Tool (ISCAT).
    - HSAG customized the ISCAT to collect data consistent with Utah's service delivery model and forwarded the ISCAT to each organization with a timeline for completion and instructions for submission. HSAG responded to organizations' ISCAT-related questions during the pre-on-site phase.
    - HSAG prepared an agenda describing all audit activities, including the type of staff needed for each session. HSAG forwarded the agendas to the respective organizations prior to the virtual

[A-3] HEDIS Compliance Audits did not include IS 6.0 beginning with HEDIS 2017; therefore, IS 6.0 was not included in the scope of the health plans' audits for HEDIS 2019.

site visit. When requested, HSAG conducted pre-audit conference calls with each organization to discuss any outstanding ISCAT questions and audit activities.

2. Conducted virtual site visits using a webinar format with each organization.
   - HSAG collected information using several methods, including interviews with key staff, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports.
3. Conducted post-virtual-site visit activities including compiling and analyzing findings, and reporting results to UDOH.

Assessment of Compliance With Medicaid Managed Care Regulations

To accomplish the stated objectives for the site reviews, for assessing each health plan's compliance with Medicaid and CHIP managed care regulations HSAG collaborated with UDOH on the development of follow-up compliance reporting tools and methods, document review and telephonic assessment processes, schedules, agendas, and scoring methodology. HSAG completed follow-up document review and telephonic interviews to assess any requirement scored *Partially Met* or *Not Met* in CY 2019. Upon completion of each review, for each health plan, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Scored* to each individual requirement reviewed and indicated where continued required actions existed, if appropriate. In addition, HSAG reviewed each health plans' administrative records related to credentialing providers. For the UMIC plans, HSAG conducted a full review of all standards, which included a review of administrative records related to adverse benefit determinations, grievances, appeals, and credentialing. HSAG organized the Medicaid managed care regulations into eight standards as follows:

Table A-1—Compliance Standards

Standard Number and Title	Regulations Included
Standard I—Coverage and Authorization of Services	438.114 438.210
Standard II—Access and Availability	438.206 438.207
Standard III—Coordination and Continuity of Care	438.208
Standard IV—Member Rights and Information	438.100 438.224 438.10
Standard V—Grievance and Appeal System	438.400 438.402 438.404 438.406 438.408 438.410

Standard Number and Title	Regulations Included
	438.414 438.416 438.420 438.424
Standard VI—Provider Participation and Program Integrity	438.12 438.102 438.106 438.214 438.608 438.610
Standard VII—Delegation Subcontracts	438.230
Standard VIII—Quality Assessment and Performance Improvement	438.236 438.330 438.242

HSAG conducted compliance review activities consistent with CMS' *EQR Protocol 3: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, October 2019 (cited earlier in this report). The CMS protocol activities for assessing health plan compliance with regulations includes five protocol activities. To conduct compliance review activities, HSAG:

1. Collaborated with UDOH on the development of both the follow-up compliance reporting tools and tools used for a full assessment of the UMIC plans.
   - Collaborated with UDOH to determine review and scoring methods and thresholds
   - Collaborated with the health plans and UDOH to determine schedules, agendas, and to explain the compliance monitoring processes and address questions.
2. Collected and reviewed data and documents and performed a preliminary review.
3. Conducted a virtual site visit using a telephonic or webinar strategy.
4. Compiled and analyzed and the data and information collected.
5. Prepared a report that delineated findings and required corrective actions (if applicable).
   - Submitted the health plan-specific draft reports to UDOH with a second draft to the health plans for review.
   - Submitted the final health plan-specific reports to the health plans and UDOH.

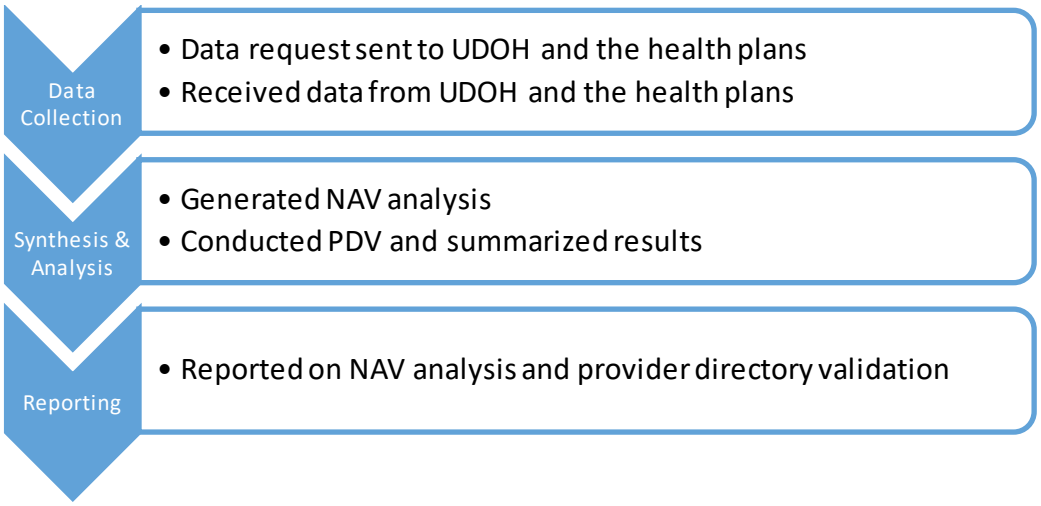
Validation of Network Adequacy

According to the Medicaid and CHIP managed care regulations released in May 2016, the activity related to 42 CFR §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than

one year from the issuance of the associated EQR protocol.[A-4] In preparation of the release of the protocol, HSAG collaborated with UDOH and the health plans to develop a provider crosswalk in CY 2019. In CY 2020, HSAG conducted a NAV analysis which included network capacity and geographic distribution analyses conducted on provider network data submitted by the health plans after the health plans applied the provider crosswalk developed in CY 2019. Additionally, HSAG performed a PDV to ensure members have access to accurate provider demographic and office information.

Figure A-2 describes HSAG's three main phases for the CY 2020 network adequacy tasks. The remainder of this section provides methodologic details for each phase.

Figure A-2—Summary of CY 2020 Network Adequacy Tasks



Network Adequacy Validation (NAV) Analysis

HSAG used the provider data submitted by the health plans to conduct a NAV analysis. The NAV analysis evaluated three dimensions of access and availability:

- **Network Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of providers associated with the health plan's provider network relative to the number of enrolled members. This provider-to-member ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a health plan's provider network to deliver services to Medicaid/CHIP members.
- **Geographic Network Distribution Analysis:** To assess the second dimension of this activity, HSAG evaluated the geographic distribution of the providers relative to member populations. For each health plan, HSAG calculated the average time and distance to the nearest three providers.

[A-4] Government Publishing Office. Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=7a43ffaad13c1c1450dc0b4101fd92a9&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_1358. Accessed on: Mar 3, 2021.

- **Provider Directory Validation (PDV):** The third dimension of this activity assessed the accuracy of the provider directories in order to ensure members have adequate and accurate provider demographic and contact information.

NETWORK CAPACITY ANALYSIS

HSAG calculated the provider ratio for each provider category defined in the provider crosswalks for the health plans. Specifically, the provider ratio measures the number of providers by provider category (e.g., PCPs, cardiologists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals.[A-5] Please note, provider counts for this analysis are based on unique providers, not provider locations.

GEOGRAPHIC NETWORK DISTRIBUTION ANALYSIS

The second dimension of this analysis evaluated the geographic distribution of providers relative to the health plans' members. While the network capacity analysis identifies whether the network infrastructure is sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluates whether the provider locations in a health plan's provider network are proportional to the health plan's Medicaid or CHIP population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially-derived metrics for the provider specialties identified in the provider crosswalks:

Percentage of members within predefined access standards[A-6]: A higher percentage of members meeting access standards indicates better geographic distribution of a health plan's providers in relation to its Medicaid/CHIP members. This metric was calculated for any provider categories for which UDOH has identified a time/distance access standard prior to initiation of the analysis.

Average travel distance (in miles) and travel time[A-7] (in minutes) to the nearest one to three providers: A smaller distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

[A-5] The availability based on provider ratio does not account for key practice characteristics—i.e., panel status, acceptance of new patients, practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

[A-6] The percentage of members within predefined standards were only calculated for provider categories with predefined access standards.

[A-7] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times are estimated by Quest Analytics software based on the following drive speeds: urban areas are estimated at a drive speed of 30 miles per hour, suburban areas are estimated at a drive speed of 45 miles per hour, rural areas are estimated at a drive speed of 55 miles per hour.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to three providers for all provider categories identified in the provider crosswalks.

PROVIDER DIRECTORY VALIDATION (PDV)

The eligible population consisted of a sample of active providers for each health plan as of June 1, 2020. Given the wide range of providers across the health plan types and to ensure meaningful results across the provider types, HSAG limited the number of provider types assessed per health plan to the provider types shown in Table A-2.

Table A-2—Provider Categories Included in the PDV by Health Plan Type

Provider Category	ACO	UMIC	MCO	CHIP MCO	PMHP	Medicaid Dental PAHP	CHIP Dental PAHP
PNC/Women's Health Providers							
OB/GYN	✓	✓	✓	✓			
Primary Care Providers							
PCP—Adult	✓	✓	✓				
PCP—Pediatric	✓		✓	✓			
BH Providers							
Behavioral Mental Health (Medical)—Adult		✓			✓		
Behavioral Mental Health (Medical)—Pediatric					✓		
Behavioral Substance Use Disorder—Adult		✓			✓		
Behavioral Substance Use Disorder—Pediatric					✓		
Behavioral Therapist—Adult		✓			✓		
Behavioral Therapist—Pediatric					✓		
Dental Providers							
All Dental Providers						✓	✓
General Dentists						✓	✓

Based on the eligible provider population, HSAG generated a random sample of providers for each health plan that maintains a contract with UDOH. For each health plan, the results generated from the sample are within ± 5 percent of the population results, at a 95 percent confidence level.

The tasks below show the steps HSAG followed to complete the validation. Task 1 shows the fields that HSAG verified when validating the health plans' online provider directories for each of the sampled providers against the submitted provider data, as applicable. Task 2 shows those items that were

validated for inclusion in the health plans' online directories at the plan level (i.e., overall review of the health plan website).

- Task 1—Provider Data Accuracy: HSAG sampled providers from each health plan and compared them to the health plan's online directory to ensure that the information was accurate, complete, and updated in a timely manner. Below is a list of indicators showing which fields HSAG used for this comparison, as applicable, per health plan type.
  - The following indicators were validated against the health plan's submitted provider file:
    - Provider's First/Middle/Last Name, Street Address, City, State, Zip Code, County, and Acceptance of New Patients
  - The following indicators were assessed as present or not present in the online directory:
    - Website URL, Provider Type/Specialty, Non-English Languages Spoken, Completed Cultural Competency Training, Accommodation for Physical Disabilities, and Any Practice Limitations
- Task 2—Health Plan Provider Directory Validation: HSAG confirmed each health plan's website has the following items:
  - Search fields for members to easily find providers by location or provider type, if applicable
  - Information on how a member can request a paper directory
  - Information on when the data were last updated

Since the PMHPs function in a slightly different manner than some of the other health plans, the PDV parameters were adjusted to best suit the nature of the services provided by the PMHPs. If a PMHP had less than 100 unique providers, the entire eligible population was sampled.

- Providers sampled for a specific PMHP were considered validated if the provider's name appeared on the provider list for the PMHP.
- The sampled provider's address and telephone number were considered validated if the address listed for the PMHP's sampled provider data matched the information listed on the PMHP's website as a location for that PMHP or if the provider was listed at that address.
- For each PMHP, the following items were noted per provider or for the entire PMHP:
  - Provider's Name, Street Address, Office or Clinic Affiliation, Website URL, Provider Type/Specialty, Acceptance of New Patients, Non-English Languages Spoken, Completed Cultural Competency Training, and Accommodation for Physical Disabilities

How Conclusions Were Drawn

Validation of Performance Improvement Projects

Each required protocol activity is evaluated using one or more evaluations elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given protocol activity as *Met*,

Partially Met, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The HSAG PIP Review Team would give the health plan a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a *General Comment* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gives the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP activities were designed to evaluate the validity and quality of a health plan's processes for conducting valid PIPs. Therefore, HSAG determined that all PIPs had the potential impact the quality domain of care. Additionally, a health plan's particular PIP also may have also been associated with the timeliness or access to care domains, depending upon the specific PIP topic. HSAG therefore analyzed each health plan's performance in conducting PIPs across the three domains of care based on those associations and the potential impact on member outcomes related to the domains of care.

Validation of Performance Measures

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG gave a validation finding of *Report* or *Not Reported*, (see Table A-3) to each performance measure. HSAG based each validation finding on how significant the errors were in each measure's evaluation elements, not by the number of elements determined to be noncompliant. Meaning, it was possible that a single error could result in a designation of *Not Reported* if the impact of the error biased the rate by more than 5 percentage points. Conversely, even if multiple errors were identified, if the errors had little or no impact on the rate, the indicator was given a designation of *Report*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each PMHP, HOME, and the SUD PAHP. HSAG forwarded these reports to UDOH and the appropriate health plan. Section 2 contains information about the health plan-specific performance measure rates and validation status.

Table A-3—Designation Categories for Performance Indicators

Report (R)	Indicator was compliant with the State's specifications and the rate can be reported.
Not Reported (NR)	This designation is assigned to measures for which (1) the organization's rate was materially biased, or (2) the organization was not required to report.

To draw conclusions about the quality and timeliness of, and access to care provided by the Utah's Medicaid and CHIP health plans, HSAG determined that each of the performance measures reported were associated to one or more of the three domains of care (quality, timeliness of, and access to services). Each measure may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance based on measure rates and on those associations and the potential impact on member outcomes related to the domains of care.

Assessment of Compliance With Medicaid Managed Care Regulations

HSAG assessed each requirement within the standards set forth at 42 CFR Part 438 and assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To make conclusions regarding the quality and timeliness of, and access to services (domains of care) provided by each health plan, HSAG determined the requirements within each standard that were associated with each of the domains of care (quality, timeliness of, and access to services). Each element may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance across the three domains of care based on those associations and potential impact on member outcomes related to the domains of care.

Validation of Network Adequacy

HSAG determined that results of network adequacy activities could provide information about health plan performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Medicaid and CHIP member access to particular provider networks (e.g. primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the health plans' ability to track and monitor their respective provider networks. Provider data submitted by health plans were also used to assess the accuracy of the online provider directory available to members.

Appendix B. Statewide Comparative Results, Assessment, Conclusions, and Recommendations

Validation of Performance Improvement Projects

Statewide Comparative Results

For CY 2020, HSAG validated one PIP for each of the four Medicaid ACOs, five Medicaid MCOs, four UMIC health plans, 12 PMHPs, and two CHIP MCOs.

Table B-1 lists the PIP topics and validation scores for each health plan.

Table B-1—CY 2020 PIP Topics Selected by Medicaid ACO, MCO, and UMIC Plans
Summary of Each Medicaid Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Health Choice	*Breast Cancer Screening*	84%	90%	*Not Met*
Health Choice UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
Healthy U	*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*	100%	100%	*Met*
Healthy U UMIC	*Improving Adults' Access to Preventive/Ambulatory Services*	100%	100%	*Met*
Molina	*Medicaid Comprehensive Diabetic Care—Eye Exams*	100%	100%	*Met*
Molina UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*Met*
SelectHealth	*Improving the Percentage of 13-year-old Female Medicaid Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	100%	100%	*Met*
SelectHealth UMIC	*7-day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members*	100%	100%	*Met*
HOME	*Impact of Clinical and Educational Interventions on Progression of Pre-Diabetes to Type II Diabetes Mellitus*	100%	100%	*Met*

Table B-2—CY 2020 PIP Topics Selected by PMHPs
Summary of Each PMHP's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Bear River	*Suicide Prevention*	95%	100%	*Met*
Central	*Inpatient Readmission Rates*	100%	100%	*Met*
Davis	*Access to Care*	100%	100%	*Met*
Four Corners	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	100%	100%	*Met*
Healthy U	*Improving Follow-up After Hospitalization for Mental Illness*	100%	100%	*Met*
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	100%	100%	*Met*
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	87%	75%	*Partially Met*
Southwest	*Outcome Questionnaire Project*	100%	100%	*Met*
Utah County	*Suicide Prevention*	100%	100%	*Met*
Valley	*Suicide Prevention*	81%	83%	*Partially Met*
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	100%	100%	*Met*
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	100%	100%	*Met*

Table B-3—CY 2020 PIP Topics Selected by CHIP Health Plans
Summary of Each CHIP Health Plan's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
Molina CHIP	*Weight Assessment and Counseling for Nutrition and Physician Activity—BMI Screening*	100%	100%	*Met*
SelectHealth CHIP	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	100%	100%	*Met*

Dental PAHPs

For CY 2020, HSAG validated one PIP for each of the two dental Medicaid PAHPs and the dental CHIP PAHP.

Table B-4 lists the PIP topics and validation scores for each dental PAHP.

Table B-4—CY 2020 PIP Topics Selected by Dental PAHPs
Summary of Each Dental PAHP's PIP Validation Scores and Status

Health Plan	PIPs	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
MCNA	*Annual Dental Visits*	100%	100%	*Met*
Premier	*Improving Dental Sealant Rates in Medicaid Members Ages 6–9*	84%	80%	*Not Met*
Premier CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	95%	90%	*Partially Met*

Statewide Opportunities for Improvement and Recommendations—Performance Improvement Projects

For CY 2020, 16 of the 26 PIPs received were new PIP topics. This includes new PIPs initiated by nine PMHPs, four UMIC plans, two ACOs (Healthy U and Molina), and one CHIP (Molina) health plan. The remaining health plans continued with the PIP topic from previous year.

The PIPs were in varying stages. Seven health plans reported PIP study design only; nine health plans and one dental plan (MCNA) reported baseline results; one health plan (Health Choice) and two dental plans (Premier and Premier CHIP) reported Remeasurement 1 results; two health plans (HOME and Utah County) submitted Remeasurement 2 results; three health plans (SelectHealth, SelectHealth CHIP, and Valley) reported Remeasurement 3 results; and one health plan (Bear River) reported Remeasurement 4 results. The health plans submitting remeasurement data were evaluated for achievement of statistically significant and sustained outcomes.

Of the 26 PIPs received, 21 PIPs received an overall *Met* validation status, demonstrating a thorough application of the PIP design principles and use of appropriate QI activities to support improvement of PIP outcomes. Three PIPs received an overall *Partially Met* validation status, and the remaining two PIPs received a *Not Met* validation status. The opportunities for improvement existed primarily in accurate analysis and interpretation of data, implementation of appropriate improvement strategies with evaluation of effectiveness of each intervention, and achievement of statistically significant outcomes across all study indicators. More specific information about the PIP validation results for CY 2020 for each health plan is included in Section 2 of this report.

In the next annual PIP submissions, HSAG recommends the following:

- The health plans must ensure that all documentation in the PIP Submission Form is documented correctly and completely to address each applicable evaluation element.
- The health plans must ensure that the data collection methodology is in accordance with the approved study design and is comparable to the baseline.
- The health plans must ensure that the narrative interpretation of results is accurate and includes all the required components in accordance with the PIP Completion Instructions.
- The health plans must continue to revisit the causal/barrier analysis at least annually determine whether the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plans' PIP submission forms must provide a comprehensive description of the causal/barrier analysis process. The health plans must document the process/steps used to determine barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis during each measurement period.
- The health plans must ensure that in addition to improving data collection, the PIP interventions address barriers toward improving member care.
- The health plans must develop an evaluation methodology to determine the performance of each intervention and its impact on the study indicators. This allows for continual refinement of improvement strategies and determines the effectiveness of the intervention. Intervention-specific evaluation results should guide next steps for each individual intervention.
- The health plans must ensure that the interventions are implemented in a timely manner to allow for impact to the remeasurement period reported.
- The health plans seek technical assistance from HSAG, if needed.

Validation of Performance Measures

Statewide Comparative Results

Table B-5 shows the ACOs' HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-5—ACOs' HEDIS 2020 Results

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2020 NCQA Quality Compass Average
Antidepressant Medication Management					
The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment for at least 84 days (12 weeks). (Effective Acute Phase Treatment)	**NA**	**50.73%**	**NA**	**50.88%**	54.94%
Appropriate Treatment for Children With Upper Respiratory Infection (URI)					
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	93.17%	94.12%	93.26%	94.84%	90.72%
Breast Cancer Screening					
The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.	**34.73%**	**49.39%**	**40.00%**	**50.02%**	58.35%
Cervical Cancer Screening					
The percentage of women 21–64 years of age who were screened appropriately for cervical cancer.	**44.04%**	**48.18%**	**54.99%**	**57.66%**	60.13%
Childhood Immunization Status					
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	78.35%	75.43%	72.02%	73.41%	70.28%
Chlamydia Screening in Women					
The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. (Total)	**32.16%**	**48.28%**	**41.14%**	**38.01%**	58.04%
Comprehensive Diabetes Care					
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing. (HbA1c Testing)	88.32%	88.56%	**88.08%**	91.67%	88.22%
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed. (Eye Exam [Retinal] Performed)	**56.93%**	58.64%	**52.07%**	65.36%	57.11%

HEDIS Measure	Health Choice	Healthy U	Molina	SelectHealth	2020 NCQA Quality Compass Average
Controlling High Blood Pressure					
The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.	61.19%	80.98%	**60.58%**	76.12%	60.75%
Immunizations for Adolescents					
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	83.80%	90.51%	84.43%	86.93%	80.40%
Prenatal and Postpartum Care					
The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. (Postpartum Care)	**65.93%**	76.89%	**74.70%**	79.56%	75.22%
Use of Imaging Studies for Low Back Pain					
The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	77.50%	**71.76%**	**73.21%**	74.76%	74.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	**56.93%**	84.67%	79.32%	90.46%	76.92%
Well-Child Visits in the First 15 Months of Life					
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	**59.12%**	**56.69%**	68.86%	**65.36%**	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**60.10%**	**67.97%**	**66.18%**	**67.00%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*
***NA** indicates that the rate was not presented because the denominator was less than 30.*

Table B-6 presents the findings reported by HOME for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table B-6—HOME RY 2020 *FUH* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	50.00%
Follow-Up Within 30 Days	97.37%

Table B-7 presents the findings reported by the PMHPs for the *Follow-Up After Hospitalization for Mental Illness* (*FUH*) measure.

Table B-7—PMHPs RY 2020 *FUH* Results

PMHP	Follow-Up Within 7 Days	Follow-Up Within 30 Days
Statewide PMHP Average	**52.33%**	**67.11%**
Bear River	60.16%	69.92%
Central	**42.00%**	78.00%
Davis	70.15%	82.84%
Four Corners	**37.50%**	**50.00%**
Healthy U	-	-
Northeastern	63.33%	73.33%
Salt Lake	**41.23%**	**59.58%**
Southwest	59.84%	71.65%
Valley	64.71%	82.35%
Wasatch	61.37%	78.97%
Weber	**49.01%**	68.38%

*Rates in **red** font indicate the rate fell below the statewide PMHP average.*
Healthy U did not submit performance measures since its contract with UDOH began September 2020.

Table B-8 presents the findings reported by Utah County for the *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure.

Table B-8—Utah County RY 2020 *IET* Results

Indicator	Utah County 2020 Rate
Alcohol Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Initiation of AOD Treatment—Total	**NR**

Indicator	Utah County 2020 Rate
Initiation of AOD Treatment—Total—Total	**NR**
Alcohol Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Opioid Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Other Drug Abuse or Dependence—Engagement of AOD Treatment—Total	**NR**
Engagement of AOD Treatment—Total—Total	**NR**

NR—Not Reportable

Table B-9 shows CHIP MCOs' HEDIS 2020 results as compared to the 2020 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-9—CHIP MCO HEDIS 2020 Results

HEDIS Measure	Molina CHIP	SelectHealth CHIP	2020 NCQA Quality Compass Average
Appropriate Treatment for Children With Upper Respiratory Infection (URI)			
The percentage of children 3 months–17 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription.	92.37%	93.07%	90.72%
Childhood Immunization Status			
The percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); and four pneumococcal conjugate (PCV) vaccines by their second birthday. (Combination 3)	84.92%	81.33%	70.28%
Immunizations for Adolescents			
The percentage of adolescents 13 years of age who had one dose of meningococcal conjugate vaccine; and one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine by their 13th birthday. (Combination 1)	90.74%	91.24%	80.40%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or obstetrician/gynecologist (OB/GYN) and who had evidence of body mass index (BMI) percentile documentation. (BMI Percentile—Total)	81.51%	92.55%	76.92%

HEDIS Measure	Molina CHIP	SelectHealth CHIP	2020 NCQA Quality Compass Average
Well-Child Visits in the First 15 Months of Life			
The percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life. (Six or More Well-Child Visits)	79.82%	78.72%	66.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
The percentage of children 3–6 years of age who received one or more well-child visits with a PCP during the measurement year.	**70.07%**	**70.73%**	74.08%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

Table B-10 shows the HEDIS 2020 results for the dental PAHPs serving the Medicaid population as compared to the 2020 NCQA Quality Compass average rates.

Table B-10—Medicaid Dental PAHPs HEDIS 2020 Results

HEDIS Measure	MCNA	Premier	2020 NCQA Quality Compass Average
Annual Dental Visit			
2–3 Years of Age	54.52%	54.02%	43.10%
4–6 Years of Age	69.75%	68.67%	63.85%
7–10 Years of Age	72.40%	71.21%	67.17%
11–14 Years of Age	66.80%	65.01%	62.53%
15–18 Years of Age	59.41%	58.16%	54.16%
19–20 Years of Age	44.95%	48.53%	38.26%
Total	65.74%	64.68%	55.46%

Table B-11 shows the HEDIS 2020 results for the dental PAHP serving the CHIP populations compared to the 2020 NCQA Quality Compass average rates. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP PAHP measure rates to these averages should be interpreted with caution. Rates that fell below the Quality Compass average rates are denoted in **red** font.

Table B-11—CHIP Dental PAHP HEDIS 2020 Results

HEDIS Measure	Premier CHIP	2020 NCQA Quality Compass Average
Annual Dental Visit		
2–3 Years of Age	47.69%	43.10%
4–6 Years of Age	**54.44%**	63.85%

HEDIS Measure	Premier CHIP	2020 NCQA Quality Compass Average
7–10 Years of Age	**58.54%**	67.17%
11–14 Years of Age	**57.20%**	62.53%
15–18 Years of Age	**50.77%**	54.16%
19–20 Years of Age	**35.29%**	38.26%
Total	**54.86%**	55.46%

*Rates in **red** font indicate the rate fell below the Quality Compass average.*

Statewide Opportunities for Improvement and Recommendations—Performance Measures

Medicaid ACOs

All ACOs except one exceeded the 2020 NCQA Quality Compass average for each of the following measure rates, representing areas of strength.

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbAc1 Testing*
- *Controlling High Blood Pressure*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Immunizations for Adolescents—Combination 1*

All ACOs fell below the 2020 NCQA Quality Compass average for the following measure rates, representing opportunities for improvement.

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

With performance in these measures consistently falling below the 2020 NCQA Quality Compass average for the ACOs, improvement efforts could be focused on increasing breast cancer, cervical cancer, and chlamydia screenings for women and required well-child visits for infants and young children.

HOME

For RY 2020, HOME calculated and reported results for the state-modified *Follow-Up After Hospitalization for Mental Illness (FUH)* measure. Since HOME used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, with HOME being a unique health plan type, results for the *FUH* measure also could not be compared to the PMHP *FUH* measure results.

PMHPs

For RY 2020, six PMHPs (Bear River, Davis, Northeastern, Southwest, Valley, and Wasatch) exceeded the statewide PMHP average for both state-modified *Follow-Up After Hospitalization for Mental Illness (FUH)* indicators, and two PMHP (Salt Lake and Four Corners) fell below the statewide average for both indicators. Healthy U did not submit performance measures since its contract with UDOH began September 2019. With performance in these measures falling below the 2020 NCQA Quality Compass average for the PMHPs, improvement efforts could be focused on increasing follow-up after hospitalization for mental illness appointments for both the 7-day and 30-day indicators.

SUD PAHP

For RY 2020, Utah County calculated and reported results for the state-modified *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)* measure. Since Utah County used a modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, because Utah County was the only health plan that reported *IET* measure rates, HSAG could not compare the results to other health plans. Utah County had errors with its source code, errors with data validation and event categorization, and was not able to provide sufficient explanation or accurate revised rates to HSAG; therefore, it received a *DNR* rating. Improvement efforts for this SUD PAHP could be focused on correcting and updating its source code and measure calculation steps to ensure that all members were appropriately included in the numerator and the denominator.

CHIP MCOs

Both CHIP MCOs exceeded the 2020 NCQA Quality Compass average on all but one measure rate, representing strength for the following measure rates:

- *Appropriate Treatment for Children With Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Both CHIP MCOs fell below the 2020 NCQA Quality Compass average for the following measure rate, representing opportunities for improvement:

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

With performance falling below the 2020 NCQA Quality Compass average for both CHIP MCOs, improvement efforts could be focused on increasing required well-child visits for young children.

Dental PAHPs

Both MCNA's and Premier's performance for the Medicaid population exceeded the 2020 NCQA Quality Compass Average for all *Annual Dental Visit* measure rates*: 2–3 Years of Age, 4–6 Years of Age*, *7–10 Years of Age*, *11–14 Years of Age*, *15–18 Years of Age*, and *19–20 Years of Age* and *Total* measure rates.

Premier's performance for the CHIP population exceeded the 2020 NCQA Quality Compass average for one of the seven *Annual Dental Visit* measure rates, indicating needed improvement for the CHIP PAHP. With these rates falling below the 2020 NCQA Quality Compass average, improvement efforts could be focused on increasing the annual dental visits for members ages 4 to 20 years and improving the *Total* indicator rate.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Comparative Results

ACOs and HOME

Table B-12 provides the number of required corrective actions by Medicaid MCO across the three-year compliance review cycle.

Table B-12—Number of Required Actions by Medicaid MCO

MCO	CY 2018	CY 2019	CY 2020
Health Choice	22	3	1
Healthy U	31	11	1
HOME	19	1	0
Molina	21	7	3
SelectHealth	40	2	1

Entering CY 2020, all five MCOs (four ACOs and HOME) had completed CAPs following the CY 2018 and CY 2019 compliance review activities. Only two of the MCOs were required to complete a CAP for only one standard area by Year 3 of the three-year compliance review cycle (Health Choice and HOME). All MCOs were required to complete corrective actions in the Member Rights and Information standard in CY 2020. Following the CY 2020 follow-up review, only one MCO (HOME) was found to have full compliance with the standards. Two MCOs (Health Choice and SelectHealth) continued to struggle with achieving compliance with Section 508 of Section 504 of the Rehabilitation Act to ensure member electronic materials and the MCOs' websites are readily accessible as defined in §438.10. Molina's provider directory still did not contain all required information about providers, and Molina continued to struggle with revising grievance and appeal policies procedures and member communications to reflect changes in federal regulations that were released in May 2016 and effective July 2017. Healthy U still did not have a process to verify (through sampling or other processes) that services presented to have been provided to members were in fact provided. The four ACOs completed CAPs as a result of CY 2020 follow-up compliance reviews.

Based on record reviews, HSAG found that all five MCOs were in full compliance with credentialing standards reviewed. For the prior authorization denials record review, one MCO (Health Choice) was in full compliance with denials processing and record-keeping requirements; one MCO (HOME) did not send an NABD to the member in one case, and for the remaining three MCOs, some NABD letters did not meet the readability requirements of 42 CFR §438.10. For the appeals record review, two MCOs (Health Choice and Molina) did not send one of 10 acknowledgement letters in a timely manner, two MCOs (Healthy U and SelectHealth) did not send one resolution letter in a timely manner, and one MCO (Molina) had several resolution letters that did not meet the readability requirements of §438.10. For the grievance record reviews, two MCOs (Health Choice and HOME) reported only one grievance for the review period. Healthy U's resolution letters included incorrect information. Molina's grievance documentation system contained incomplete grievance details and SelectHealth had three of 10 resolutions fall outside the required time frame and demonstrated general confusion between when to process a member contact as an appeal or a grievance.

Utah Medicaid Integrated Care (UMIC) Plans

The four UMIC plans initiated operations in January 2020. As such, HSAG conducted a full compliance review inclusive of all standards. While findings were identified in most standards, overall, the plans scored well in the Coordination and Continuity of Care, Subcontracts and Delegations, and Quality Assessment and Performance Improvement standards.

Table B-13 provides the number of required corrective actions assigned in CY 2020 by UMIC plan.

Table B-13—Number of Required Actions by UMIC Plan

UMIC Plan	CY 2020
Health Choice	24
Healthy U	27

UMIC Plan	CY 2020
Molina	18
SelectHealth	24

The most common required corrective actions were related to:

- NABDs or member-specific grievance and appeal communications not being clear or not at an easy-to-understand reading level (all four UMIC plans).
- Not accurately depicting timely access standards in policies and procedures and/or member informational materials (all four UMIC plans).
- Member communications not including taglines that contained the required information (all four UMIC plans).
- Not meeting requirements related to Section 508 of Section 504 of the Rehabilitation Act for electronic member materials and/or the health plan's website (three of four UMIC plans).
- Policies and procedures or member-specific communication inaccurately depicting various time frames and requirements related to the Grievance and Appeal System standard.

PMHPs

Table B-14—Number of Required Actions by PMHP

MCO	CY 2018	CY 2019	CY 2020
Bear River	24	3	0
Central	17	0	0
Davis	13	1	0
Four Corners	22	3	0
Northeastern	11	0	0
Healthy U*	NA	NA	27
Salt Lake	11	0	0
Southwest	20	1	1
Utah County**	33	7	0
Valley**	35	4	0
Wasatch	22	2	0
Weber	24	2	0

*Healthy U PMHP began operations in September 2020.

**Utah County and Valley contracts with UDOH ended in June 2020; therefore, HSAG did not conduct record reviews for these PMHPs or assign ongoing required corrective actions.

In CY 2020 HSAG conducted compliance monitoring activities for 12 PMHPs. Healthy U was operating as a new PMHP as of September 2020; therefore, HSAG conducted a full review of all requirements for Healthy U and follow-up reviews for the remaining PMHPs.

Healthy U's PMHP full compliance review in CY 2020 resulted in 27 required corrective actions for Healthy U across six of the eight standards. Healthy U was found to be in full compliance with the Coordination and Continuity of Care and Quality Assessment and Performance Improvement standards.

Entering CY 2020, three of the 11 PMHPs that had follow-up compliance review activities in CY 2019 (Central, Northeast, and Salt Lake) did not have any continued required corrective actions. The required corrective actions among the remaining eight PMHPs were primarily related to ensuring that members received provider directories in the required format and/or that contained all the required information (seven PMHPs). Five PMHPs had required actions related to ensuring that members receive correct information about the grievance and appeal system in a readily accessible format and implementing the required time frames for processing grievances and appeals. Three PMHPs did not yet have a process to ensure (through sampling or other methods) that members received the services that were represented to have been furnished.

Following CY 2020 follow-up compliance reviews, only one PMHP had a continued required corrective action. Southwest's provider directory did not yet inform members of non-English languages spoken by its providers.

HSAG conducted record reviews for nine applicable PMHPs. Six PMHPs demonstrated full compliance with credentialing requirements. Three PMHPs (Davis, Southwest, and Weber) conducted elements of primary source verification (education, licensure, or exclusion searches) following the date of hire. Only two PMHPs (Salt Lake and Weber) did not report any denials or appeals. While Salt Lake demonstrated full compliance with denial and appeal records reviewed, Weber had a few issues with timeliness of member-specific acknowledgement and resolution letters.

HSAG found that six PMHPs reported less than 10 grievances for the review period, a particularly small number, and recommended that these organizations verify definitions and grievance tracking and documentation processes to ensure all Medicaid member grievances are captured. Six PMHPs were found to be in full compliance with grievance processing, and three (Four Corners, Northeastern, and Southwest) received a recommendation to enhance documentation of grievance acknowledgement.

CHIP MCOs

Table B-15 provides the number of required corrective actions by CHIP MCO across the three-year compliance review cycle.

Table B-15—Number of Required Actions by CHIP MCO

MCO	CY 2018	CY 2019	CY 2020
Molina	21	7	3
SelectHealth	40	3	1

Entering CY 2020, HSAG found that Molina and SelectHealth had ongoing findings in the Member Rights and Information, Grievance and Appeal System, and Provider Participation and Program Integrity standards. Following the CY 2020 reviews, Molina continued to struggle with the required content of the provider directory and accurately informing members of the time frames related to appeal processing. SelectHealth continued to struggle with ensuring that provider directories include all the required information.

Based on CY 2020 record reviews, HSAG found that both CHIP MCOs were in full compliance with credentialing requirements. Molina depicted outdated appeal time frames in its denial letters (i.e., NABDs), and SelectHealth did not report any denials during the review period. Molina did not report any appeals while SelectHealth reported one appeal, which was found to be in full compliance with the requirements. HSAG reviewed a full sample of grievances for Molina and found that grievance acknowledgements were not well documented. SelectHealth reported only three grievances during the review period, which HSAG found to be in full compliance with the requirements. HSAG also found, however, that SelectHealth closed grievances without processing them if members did not follow verbal grievances with a written "formal" grievance, which HSAG found to be noncompliant with managed care regulations.

Dental PAHPs—Medicaid and CHIP

Table B-16—Number of Required Actions by Dental PAHP

MCO	CY 2018	CY 2019	CY 2020
MCNA	12	0	0
Premier (Medicaid and CHIP)	33	3	0

In CY 2019, MCNA achieved full compliance; therefore, in CY 2020 HSAG only conducted a review of denial, appeal, grievance, and credentialing records for this PAHP.

Following the 2019 review, Premier and Premier CHIP had ongoing required actions to resolve pertaining to the Member Rights and Information, and Grievances and Appeals standards. In particular, HSAG found that both lines of business were missing demographic information in the provider directory and that the requirement for a member to follow an oral appeal with a written appeal was missing from their policies. Premier CHIP had additional findings in CY 2019 in the Coverage and Authorization of Services standard, specifically that the CHIP NABD letter included an incorrect time

frame for a member to file an appeal. In CY 2020, HSAG found that Premier and Premier CHIP had corrected these items. HSAG did not identify any ongoing required actions in CY 2020 for the dental PAHPs.

For record reviews, MCNA's credentialing files and denials records were in full compliance with the requirements. MCNA's appeals records were found to be in compliance with all requirements except the requirement for resolution letters to be easy for members to understand. HSAG also found that MCNA's grievance records were in compliance with all requirements; however, HSAG found that MCNA did not document "verbal complaints" as grievances and did not keep any records of this category of grievances.

One Premier credentialing file contained conflicting dates. HSAG found Premier's denials documentation to be unclear, and that member NABD communications did not meet the requirements of §438.10. HSAG found that Premier's appeal communications to members depicted inaccurate appeals processing and State fair hearing time frames and that Premier closed appeals when members did not submit written follow-up to oral appeals after five days of the oral appeal. Premier submitted a full Medicaid grievance sample of 10 records, which HSAG found to be in full compliance with the requirements, while Premier did not report any grievances for it CHIP line of business.

Statewide Opportunities for Improvement and Recommendations—Compliance With Medicaid Managed Care Regulations

As a result of the CY 2020 reviews, HSAG found that Utah's managed care entities performed very well pertaining to requirements associated with the Coordination and Continuity of Care and Quality Assessment and Performance Improvement standards. The plans that underwent a follow-up compliance monitoring review of the CY 2019 CAP made great strides in correcting deficiencies and coming into compliance with federal regulations and State contract requirements across all standards.

Among the health plans, HSAG identified areas with ongoing issues primarily related to record reviews. Pertaining to the Coverage and Authorization of Services standard, HSAG found a lack of clarity in the NABD letters sent to members, the use of complex or confusing language or medical jargon that was not explained, inaccurate State fair hearing timelines, unclear or inaccurate processes or timelines for members to request the continuation of benefits in informational appeal attachments, and the use of inappropriate timeline processes for NABD extensions and expedition requests. For these issues, HSAG recommends that UM supervisors examine NABD letters to identify opportunities to enhance clarity and accuracy, examine processes for expedition requests and extensions, and develop a process where all NABD letters are scrutinized for ease of understanding before they are mailed to the member. HSAG also found that some plans used a peer-to-peer or provider consultation process to reconsider or review a denial decision, rather than processing these requests as appeals. HSAG recommends that these processes are reviewed to confirm that they function within the parameters of the denial and appeal processes, ensuring that members are granted appeal rights, including notifications.

The most common ongoing opportunities for improvement HSAG identified within the Access and Availability standard related to the managed care entities not complying with the network adequacy or timely access standards provided in the State contract as their benchmark for determining the adequacy of the provider, hospital, and pharmacy network. HSAG recommends that health plans review their State contract to determine how to assess the adequacy and accessibility of their network for their member population. Additionally, while many managed care entities improved their cultural competency training, some plans still demonstrated deficiencies in this area. HSAG recommends that these plans look to national organizations, such as CMS, the American Hospital Association, and other organizations or associations, for ideas on how to establish and support a meaningful program.

Pertaining to the Member Rights and Information standard, the most common ongoing opportunities for improvement HSAG identified were related to enhancing the content of health plan websites and searchable provider directory accessibility (Section 508 compliance); improving the font size of documents to meet guidelines; and including large print where indicated (i.e., taglines) to comply with requirements of §438.10. HSAG recommends that MCOs still experiencing challenges with Web accessibility consider contracting with a third-party technology firm to assist with ideas and innovations for simplifying the website or enhancing the accessibility technology. Pertaining to the provider directory, many Utah health plans have struggled with including all required demographics in their provider directory (provider URL, whether a provider had completed cultural competency training, non-English languages spoken by individual providers, etc.). In CY 2020 HSAG found that many health plans were able to remedy these findings; however, for a few plans the findings remained. HSAG recommends that these plans expand their strategies to collect this information and make it available to members in the provider directory.

HSAG found that the most consistent and critical areas needing improvement across health plan types fell under the Grievance and Appeal System standard. Many health plans could benefit from strengthening working definitions for "medical necessity," "grievances," and "appeals"; aligning appeal resolution processes, including the proper use of expeditions and extensions when needed; removing limitations to member appeals by eliminating artificial barriers to members filing appeals; notifying members of their right to grieve an extension; collecting and counting all grievances, including those that are resolved promptly; and treating oral inquiries from members seeking to file an appeal as an actual appeal to establish the earliest possible filing date. HSAG recommends that health plans that are struggling in these areas consult the regulations at 42 CFR §438 Subpart F Grievance and Appeal Systems and the State contract language regarding grievances, appeals, and State fair hearings to reconcile policies and procedures to align with the regulations.

Pertaining to the Provider Participation and Program Integrity standard, HSAG found that some health plans needed to enhance provider agreements, expand the credentialing policy to include provisions for provider retention, and ensure that providers receive comprehensive information about the appeal and grievance process.

Pertaining to the Delegation Subcontracts standard, HSAG found that some health plans had yet to revise or append delegation agreements to include all required language.

Network Adequacy

Statewide Comparative Results

Table B-17 shows the percentage of sampled providers found and not found in the provider directory for each health plan.

Table B-17—Percentage of Sampled Providers Found in the Provider Directory by Health Plan*

Health Plan	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	Percentage	Count	Percentage	Count	Percentage
ACOs							
Health Choice	350	220	62.9%	114	32.6%	16	4.6%
Healthy U	364	271	74.5%	91	25.0%	2	0.5%
Molina	364	277	76.1%	69	19.0%	18	4.9%
SelectHealth	354	190	53.7%	146	41.2%	18	5.1%
UMICs and HOME MCO							
Health Choice	360	152	42.2%	195	54.2%	13	3.6%
Healthy U	375	200	53.3%	168	44.8%	7	1.9%
HOME	364	62	17.0%	291	79.9%	11	3.0%
Molina	375	259	69.1%	102	27.2%	14	3.7%
SelectHealth	363	198	54.5%	146	40.2%	19	5.2%
CHIP MCOs							
Molina	364	282	77.5%	72	19.8%	10	2.7%
SelectHealth	354	191	54.0%	141	39.8%	22	6.2%
PMHPs							
Bear River	32	32	100.0%	0	0.0%	0	0.0%
Central	28	19	67.9%	7	25.0%	2	7.1%
Davis	99	83	83.8%	13	13.1%	3	3.0%

Health Plan	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	Percentage	Count	Percentage	Count	Percentage
Four Corners	25	22	88.0%	3	12.0%	0	0.0%
Healthy U	59	4	6.8%	54	91.5%	1	1.7%
Northeastern	39	20	51.3%	19	48.7%	0	0.0%
Salt Lake	322	79	24.5%	214	66.5%	29	9.0%
Southwest	127	29	22.8%	95	74.8%	3	2.4%
Valley	18	0	0.0%	18	100.0%	0	0.0%
Wasatch	11	0	0.0%	11	100.0%	0	0.0%
Weber	86	76	88.4%	10	11.6%	0	0.0%
Dental PAHPs							
MCNA	223	208	93.3%	9	4.0%	6	2.7%
Premier	234	172	73.5%	57	24.4%	5	2.1%
CHIP Dental PAHPs							
Premier CHIP	257	202	78.6%	29	11.3%	26	10.1%

* Percentage totals may not equal 100 percent due to rounding

Table B-18 displays the number of provider categories meeting the time/distance standards by health plan statewide and by urbanicity. Health plans had to meet the standard for each urbanicity (i.e., urban, rural, and frontier) to meet the statewide time/distance standard for a provider category. UMICs operate only in urban areas. Since most PMHPs are inherently regional, statewide results are not presented.

Table B-18—Compliance With Time/Distance Standards by Health Plan Statewide and Urbanicity

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
ACOs									
Health Choice	58	37	63.8%	55	94.8%	41	70.7%	38	65.5%

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Healthy U	58	42	72.4%	53	91.4%	42	72.4%	50	86.2%
Molina	58	38	65.5%	39	67.2%	43	74.1%	45	77.6%
SelectHealth	58	39	67.2%	56	96.6%	41	70.7%	45	77.6%
UMICs and HOME MCO									
Health Choice	44	38	86.4%	NA	NA	NA	NA	38	86.4%
Healthy U	44	40	90.9%	NA	NA	NA	NA	40	90.9%
HOME	65	36	55.4%	56	86.2%	36	55.4%	55	84.6%
Molina	44	39	88.6%	NA	NA	NA	NA	39	88.6%
SelectHealth	44	37	84.1%	NA	NA	NA	NA	37	84.1%
CHIP MCOs									
Molina	41	14	34.1%	14	34.1%	23	56.1%	30	73.2%
SelectHealth	41	10	24.4%	10	24.4%	20	48.8%	26	63.4%
PMHPs									
Bear River	9	NA	NA	2	22.2%	2	22.2%	0	0.0%
Central	9	NA	NA	2	22.2%	2	22.2%	0	0.0%
Davis	9	NA	NA	6	66.7%	0	0.0%	3	33.3%
Four Corners	9	NA	NA	3	33.3%	3	33.3%	0	0.0%
Healthy U Summit	9	NA	NA	3	33.3%	4	44.4%	0	0.0%
Northeastern	9	NA	NA	2	22.2%	0	0.0%	0	0.0%
Salt Lake	9	NA	NA	3	33.3%	2	22.2%	8	88.9%
Southwest	9	NA	NA	4	44.4%	4	44.4%	0	0.0%
Valley	9	NA	NA	2	22.2%	0	0.0%	0	0.0%
Wasatch	9	NA	NA	0	0.0%	0	0.0%	0	0.0%

Health Plan	Number of Provider Categories	Statewide*		Frontier		Rural		Urban	
		Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)
Weber	9	NA	NA	0	0.0%	6	66.7%	6	66.7%
Dental PAHPs									
MCNA	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%
Premier	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%
CHIP Dental PAHP									
Premier CHIP	3	3	100.0%	3	100.0%	3	100.0%	3	100.0%

Overall network adequacy results are summarized below:

- The results of the PDV analysis show that the percentages of providers found in the health plan directory and match percentages between the plan-submitted provider data and the online provider directory varied greatly by health plan and study indicator.
- The ACOs, MCOs, and CHIP MCOs generally had high match percentages on the provider information (except Provider County, for which these health plans had a match percentage of less than 2 percent) for the providers that could be found in the health plan online provider directory.
- The PMHPs also had high match percentages for the providers found in the provider directories, although HSAG found less than 10 percent of the sampled providers for a few health plans (i.e., Healthy U, Valley, and Wasatch) in the respective provider directories.
- Geographic network distribution analysis results indicate that the ACOs generally maintained a geographically accessible network, with members across the State having access to providers within the time/distance standards in at least 37 of 58 provider categories for all ACOs.
- In general, the ACOs met the time/distance standards for the largest number of provider categories in frontier counties, which may be more indicative of the longer time/distance standards in these counties.
- The PMHPs operate regionally and have demonstrated a wide range in the percentage of members with access to providers. Based on the provider network reported by Wasatch, the health plan did not meet the time/distance standard for any of the provider categories in any urbanicity. Conversely, Salt Lake met the urban time/distance standards for eight of the nine provider categories, indicating a high level of access for its members.

- The Medicaid dental PAHPs and CHIP PAHP met the time/distance standard in all provider categories in frontier, rural, and urban areas, indicating that members have access to dental providers within the time/distance standards.

Statewide Opportunities for Improvement and Recommendations—Network Adequacy

HSAG recommends the following for UDOH and the health plans to strengthen the Medicaid and CHIP managed care provider networks and ensure members' timely access to health care providers:

- Accurate provider information is essential to ensure that Medicaid and CHIP members have access to timely health care and appropriate providers. The PDV results show a varying level of agreement between the provider data submitted by the health plans and the plan-specific online provider directories. UDOH should collaborate with health plans with low match percentages to conduct a root cause analysis to determine the reason for the low match percentage rates for some indicators.
- This PDV focused on whether the information in the submitted provider data and the online provider directory aligned. This PDV analysis cannot confirm whether the information is accurate and up to date for the providers. As a follow-up to this study, HSAG recommends conducting telephone surveys to validate the information in the provider demographic data and online directories. These surveys can be performed concurrently with appointment availability surveys.
- As the provider ratios and geographic distribution represent the potential capacity and distribution of contracted providers and may not directly reflect the availability of providers at any point in time, UDOH should use appointment availability and utilization analyses to evaluate providers' availability and members' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- UDOH should conduct an in-depth review of provider categories for which each health plan did not meet either the time/distance contract standards, with the goal of determining whether or not the failure of the health plan to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area. Future analyses should evaluate the extent to which the health plans have requested exemptions from UDOH for provider categories in which providers may not be available or willing to contract with the health plan.
- In addition to assessing the number, distribution, and availability of providers, UDOH should review patient satisfaction survey results and grievance and appeals data to evaluate the degree to which members are satisfied with the care they have received.

Appendix C. Assessment of Health Plan Follow-Up on Prior Year's Recommendations

Medicaid ACOs Providing Physical Health Services

Health Choice Utah

Validation of Performance Improvement Projects

Health Choice's *Breast Cancer Screening* PIP received a *Met* score for 91 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results. In the 2020 PIP submission, the health plan continued to have deficiencies in the narrative interpretation of the data.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Health Choice has responded that it engaged in the following QI initiatives:

- For the measures related to increasing screenings for women (breast cancer, cervical cancer), Health Choice reported that performance improvement coordinators (PICs):
- Provided education for members on *BCS* and *CCS* and why these screenings are important.
- Worked with the Outreach Department to create new informational brochures and pamphlets to help women understand the importance of early detection as well as fundamentally educate women on these cancers and what an appointment for this would look like.
- Called all members with breast cancer and cervical cancer gaps and offered assistance to schedule an appointment for a mammogram/Pap.
- Educated providers on the importance of recommending cancer screenings.
- Delivered gap lists including *BCS* and *CCS* lists to all participating providers every month.
- Set up a process with the HCU Clinical Services team in which PICs are notified when a member delivers a baby; the PIC then calls the member's OB to confirm that a postpartum visit has been scheduled and reminds the provider to perform a Pap during that visit if the member is due.
- For the measures related to required well-child visits for infants and young children, PICs:
- Called the parents or guardians of all members with well-care visits [due] and offered assistance to schedule an appointment for a well-care visit.
- Educated providers on the importance of recommending well-care visits and encouraged them to conduct well-care visits anytime the child is in the office (if the child's condition permits).

- Delivered gap lists including infant and child well-care visit gaps to all participating providers every month.
- For the measures related to documentation of the BMI percentile for children ages 3 to 17:
- PICs educated providers on the importance of measuring, calculating, and addressing BMI at every visit.
- PICs confirmed that for EMRs [electronic medical records] that automatically calculate BMI percentile, the BMI is documented in a compliant format (as a percentile, not as a value or a range).
- For the very few practices with noncompliant documentation, the PIC recommended a change to the EMR and provided the practice with information on compliant documentation.
- Related to the appropriate management of diabetes, Health Choice reported:
- Due to staffing and unexpected growth in membership, disease management programs were put on hold during 2020. We do have a diabetes management program completed and are working to implement it with members who are currently in case management.
- We continue to refer members to reliable community resources for disease management.
- Our pharmacy team actively works with members receiving diabetes and cardiovascular medications to ensure they complete their fills and are compliant with their medication regimen.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements, as well as a review of administrative records related to credentialing of providers. Health Choice scored well in many standard areas. Following the review, Health Choice completed a CAP for requirements found to be out of compliance in the standard area of member rights and information. In CY 2020, HSAG conducted a virtual follow-up review of Health Choice's CAP during which Health Choice demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review in CY 2020, HSAG identified one ongoing required action related to member information, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Health Choice's provider networks. In response to HSAG's recommendations, Health Choice reported that it continues to streamline data entry in MedMC (data system) to be as uniform as possible. Health Choice has standardized and corrected the addresses, provider titles, and abbreviations in the database. The health plan also reported that quarterly geo-access reports are generated to assess adequacy improvement opportunities. Due to the rural nature of many counties and the centralized nature of others (i.e., the majority of Utah County's provider specialties are located in Provo, leaving communities on the county borders outside the time/distance standards), most instances of inadequacy result from a lack of providers within the

time/distance area. However, as providers are located or as inadequacies due to other reasons are found, Health Choice places recruiting efforts on bringing those provider specialties in network.

While Health Choice reported that classifications of specialty and title are not uniform due to its database design, HSAG's provider crosswalk can help standardize provider classification within and across health plans. In CY 2020, Health Choice submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

Healthy U

Validation of Performance Improvement Projects

In CY 2020, Healthy U submitted a new PIP, *Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Healthy U has responded that it engaged in the following QI initiatives:

- For the measures related to increasing screenings for women (breast cancer, cervical cancer, and chlamydia), Healthy U reported:
- Continuing to conduct outreach to members and providers to increase compliance rates with the women's health measures.
- Using HEDIS prospective data, identifying women ages 21 through 74 years who are due for cervical cancer and/or breast cancer screening to send reminder letters.
- PCPs receive a list of their patients who were overdue for these exams and are encouraged to contact these members to schedule appointments.
- Starting to make member phone outreach calls to help members with scheduling appointments or finding a provider.
- For the care for women following delivery, Healthy U:
- Makes outreach calls to all high-risk pregnant members for referral into our U Baby Care Management program.
- Follow women identified for the program throughout the pregnancy and postpartum period. Once a woman delivers, a care manager reaches out to complete a postpartum questionnaire which assesses birth control, completion of a postpartum visit, and screens for postpartum depression.
- Sends educational materials and resources about prenatal/postnatal visits, tobacco cessation, mental health, and nutrition through a secure email platform to all pregnant members, regardless of risk status.

- For the measures related to the required well-child visits for infants and young children, Healthy U reported:
- Continues to offer parents/guardians of children turning 3, 4, 5, or 6 years of age a $25 gift card for receiving a well-child visit during 2020.
- Sends postcards to members informing them of this initiative and encouraging them to schedule the exam.
- Providers receive a list of their patients who are due for a well visit to schedule appointments.
- In addition, Healthy U emailed members immunization reminders and faxed providers lists of members who were overdue for age-appropriate immunizations.
- Healthy U is planning to begin phone outreach to members in 2021 to remind parents of the importance of well visits and assist with scheduling appointments or finding a provider.
- Related to the appropriate management of diabetes, Healthy U reported:
- Completing outreach to members and providers to increase compliance with diabetic eye exams, using HEDIS prospective run data.
- Information was sent to members explaining the importance of diabetic eye exams and how to schedule an appointment with an eye care provider. The member letter also contained a Diabetic Eye Exam Communication Form that members could take to their eye care provider. The form instructed the member and the eye care provider to send the form to the member's PCP.
- PCPs received a list of patients who were overdue for these exams to encourage follow-up. Healthy U also conducted member phone outreach to educate and encourage members to schedule diabetic eye exam appointments.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Healthy U scored well in many standard areas. Following the review, Healthy U completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, access and availability, member rights and information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Healthy U's CAP during which Healthy U demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified one ongoing required action related to provider participation and program integrity, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Healthy U's provider networks. In response to HSAG's recommendations, Healthy U responded that the network deficiency for pediatric specialists is very

likely based on the Healthy U member's home ZIP Code not being within the mileage standard to Primary Children's or Riverton Hospital. This is attributed to the lack of supply of pediatric specialists throughout Utah and the Intermountain region. Therefore, Healthy U believes this is not a true contracting opportunity. Healthy U also responded that the reported deficiencies for infusion, diagnostic radiology, and lab are very likely a data issue and not a true network deficiency. These services are generally included within hospitals and were not included in the data file and therefore are not showing as member access points for these services. Additionally, the health plan does not include all access points for a lab in its data due to the complexity of maintaining all lab and draw station locations.

Molina Healthcare of Utah

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Medicaid Comprehensive Diabetic Care—Eye Exams.* Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Molina focus improvement efforts on the following:

- Increasing screenings for women (breast cancer, cervical cancer, and chlamydia)
- Care for women following delivery
- Required well-child visits for infants and young children
- Documentation of BMI percentile for children ages 3 to 17
- Appropriate management of conditions for members with diabetes and high blood pressure
- Decreasing the use of clinical imaging for members with low back pain

In 2020, Molina reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Began using telemedicine to complete patient visits.
- Seven high-volume pediatric offices agreed to participate in a bonus program in which they are rewarded for completing preventive services and immunizations for their Molina pediatric patients.
- Utilized incentives to pregnant women to encourage them to continue obtaining prenatal care and postpartum care.
- Utilized incentive programs for patients to ensure they were still completing wellness services.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Molina scored well in many standard areas. Following the review, Molina completed a CAP for requirements found to be out of compliance in the standard areas of member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Molina's CAP during which Molina demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified ongoing required actions related to member information and the grievance and appeal system which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Molina's provider networks. In response to HSAG's recommendations, Molina responded that the health plan's performance in the rural and frontier counties for pediatric specialties was primarily due to lack of providers and recommended updating network standards to reflect the same. Additionally, Molina responded that it will conduct an analysis of its pediatric specialties to determine opportunities to more accurately reflect traveling physicians and the use of telehealth to improve adequacy based on current time/distance standards. Molina also recognizes a portion of the challenges seen in urban and rural areas are due to data integrity issues. Since the 2018 study and follow-up, the health plan has taken steps to correct data integrity issues through self-auditing provider records to ensure information is accurately reported and reviewing provider communities, competitor networks, and other resources to identify additional providers to include in the network.

Based on CY 2019 recommendations, Molina responded that it has reviewed provider information, corrected spelling errors, and found that the provider specialties accurately reflect the provider's licensed specialty and match the provider's taxonomy codes. Molina reported that it will continue to review how specialties are classified and look for ways to streamline provider specialty representation. In CY 2020, Molina submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

SelectHealth Community Care

Validation of Performance Improvement Projects

SelectHealth's *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*

PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, SelectHealth has reported the following QI initiatives:

- Related to increasing screenings for women (breast cancer, cervical cancer, and chlamydia), SelectHealth:
- Created a Women's Health brochure. The brochure addresses cervical cancer screening, colon cancer screenings, vaccinations, chlamydia testing, breast cancer screening, wellness, and depression screenings.
- Specifically, for cervical cancer screening, SelectHealth also improved the process and look of the Women's Preventive Health Report. This is sent to providers and encourages them to set up appointments with their patients for the necessary screenings.
- Included chlamydia screening rates in comparison to the national benchmarks for OB/GYN/CNM [obstetrician/gynecologist/certified nurse-midwife] providers in the publicly reported quality ribbon ratings that were published this year on the SelectHealth provider search page. The hope is that this will draw attention to the measurements for the community (SelectHealth reports having included some patient education with the ribbons online) and also for the providers so that they are encouraged to continue educating the patients.
- Is also considering a program next year for self-swabbing for HPV to improve *CCS* and chlamydia screening. It is just in the discussion process right now and would pilot at a certain clinic that has been interested.
- Organized a breast cancer screening taskforce between SelectHealth Quality Improvement, SelectHealth Medical Home, Castell (SelectHealth's delegate for Practice Transformation and provider support), R1 (SelectHealth's delegate for administrative services), Intermountain Imaging Services, Intermountain Internal Medicine, and Intermountain Women's Services. The purpose was to decrease wait times, improve access, coordinate scheduling workflows, and share data so outreach was not overlapping and potentially abrasive. This group started in 2019 but grew to include appropriate stakeholders in 2020.
- Moved outreach from Symphony RM to Castell. This change has resulted in more members being contacted with the offer to schedule a mammogram directly without the need for transfers or conference calls.
- Mailed out the annual breast cancer screening brochure. It was not significantly changed this year but is planned to undergo a rewrite in 2021.
- For measures related to required well-child visits for young children, SelectHealth:
- Continued the three-part member directed outreach for well-child visits for young children. Part 1 was an appointment reminder outreach that consists of one contact two months before the

anticipated due date of a well exam based on prior year claims. This is a brief touch to parents/guardians with a high propensity to close clinical gaps. Part 2 consisted of a parent education IVR [interactive voice response] call/email with a opt-in for a 30-day reminder call/email/SMS [short message service]. This reaches out to parents of children with no claim for a well-child visit in the prior year. Part 3 was an IVR call that goes out in August and September to members who still have a well-visit gap. During 2020 all of these communications were updated with COVID-19 language informing members that their child still needs a well visit during the pandemic and that provider offices are open.

- Updated the IVR communications to comply with the new NCQA *WCV* measure.
- In 2020, also worked on a *Protect Your Child With Preventive Care* brochure. SelectHealth reported hoping to have this new brochure finalized and available to send during Q1 2021 to members least likely to schedule a well exam based on prior claims.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. SelectHealth scored well in many standard areas. Following the review, SelectHealth completed a CAP for requirements found to be out of compliance in the standard areas of member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of SelectHealth's CAP during which SelectHealth demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG identified one ongoing required action related to member information, which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of SelectHealth's provider networks. In response to HSAG's recommendation, SelectHealth responded that the SelectHealth Provider Development team will actively work with the Provider Relations team to research whether there are available providers of this specialty type in the identified counties based on the Medicaid Known Provider Look Up tool, reach out to any available providers and explore the possibility of a contract, and make best efforts to fill these deficiencies by offering a contract and proceeding with system setup and enrollment with the new providers. SelectHealth reported that the success of these ongoing efforts is contingent on availability and willingness of providers to join the Medicaid/CHIP network. According to the Medicaid Known Provider Look Up tool, there are deficiencies in all rural and frontier counties for the following provider categories: Behavioral Health, OB/GYN, and Primary Care—Pediatric.

Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services

Health Choice

Validation of Performance Improvement Projects

In CY 2020, Health Choice submitted a new PIP, *Follow-Up After Hospitalization for Mental Illness*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Health Choice's UMIC line of business; therefore, this section is not applicable for Health Choice.

Validation of Network Adequacy

CY 2020 was the first year of the network adequacy study for Health Choice's UMIC provider network. Therefore, this section is not applicable for Health Choice.

Healthy Outcomes Medical Excellence (HOME)

Validation of Performance Improvement Projects

HOME's *Impact of Clinical and Educational Intervention on Progression of Pre-Diabetes to Type II Diabetes Mellitus* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In CY 2019, HSAG recommended that HOME focus improvement efforts on the following:

- Add a column in its tracking spreadsheet to denote who was or was not counted in the calculation of the performance measure. HSAG recommended that HOME investigate the substantial difference between the rate for members receiving a follow-up service within seven days following a hospitalization and the rate for members receiving a follow-up service within 30 days following a hospitalization.
- Determine if barriers exist that negatively impact members' ability to receive services within seven days following a hospitalization and determine if targeted interventions will improve this rate.

In 2020, HOME reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Refined verification and validation processes of hospitalizations and follow-up appointments.
- HOME case managers began documenting all reported inpatient encounters and follow-up visits that are cross-checked with linked claims.
- Adding another layer to ensure accuracy of data, this information is reconciled with patients' records housed in the EMR system, Epic.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. HOME scored well in many standard areas. Following the review, HOME completed a CAP for one requirement found to be out of compliance in the standard area of member information. In CY 2020, HSAG conducted a virtual follow-up review of HOME's CAP during which HOME demonstrated improvement in that standard area that had been less than fully compliant in the previous review year. During the follow-up review, HSAG determined the requirement to be met and HOME to be fully compliant.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of HOME's provider networks, and HSAG had made the following recommendations:

- Assess available data values in HOME's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met—behavioral health providers, pediatric specialists and additional physical health specialties—to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with HOME, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, HOME submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Healthy U

Validation of Performance Improvement Projects

In CY 2020, Healthy U submitted a new PIP, *Improving Adults' Access to Preventive/Ambulatory Care Services.* Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Healthy U's UMIC line of business; therefore, this section is not applicable for Healthy U.

Validation of Network Adequacy

CY 2020 was the first year for the network adequacy study of Healthy U's UMIC provider network. Therefore, this section is not applicable.

Molina

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Follow-Up After Hospitalization for Mental Illness*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for Molina's UMIC line of business; therefore, this section is not applicable for Molina.

Validation of Network Adequacy

CY 2020 is the first year for Molina's network adequacy study for the UMIC line of business. Therefore, this section is not applicable.

SelectHealth

Validation of Performance Improvement Projects

In CY 2020, SelectHealth submitted a new PIP, *7–Day Follow–Up After Hospitalization for Mental Illness for Medicaid Integration Members*. Therefore, this section is *Not Applicable* for this PIP.

Assessment of Compliance With Medicaid Managed Care Regulations

CY 2020 was the first year of operations for SelectHealth's UMIC line of business; therefore, this section is not applicable for SelectHealth.

Validation of Network Adequacy

CY 2020 is the first year for SelectHealth's network adequacy study for the UMIC line of business. Therefore, this section is not applicable.

Medicaid PIHP and PAHP PMHPs Providing Mental Health and/or Substance Use Disorder Services

Bear River Mental Health Services

Validation of Performance Improvement Projects

Bear River's *Suicide Prevention* PIP received a *Met* score for 90 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement in the narrative interpretation of results. In the 2020 PIP submission, the health plan addressed the deficiencies in the narrative interpretation of the data.

Validation of Performance Measures

In CY 2019, HSAG recommended that Bear River focus improvement efforts on the following:

- Ensuring that members receive a Bear River-furnished service within seven days and within 30 days following discharge from a hospitalization.
- Have processes in place to document and track authorizations for inpatient hospitalization to ensure accurate performance measure calculation.
- Implement quality checks to ensure that State specifications are followed during the measure calculation process.

In 2020, Bear River reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Implemented review of the HEDIS report quarterly at the executive team meeting. This allows supervisors to see how Bear River is doing with its follow-up.
- Implemented regular reviews of the HEDIS report during the quarterly QIP meeting so that QIP members can remind staff of the importance of follow-up with members after hospitalization.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Bear River scored well in many standard areas. Following the review, Bear River completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Bear River's CAP during which Bear River demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the follow-up review, HSAG determined the requirements to be met and Bear River to be fully compliant.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Bear River's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Bear River's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Bear River, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Bear River submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Central Utah Counseling Center

Validation of Performance Improvement Projects

In CY 2020, Central submitted a new PIP, *Inpatient Readmission Rates*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Central has responded that is initiated the following activities:

- Added two additional columns (i.e., "Numerator" and "Denominator") to its tracking spreadsheet that include a "Yes" response in the drop-down list to identify cases that are either numerator or denominator compliant and ensure accurate performance measure calculation.
- Updated and improved its spreadsheet used for tracking of all inpatient stays to include vital information for the determination of inclusion/exclusion in the PMV.
- Also began a QI project that will better meet the needs of clients upon discharge from hospitals. This includes having an assigned case manager working with them.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Central demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Central had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Central's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Central's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Central, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Central submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Davis Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Davis submitted a new PIP, *Access to Care.* Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Davis related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Davis scored well in many standard areas. Following the review, Davis completed a CAP for requirements found to be out of compliance in one standard area of member information. In CY 2020, HSAG conducted a virtual follow-up review and determined that Davis demonstrated full compliance in the standard area that had been less than fully compliant in the previous review year. Therefore, HSAG found that Davis had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Davis's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Davis's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Davis, the inability to identify the providers in the data using the standard definitions, or something else.

To address these recommendations, in CY 2020, Davis reported that it has:

- Actively worked to create and organize an active provider database to better monitor and regulate its provider network.
- Recently purchased rights to utilize Modio OneView, a cloud-based platform that securely manages and stores providers' credentials and licensure in one easily accessible place. This is anticipated to not only allow the agency to more effectively and efficiently perform credentialing efforts for both Medicaid and other payors, but also allow the agency to improve efforts to track training, continuing education, and other certifications that are critical to maintain a strong provider network and meet the needs of the members.

In addition, in CY 2020, Davis successfully submitted data for the network adequacy activity using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

Four Corners Community Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Four Corners submitted a new PIP, *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Four Corners focus improvement efforts on the following:

- Perform a review of the Medicaid Managed Care System (MMCS) to check for enrollment 30 days past the date of hospital discharge to ensure members who were enrolled during this time frame are appropriately included.
- Use its EHR, Credible, as well as claims information when conducting a secondary review to ensure members who meet the performance measure specifications are accurately included, which could result in an improvement in the measure rates.
- Date stamp any paper claims received via mail to ensure inclusion of appropriate members in the rate calculations.

In 2020, Four Corners reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- The accounts payable specialist stamps the paper claims as received via USPS mail.
- The billing specialist doublechecks all hospitalizations and verifies the member's Medicaid eligibility using MMCS.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Four Corners scored well in many standard areas. Following the review, Four Corners completed a CAP for requirements found to be out of compliance in the standard areas of access and availability and member information. In CY 2020, HSAG conducted a virtual follow-up review and identified that Four Corners demonstrated full compliance in the standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Four Corners had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Four Corners' provider networks, and HSAG had made the following recommendations:

- Assess available data values in Four Corners' provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Four Corners, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Four Corners submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Northeastern Counseling Center

Validation of Performance Improvement Projects

In CY 2020, Northeastern submitted a new PIP, *Inpatient Post Discharge Engagement and Suicide Intervention*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Northeastern Counseling Center related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Northeastern demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG determined that Northeastern had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Northeastern's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Northeastern's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Northeastern, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Northeastern submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Salt Lake County Division of Mental Health

Validation of Performance Improvement Projects

In CY 2020, Salt Lake submitted a new PIP, *Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Salt Lake County related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Salt Lake demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Salt Lake had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Salt Lake's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Salt Lake's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Salt

Lake, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Salt Lake submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Southwest Behavioral Health Center

Validation of Performance Improvement Projects

In CY 2020, Southwest submitted a new PIP, *Outcome Questionnaire (OQ) Project*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, Southwest has responded with the following information:

- Over this past year, Southwest has worked with, and trained, both front-office and back-office staff in using the same protocol and practice when entering and documenting a client's enrollment date. The Center discussed this practice at length with the EQRO team during the site visit and has developed a process anticipated to be the most useful and reasonable way to ensure consistency in recording.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Southwest scored well in many standard areas. Following the review, Southwest completed a CAP for requirements found to be out of compliance in one standard area related to member information. In CY 2020, HSAG conducted a virtual follow-up review of Southwest's CAP during which Southwest demonstrated improvement in the standard area that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Southwest's provider networks. In response to HSAG's recommendations, Southwest reported that it worked to clean up the variances in license designations

to maintain a more consistent way of reporting. In CY 2020, Southwest submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. Additionally, Southwest continued to seek to fill vacant positions with qualified and licensed candidates including using intern and practicum slots to entice future candidates. The health plan also reported using a productivity-based incentive plan to aid in retention of qualified staff and expand its subcontractor network to meet the minimum treatment timelines.

Utah County Department of Drug and Alcohol Prevention and Treatment

Validation of Performance Improvement Projects

Utah County's *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the PIP achieving real improvement. In the 2020 PIP submission, the health plan addressed the deficiency. Both the study indicators demonstrated statistically significant improvement over baseline.

Validation of Performance Measures

Utah County no longer has a contract directly with the State of Utah and therefore did not provide updates on PMV recommendations from the CY 2019 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Utah County scored well in many standard areas. Following the CY 2019 review, Utah County completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, provider participation and program integrity, and QAPI. In CY 2020, HSAG reviewed Utah County's CAP and provided feedback. HSAG did not assign continued required actions due to Utah County's contract with UDOH ending in June 2020.

Validation of Network Adequacy

Utah County no longer has a contract directly with the State of Utah, and therefore did not provide updates on network adequacy recommendations from the CY 2019 technical report.

Valley Behavioral Health

Validation of Performance Improvement Projects

Valley's *Suicide Prevention* PIP received a *Met* score for 95 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified an opportunity for improvement with the improvement strategies. In the 2020 PIP submission, the health plan was again unable to achieve a *Met* score for all applicable evaluation elements, receiving a *Met* score for only 81 percent of all applicable evaluation elements.

Validation of Performance Measures

Valley no longer has a contract directly with the State of Utah and therefore did not provide updates on the PMV recommendations in the CY 2020 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Valley scored well in many standard areas. Following the CY 2019 review, Valley completed a CAP for requirements found to be out of compliance in the standard areas of member information and grievance and appeals system. In CY 2020, HSAG reviewed Valley's CAP and provided feedback. HSAG did not assign continued required actions due to Valley's contract with UDOH ending In June 2020.

Validation of Network Adequacy

Valley no longer has a contract directly with the State of Utah and therefore did not provide updates on the network adequacy recommendations in the CY 2020 technical report.

Wasatch Behavioral Health

Validation of Performance Improvement Projects

In CY 2020, Wasatch submitted a new PIP, *Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ [Youth Outcomes Questionnaire] Outcome Measures*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

Wasatch did not provide any information regarding the recommendations in the CY 2020 technical report.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Wasatch scored well in many standard areas. Following the review, Wasatch completed a CAP for requirements found to be out of compliance in the standard areas of member information, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Wasatch's CAP during which Wasatch demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the 2020 follow-up review, HSAG identified ongoing required actions related to member information and provider participation and program integrity which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Wasatch's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Wasatch's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Wasatch, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Wasatch submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

Weber Human Services

Validation of Performance Improvement Projects

In CY 2020, Weber submitted a new PIP, *Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder (OUD)*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations related to PMV for Weber.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Weber scored well in many standard areas. Following the review, Weber completed a CAP for requirements found to be out of compliance in the standard area related to member information. In CY 2020, HSAG conducted a virtual follow-up review of Weber's CAP during which Weber demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Weber's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Weber's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Weber, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Weber submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. The health plan did not provide any information on the network adequacy findings and recommendations listed in the CY 2019 report.

CHIP MCOs Providing Both Physical and Mental Health Services

Molina Healthcare of Utah

Validation of Performance Improvement Projects

In CY 2020, Molina submitted a new PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*. Therefore, this section is *Not Applicable* for this PIP.

Validation of Performance Measures

In CY 2019, HSAG recommended that Molina focus improvement efforts on the following:

- Well-child visits for infants and young children
- Documentation of BMI percentile for children ages 3 to 17

In 2020, Molina reported that it implemented the following quality initiatives as a result of HSAG's CY 2019 recommendations:

- Began using telemedicine to complete patient visits.
- Seven high-volume pediatric offices agreed to participate in a bonus program in which they are rewarded for completing preventive services and immunizations for their Molina pediatric patients.
- Molina also utilized incentive programs for patients to ensure they were still completing wellness services.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up compliance review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Molina scored well in many standard areas. Following the review, Molina completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization, member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of Molina's CAP during which Molina demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified ongoing required actions related to member information and the grievance and appeal system which were not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Molina's provider networks. In response to HSAG's recommendations, Molina responded that the plan's performance in the rural and frontier counties for pediatric specialties was primarily due to lack of providers and recommended updating network standards to reflect the same. Additionally, Molina will conduct an analysis of its pediatric specialties to determine opportunities to more accurately reflect traveling physicians and the use of telehealth to improve adequacy based on current time/distance standards. Molina also recognizes that a portion of the challenges seen in urban and rural areas are due to data integrity issues. Since the 2018 audit and follow-up, the health plan has taken steps to correct data integrity issues through self-auditing provider records to ensure information is accurately reported and reviewing provider communities, competitor networks, and other resources to identify additional providers to include in the network.

Based on CY 2019 recommendations, Molina responded that it has reviewed provider information, corrected spelling errors, and found that the provider specialties accurately reflect the provider's licensed specialty and match the provider's taxonomy codes. Molina reported that it will continue to review how specialties are classified and look for ways to streamline provider specialty representation. In CY 2020, Molina submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials.

SelectHealth CHIP

Validation of Performance Improvement Projects

SelectHealth's *Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In response to the Findings and Recommendations in last year's report, SelectHealth has responded with the following information:

- Required well-child visits for young children

  SelectHealth continued the three-part member directed outreach for well-child visits for young children. Part 1 was an appointment reminder outreach that consists of one contact two months before the anticipated due date of a well exam based on prior year claims. This is a brief touch to parents/guardians with a high propensity to close clinical gaps. Part 2 consisted of a parent education IVR call/email with an opt-in for a 30-day reminder call/email/SMS. This reaches out to parents of children with no claim for a well-child visit in the prior year. Part 3 was an IVR call that

goes out in August and September to members who still have a well-visit gap. During 2020 all of these communications were updated with COVID-19 language informing members that their child still needs a well visit during the pandemic and that provider offices are open. The communications were also updated to comply with the new NCQA *WCV* measure. In 2020 we also worked on a *Protect Your Child With Preventive Care* brochure. We hope to have this finalized and available to send during Q1 2021 to members least likely to schedule a well exam based on prior claims.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. SelectHealth scored well in many standard areas. Following the review, SelectHealth completed a CAP for requirements found to be out of compliance in the standard areas of member information, grievance and appeal system, and provider participation and program integrity. In CY 2020, HSAG conducted a virtual follow-up review of SelectHealth's CAP during which SelectHealth demonstrated improvement in standard areas that had been less than fully compliant in the previous review year. During the CY 2020 follow-up review, HSAG identified one ongoing required action related to member information which was not adequately addressed and required a continuing CAP.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of SelectHealth's provider networks. In response to HSAG's recommendation, SelectHealth responded that SelectHealth Provider Development will actively work with the Provider Relations team to research whether there are available providers of this specialty type in the identified counties based on the Medicaid Known Provider Look Up tool, reach out to any available providers and explore the possibility of a contract, and make best efforts to fill these deficiencies by offering a contract and proceeding with system setup and enrollment with the new providers. SelectHealth reported that the success of these ongoing efforts is contingent on availability and willingness of providers to join the Medicaid/CHIP network. According to the Medicaid Known Provider Look Up tool, there are deficiencies in all rural and frontier counties for the following provider categories—Behavioral Health, OB/GYN, and Primary Care—Pediatric.

PAHPs Providing Medicaid Dental Services

Premier Access

Validation of Performance Improvement Projects

Premier's *Improving Dental Sealant Rates in Members Ages 6–9* PIP received a *Met* score for 56 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the study population, indicators, data collection, and interventions. In the 2020 PIP submission, the health plan addressed the recommendations from the 2019 validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Premier Access related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Premier scored well in many standard areas. Following the review, Premier completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and grievance and appeal system. In CY 2020, HSAG conducted a virtual follow-up review of Premier's CAP during which Premier demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Premier had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Premier's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Premier's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Premier, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Premier reported that its network adequacy exceeded all requirements and that it did not undertake any improvement activities outside of standard engagement with the Utah provider community.

MCNA

Validation of Performance Improvement Projects

MCNA's *Annual Dental Visits* PIP received a *Met* score for 100 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for MCNA related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. MCNA demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that MCNA had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of MCNA's provider networks, and HSAG had made the following recommendations:

- Assess available data values in MCNA's provider data systems and standardize available data value options to ensure complete and accurate data.
- Continue to monitor statewide compliance with time/distance standards.

In CY 2020, MCNA submitted data for network adequacy using HSAG's provider crosswalk which included standard definitions for provider categories based on provider specialty, provider type, taxonomy codes, and provider credentials. MCNA also met 100 percent of the time/distance standards statewide for both general dentists and specialist dentists.

PAHP Providing CHIP Dental Services

Premier Access—CHIP

Validation of Performance Improvement Projects

Premier's *Improving Dental Sealant Rates in CHIP Members Ages 6–9* PIP received a *Met* score for 50 percent of the applicable evaluation elements in the 2019 PIP Validation Tool. HSAG identified opportunities for improvement with the study population, indicators, data collection, and interventions. In the 2020 PIP submission, the health plan addressed the recommendations from the 2019 validation.

Validation of Performance Measures

In CY 2019, HSAG did not identify any recommendations for Premier Access related to PMV.

Compliance Monitoring

In CY 2019, HSAG conducted a telephonic follow-up review, which included a review of all standard requirements that received a *Partially Met* or *Not Met* score in CY 2018 as well as a review of administrative records related to credentialing of providers. Premier scored well in many standard areas. Following the review, Premier completed a CAP for requirements found to be out of compliance in the standard areas of coverage and authorization of services, member information, and grievance and appeal system. In CY 2020, HSAG conducted a virtual follow-up review of Premier's CAP during which Premier demonstrated full compliance in standard areas that had been less than fully compliant in the previous review year. Therefore, HSAG found that Premier had successfully implemented its required actions and did not have any further required corrective actions for CY 2020.

Validation of Network Adequacy

CY 2019 was the first comprehensive review of Premier's provider networks, and HSAG had made the following recommendations:

- Assess available data values in Premier's provider data systems and standardize available data value options to ensure complete and accurate data.
- Assess the provider categories for which standards were not met to understand if the reason was a lack of providers in the area with whom to contract, providers who chose not to contract with Premier, the inability to identify the providers in the data using the standard definitions, or something else.

In CY 2020, Premier reported that its network adequacy exceeded all requirements and that it did not undertake any improvement activities outside of standard engagement with the Utah provider community.

Appendix D. Summary of PIP Interventions by Plan Type and PIP Topic

Table D-1 on the following page includes information about interventions each health plan implemented for PIP topics submitted for validation in CY 2020.

Table D-1—Health Plan Interventions by Plan Type and PIP Topic

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Medicaid ACOs Providing Physical Health Services			
Health Choice	*Breast Cancer Screening*	1. The percentage of measure-eligible women 50–74 years of age who had a mammogram to screen for breast cancer during the measurement year.	• The Health Choice performance improvement coordinator (PIC) team used the Utah Health Information Network (UHIN) to obtain better contact information for members. • Implemented the PIC program to perform provider outreach, supply care gap reports, and work with practice quality champions to close gaps in care. • Partnered with a mobile mammography van to provide mammogram screenings to members in southern Utah.
Healthy U	*Improving Access to Well-Child Visits Among 3-, 4-, 5-, and 6-Year-Olds*	1. The percentage of children 3–6 years of age who received one or more well-child visits with a primary care provider during the measurement year.	• Parents of Healthy U children in the target age group will receive a $25 gift card incentive for obtaining a well-child visit. • Healthy U will send PCPs a list of attributed members who are overdue for well-child visits. PCPs will be encouraged to call members to schedule appointments. • Healthy U is developing a project with Take Care Utah to provide outreach to non-attributed members. Take Care Utah will assist members with identifying a PCP, making an initial appointment, and ensuring that the member follows through with the appointment.
Molina	*Medicaid Comprehensive Diabetic Care—Eye Exams*	1. The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who received a retinal eye exam.	• Partnered with Care Connections, a vendor that completes in-home diabetic exams for members. • Mailed $40 Walmart gift cards as incentives for members upon completion of a retinal eye exam. • Partnered with VSP Vision Care (VSP) to increase diabetic member awareness by sending letters including VSP contact information so

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
			members can call and obtain benefit information and assistance with scheduling eye exams. • Dissemination of a monthly missing services gap list to value-based contracting (VBC) groups so they can encourage and assist members in obtaining an eye exam.
SelectHealth	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday*	1. The percentage of 13-year-old female Medicaid members who had at least 2 doses of Human Papilloma Virus (HPV) vaccine prior to their 13th birthday.	• Scheduled meetings with Utah Statewide Immunization Information System (USIIS) staff to improve the data exchange process, and then standardize the internal process to ensure consistent data availability. • Updated the programming and member communications to reflect changes to the recommended HPV vaccine dosing schedule and HEDIS measure specifications. • Revised the reward program member mailings to clarify what is required to receive the gift cards. These letters are being mailed to members at 11 years, 10 months of age. • Created a reminder program for parents and providers of members who have received the first dose of the HPV vaccine series. The program includes a reminder letter to members, which is mailed at five and seven months after their first dose and informs them of their next dose due date. The program also includes a report to providers that indicates members who are due for the HPV vaccine.
Medicaid MCOs Providing Physical Health, Mental Health, and Substance Use Disorder Services			
Healthy Outcomes Medical	*Impact of Clinical and Educational Interventions on Progression of Pre-*	1. Percentage of HOME enrollees in the identified pre-diabetic study cohort, who had a most recent	• Continued to assign a dedicated nurse case manager to meet with patients and caregivers at the time of clinic visits to explain the importance of regular monitoring, lifestyle modifications, and regular clinic visits. Additionally, the nurse case manager will notify

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Excellence (HOME)	*Diabetes to Type II Diabetes Mellitus*	HbA1c < 5.7 in the measurement period.	providers of PIP participants' upcoming appointments during morning rounds. • Continued to adjust the provider schedule to increase availability of the nutritionist. • At every visit, the providers closely evaluate medication regimes leading to polypharmacy and include metformin as deemed clinically appropriate to the identified cohort. • Educate PCPs to refer patients to a nutritionist whenever clinically indicated. The nurse case manager will add the "need for nutritional counseling" to the notification of upcoming appointments to PCPs.
Health Choice Utah	*Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days 2. Follow-Up After Hospitalization for Mental Illness within 30 Days	• Health Choice had not progressed to reporting interventions for this project.
Healthy U	*Improving Adults' Access to Preventive/Ambulatory Care Services*	1. The percentage of members 20 year of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	• Healthy U had not progressed to reporting interventions for this project.
Molina Healthcare of Utah	*Follow Up After Hospitalization for Mental Illness*	1. The percentage of discharges for members 6 years of age and older who were hospitalized for	• Molina had not progressed to reporting interventions for this project.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.	
SelectHealth	*7-Day Follow-Up after Hospitalization for Mental Illness for Medicaid Integration Members*	1. Percentage of Medicaid Integration members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	• SelectHealth had not progressed to reporting interventions for this project.
Medicaid PMHPs Providing Mental Health Services			
Bear River	*Suicide Prevention*	1. The percentage of members who received a Columbia-Suicide Severity Rating Scale (C-SSRS) screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	• Training to address that all members who need a safety plan receive one. This topic is addressed in ongoing training, and staff members are reminded of the requirement to create a safety plan for new admits. • Emphasis on making sure the same-day safety plans are created and recorded.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Central	*Inpatient Readmission Rates*	1. The percentage of psychiatric discharges from the denominator that did not have a psychiatric readmission within 12 months.	• Implement a standardized care approach wherein all Medicaid enrollees will not only have a primary therapist assigned to the case, but an additional and specific case manager who will make frequent/weekly outreach to individuals discharged from inpatient settings for one year following discharge.
Davis	*Access to Care*	1. Percentage of initial appointments scheduled within 7 calendar days from first contact. 2. Percentage of second appointments scheduled within 14 calendar days from the initial appointment for members who were admitted into the treatment.	• Intake and evaluating staff have been informed of the seven-calendar-day requirement. • The Substance Treatment Program director is notified when a clinical staff member is unavailable and, if needed, assists in ensuring that the member is seen within 14 days.
Four Corners	*Increasing the Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. Percentage of members diagnosed with F11 code, who received 20 or more services within 6 months of admission into OUD treatment.	• Four Corners had not progressed to the Implementation stage and reporting QI activities during this validation cycle.
Healthy U	*Improving Follow-Up After Hospitalization for Mental Illness*	1. Follow-Up After Hospitalization for Mental Illness within 7 Days	• Healthy U had not progressed to reporting interventions for this project.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		2. Follow-Up After Hospitalization for Mental Illness within 30 Days	
Northeastern	*Inpatient Post Discharge Engagement and Suicide Intervention*	1. Percentage of inpatient discharges where members received a formal covered service per the HEDIS [Healthcare Effectiveness Data and Information Set] protocol or a documented "Caring Contact" (i.e., documented "outreach") 1 to 3 business days post discharge. 2. Percentage of inpatient discharges where members received a personalized Safety Plan 1–7 days post discharge with or through Northeastern Counseling. 3. Percentage of inpatient discharges where members received a Columbia Suicide Severity Risk Screening 1–7 days post inpatient discharge. 4. Percentage of inpatient discharges where members received a formal covered service or a documented	• Train clinicians, suicide prevention specialists, and support staff (including temporary staff) that the three-business-day follow-up requirement applies to anyone being discharged from an inpatient unit. • Train clinicians and suicide prevention specialists regarding service and/or Caring Contact expectations (i.e., within 31 to 60 days) that include the following: – Tracking in Credible and on the tracking spreadsheet is required for 31-to-60-day follow-up and Caring Contacts. – Members who choose to follow up with providers other than Northeastern must still have Caring Contacts within the time frames of this project, including 31 to 60 days. – Members who do not show up for an appointment or who do not cancel the appointment with support staff are to be contacted by the clinician or suicide prevention specialist within the time frames of this project and are to use the Caring Contact follow-up service in the EMR to document those actions 31 to 60 days post inpatient discharge. • The clinical director, suicide prevention specialist, and back-up specialist have developed a spreadsheet to track inpatient discharges as they occur with daily follow-up. A marker in the EMR has also been added for inpatient discharge members, which remains in place for 60 days post inpatient discharge.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		"Caring Contact" (i.e., documented "outreach") 31 to 60 days post inpatient discharge.	
Salt Lake	*Increasing Treatment Engagement and Retention for Members with Opioid Use Disorder in Salt Lake County*	1. Percentage of members who have been diagnosed with an OUD and who may have received MAT services. 2. Percentage of members who received MAT services and remained in treatment longer than 6 months.	• Provide two-hour MAT training for peer recovery coaches (PRCs) offering services in the Optum Medical network of SUD providers. • Provide training to provider administrative staff (billing) to ensure the diagnoses for OUD are entered correctly. • Requested access to pharmacy data from UDOH.
Southwest	*Outcome Questionnaire Project*	1. The percentage of psychotherapy sessions during which the OQ is reviewed with a member who is age 18 or older at the time of service.	• A monthly OQ administration report is sent to the manager, which is reviewed by the manager with the clinicians and the clinical director.
Utah County Department of Drug and Alcohol Prevention and Treatment	*Suicide Prevention*	1. The percentage of members who received a C-SSRS screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2	• Removed the current C-SSRS and Stanley Brown Safety Plan (SBSP) versions from the EHR and replaced them with new versions. • Continued training the clinicians on how to use the SBSP if the C-SSRS result was 2 or higher.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		or higher and received a same-day safety plan.	
Valley	*Suicide Prevention*	1. The percentage of members who received a C-SSRS screening during a face-to-face outpatient visit. 2. The percentage of members who had a C-SSRS screening completed with a score of 2 or higher and received a same-day safety plan.	• Provided feedback to staff on the number of C-SSRS screenings and safety plans completed. • Included the C-SSRS as a mandatory document in the assessment tool. • Worked with the EHR vendor to add information to the C-SSRS and safety plan report. • Provided clinicians with an updated report that identified members in need of an assessment. • Provided additional training to subcontractors on completing the C-SSRS and identifying high-risk members who would benefit from a safety plan. • Designated an employee to track the C-SSRS and safety plans received from the subcontractors and input them into the EHR for the subcontractors.
Wasatch	*Increasing Appropriate Clinical Support Tool Utilization in Conjunction with Y/OQ Outcome Measures*	1. The percentage of Y/OQ signal cases wherein CST was administered during a four-month window surrounding the signal event.	• Reports on CST usage will be provided monthly to program managers. Reports will contain: – The percentage of clinicians who administered CSTs within the last four months, indicated by the Y/OQ instruments. – Information on which clinicians are using the CSTs accurately and which clinicians are not. • Program managers will provide monthly reports to the executive director regarding improvement in the number of CSTs the clinics are collecting.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
Weber	*Increasing Treatment Engagement and Retention for Clients with an Opioid Use Disorder*	1. The percentage of members diagnosed with opioid use disorder, who received at least 6 case management or peer support services per year. 2. The percentage of members diagnosed with opioid use disorder that were discharged from treatment and who successfully completed the treatment.	• The health plan had not progressed to identifying barriers and interventions at the time of the PIP submission.
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Molina—CHIP	*Weight Assessment and Counseling for Nutrition and Physical Activity—BMI Screening*	1. The percentage of members 3–17 years of age who had an outpatient visit with a PCP [primary care physician] or OB/GYN [obstetrician/gynecologist] and who had evidence of BMI percentile documentation during the measurement year.	• Conducted targeted outreach to six high-volume pediatric groups to disseminate monthly reports of children needing well-child visits. • Disseminate a missing services list to value-based contracting (VBC) groups and conduct monthly discussions with providers for support. • Research billing code issue reasons. Collaborate with various plan staff to develop mitigation strategies. Educate providers regarding coding issues and resolutions.
SelectHealth—CHIP	*Improving the Percentage of 13-year-old Female Children's Health Insurance Program (CHIP) Members*	1. The percentage of 13-year-old female CHIP members who had at least 2 doses of Human Papilloma Virus	• Scheduled meetings with USIIS staff to improve the data exchange process, and then standardize the internal process to ensure consistent data availability.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
	who had 2 Doses of Human Papilloma Virus (HPV) Vaccine Prior to Their 13th Birthday	(HPV) vaccine prior to their 13th birthday.	• Updated the programming and member communications to reflect changes to the recommended HPV vaccine dosing schedule and HEDIS measure specifications. • Revised the reward program member mailings to clarify what is required to receive the gift cards. These letters are being mailed to members at 11 years, 10 months of age. • Created a reminder program for parents and providers of members who have received the first dose of the HPV vaccine series. The program includes a reminder letter to members, which is mailed at five and seven months after their first dose and informs them of their next dose due date. The program also includes a report to providers that indicates members who are due for the HPV vaccine.
PAHPs Providing Medicaid Dental Services			
Premier Access	*Improving Dental Sealant Rates in Members Ages 6–9*	1. The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	• Created and mailed a compelling wafer-sealed member communication which will encourage the member to unseal it. • Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education.
MCNA	*Annual Dental Visits*	1. The percentage of members ages 1–20 who had at least one dental visit during the measurement year. This measure was selected by the plan using nationally recognized CMS 416 specifications.	• MCNA member service representatives (MSRs) will offer assistance with scheduling an appointment when an alert is triggered in the DentalTrac system during inbound calls, which indicates the member is overdue for a preventive dental visit. • Send text messages once a month to members who have no claims history on file. • Provide monthly member rosters to high-volume providers of members who have not had a dental checkup in the current reporting year to a primary care dentist (PCD)/dental home.

Health Plan Name	PIP Topic	Study Indicator Descriptions	Interventions
		2. The percentage of members ages 21 and older who had at least one dental visit during the measurement year. This measure was selected by the plan using like criteria to the nationally recognized CMS 416 specifications for members under age 21.	• Conduct outbound calls to members who have not had a dental checkup within the last six months to encourage them to schedule an appointment.
PAHP Providing CHIP Dental Services			
Premier Access—CHIP	*Improving Dental Sealant Rates in CHIP Members Ages 6–9*	The percentage of members 6–9 years of age who received a dental sealant during the measurement year.	• Created and mailed a compelling, wafer-sealed member communication which will encourage the member to unseal it. • Outreach to providers as soon as normal business practices are resumed and encourage application of dental sealants through education.

ATTACHMENT 3

Pending 1115 Waiver Amendments

UTAH DEPARTMENT OF HEALTH MEDICAID

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Utah Department of Health
Executive Director's Office

Richard G. Saunders
Executive Director

Heather R. Borski, M.P.H., M.C.H.E.S.
Deputy Director

Division of Medicaid and Health Financing
Nate Checketts
Director, Division of Medicaid and Health Financing

February 19, 2021

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

Dear Administrator Richter:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the 1115 Primary Care Network (PCN) Demonstration Waiver. This amendment is a result of House Bill 6003 "Premium Subsidy Amendments", which passed during the 2020 Sixth Special Session of the Utah State Legislature. Approval of this amendment will allow the State to increase the maximum reimbursement allowable under Utah's Premium Partnership for Health Insurance Program (UPP), from $150 per enrollee per month, to a higher amount, through the state administrative rulemaking process, rather than by waiver amendment.

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

Respectfully,

Emma Chacon
Emma Chacon (Feb 19, 2021 08:01 MST)

Emma Chacon
Operations Director
Medicaid and Health Financing

Utah 1115 Primary Care Network Demonstration Waiver

Amendment Request

Utah's Premium Partnership for Health Insurance (UPP)

Premium Reimbursement Increase

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

Contents

State of Utah
Section 1115 Demonstration Amendment
Utah's Premium Partnership for Health Insurance (UPP)
Premium Reimbursement Increase

Section I. Program Description and Objectives

During the 2020 General Session, the Utah State Legislature passed, and Governor Herbert signed into law, House Bill 436 "Health and Human Services Amendments". This legislation directed the Utah Department of Health (UDOH), Division of Medicaid and Health Care Financing (DMHF) to increase the maximum premium reimbursement amount allowable under Utah's Premium Partnership for Health Insurance program (UPP). The UPP program is currently authorized under Utah's 1115 demonstration waiver. Through this demonstration, working adults, their spouses, and their children up to age 26 may receive premium reimbursement if they have access to a qualified employer-sponsored insurance plan (ESI) or COBRA. The reimbursement amounts are currently capped at $150 per enrollee per month for adults, and $120 per enrollee per month for children (with an additional $20 per month for children if the plan provides dental coverage).

This amendment request seeks to allow the State to increase the maximum reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount, through the state administrative rulemaking process, rather than by waiver amendment. As directed by House Bill 436, the State may increase the maximum premium reimbursement amount each subsequent fiscal year to keep pace with the increase in insurance premiums costs, subject to appropriation of additional funding. For the first fiscal year of implementation, the maximum reimbursement amount will be $300 per adult enrollee per month. The State is not requesting to increase the reimbursement amount for children under age 19.

As currently approved under Utah's 1115 demonstration waiver, the maximum premium reimbursement amount will not exceed the individual/family's share of the costs of the premium.

Goals and Objectives

This Demonstration furthers the objectives of Title XIX of the Social Security Act by assisting demonstration eligible individuals in obtaining employer-sponsored insurance, thereby reducing the number of uninsured individuals in the State of Utah.

Currently, 51 percent of UPP eligible individuals receive the maximum reimbursement of $150 per adult per month. The State believes increasing the maximum premium reimbursement amount will allow individuals to continue to purchase much needed health insurance as the costs of health coverage rise.

Operation and Proposed Timeline

The Demonstration will continue to operate statewide. The State intends to implement the premium increase the beginning of the first month after approval, if possible. The State requests to operate the Demonstration through the end of the current waiver approval period, which is June 30, 2022.

Demonstration Hypotheses and Evaluation

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

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

The following hypotheses will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
The demonstration will assist previously uninsured individuals in obtaining employer-sponsored health insurance.	-Members receiving assistance obtaining employer-sponsored health insurance -Total costs of assistance provided to members	-Medicaid data warehouse	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons

Section II. Demonstration Eligibility

Individuals must meet the criteria for the following demonstration populations (as currently approved under the State's 1115 demonstration waiver) to be eligible to receive the increased premium reimbursement:

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

- Demonstration Population V- comprised of adults age 19 through 64 with countable gross family income over 133 percent FPL and up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is

able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

Projected Enrollment

The projected enrollment for individuals in this demonstration (Demonstration groups III and V) is 380 adults per month.

Section III. Demonstration Benefits and Cost Sharing Requirements

The sole benefit provided to individuals eligible for premium assistance under this demonstration (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans. The maximum premium assistance amount must not exceed the individuals' share of the premium, and may not exceed the amount as will be stated in State Administrative Rule R414-320-16. This maximum monthly premium amount at the time of implementation of this amendment will be $300 per eligible adult.

Individuals eligible under this demonstration will have cost sharing requirements (including the out-of-pocket maximum) as set by their qualified ESI plan.

Section IV. Delivery System

Individuals eligible under this demonstration will receive services through the delivery systems provided by their respective qualified plan for ESI or COBRA premium assistance.

Section V. Implementation and Enrollment in Demonstration

Eligible individuals will be enrolled in the Demonstration as of the implementation date of this amendment.

Section VI. Demonstration Financing and Budget Neutrality

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

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

	DY19 (SFY 21)	DY 20 (SFY 22)
Member Months	1,140	4,560
Expenditures	$243,250	$973,000

Section VII. Proposed Waiver and Expenditure Authority

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

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(34)- Retroactive Eligibility	To permit the State to not provide retroactive eligibility for individuals under this demonstration.
Section 1902(a)(14) Cost Sharing Requirements	To permit individuals affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing requirements (including the out-of-pocket maximum) as set by the individual's qualified ESI plan.
Section 1902(a)(23)(A) Freedom of Choice	To enable the state to restrict freedom of choice of providers for individuals under this demonstration.

Expenditure Authority

The State requests expenditure authority to provide premium assistance related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the insurance premium for employer sponsored health insurance to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses, and their children (age 19 through 26), who are enrolled in their parents' employer sponsored insurance (ESI) plan, who are not otherwise eligible for Medicaid.

The State also requests expenditure authority to provide premium assistance related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above the Medicaid standard but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

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

Two public hearings to take public comment on this request were held. The first public hearing was held on May 21, 2020 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing was held on May 26, 2020 from 4:30 p.m. to 5:30 p.m. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing. The MCAC meeting minutes can be found in Attachment 3.

No comments were provided during the public hearings. However, three individuals asked questions regarding benefits for Adult Expansion beneficiaries, the effective date of the amendment, and budget

concerns due to the COVID-19 emergency. The questions asked did not require any changes to the amendment.

Public Comment

The public comment period was held May 18, 2020 through June 17, 2020. No public comments were submitted to the State.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, DMHF began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on June 12, 2020 to present this demonstration amendment. No feedback or concerns were provided. The UIHAB meeting agenda can found in Attachment 4.

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 IX. Demonstration Administration

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

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

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

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 15 (SFY 17)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WOW
Current Eligibles					*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	0	377,866	0.0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	5.3%	0	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults with Children					*PCN ends 3/31/19*					
Pop Type:	**Hypothetical**									
Eligible Member Months	5.9%	0	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	5.3%	0	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure					$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children *							*Anticipated start date of 4/1/21*			
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	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 23,415,350	$ 33,251,572	$ 62,403,693
Demo Pop I - PCN Childless Adults					*PCN ends 3/31/19*					
Pop Type:	**Medicaid**									
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure					$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults *							*Anticipated start date of 4/1/21*			
Pop Type:	**Medicaid**									
Eligible Member Months	159	0		2.5%	163	167	171	176	180	
PMPM Cost	68.45	0		5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure					$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Targeted Adults					*Started 11/1/17*		*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**						*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		0	0	2.5%	78,000	78,000	$ 126,000	172,200	176,505	
PMPM Cost		0	$ -	5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure					$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults						*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Pop Type:	**Expansion**									
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure					$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care							*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**									
Eligible Member Months		0			-		720	1,440	1,440	

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
PMPM Cost	5.3%	0		5.3%	$ -		$ 2,100.00	$2,211.30	$2,328.50	
Total Expenditure					$ -		$ 1,512,000	$ 3,184,272	$ 3,353,038	$ 8,049,310
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**									
								Anticipated start date of 1/1/21		
Eligible Member Months	2.5%	0			412,361	412,361	412,361	398,181	393,600	
PMPM Cost	5.3%	0			$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure					$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
							21.50674765			
Dental - Aged										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months	2.5%	0	108,000				54,000	156,300	160,208	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment										
Pop Type:	**Hypothetical**							*Anticipated start date of 1/1/21*		
Eligible Member Months	13.5%	0	126					63	143	
PMPM Cost	5.0%	0						$ 18,671.00	$ 19,606.55	
Total Expenditure					$ -	$ -	$ -	$ 1,176,273	$ 2,803,737	$ 3,980,010
Former Foster										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure					$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)										
Pop Type:	**Hypothetical**									
Eligible Member Months	6.9%	18	36,913	6.9%	39,456.31	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Started 5/1/19*				
Eligible Member Months	0.0%	0	4,018	0.0%		670	4,018	4,018	4,018	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations										
Pop Type:	**Hypothetical**							*Assumes start date of 7/1/20*		
Eligible Member Months	1.75%		3,200	1.75%	-			38,400	39,072	
PMPM Cost	3.0%			3.0%	-		$ -	$ 520.00	$ 535.60	
Total Expenditure					-		$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)										

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
Pop Type:	**Hypothetical**							*Assumes start date of 1/1/21*		
Eligible Member Months	2.5%		16,835	2.5%	-			8,418	17,256	
PMPM Cost	5.3%			5.3%	-		$ -	$ 13,527	$ 14,244	
Total Expenditure					-		$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		339,828	2.5%	-		169,914	348,324	357,032	
PMPM Cost	5.3%			5.3%	$ -		$ 671.61	$ 707.21	$ 744.69	
Total Expenditure					$ -		$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		400,973	2.5%	-		200,487	410,997	421,272	
PMPM Cost	5.3%			5.3%	-		$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure					-		$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								10,292	10,832	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		121,473	5.25%	-		58,671	123,503	129,987	
PMPM Cost	5.3%			5.3%	$ -		$ 656.90	$ 691.72	$ 728.38	
Total Expenditure					$ -		$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								32,570	34,280	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		384,418	5.25%	-		185,674	390,844	411,363	
PMPM Cost	5.3%			5.3%	-		$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure					-		$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715

* Beginning 4/1/21 UPP will reimburse client up to $300 for employer sponsored insurance

Start date of 5/1/19 (2 months of SFY19) — $ 6,632,503,941

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**						*Anticipated start date of 4/1/21*		
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 23,415,350	$ 33,251,572	$ 62,403,693
Demo Pop I - PCN Childless Adults					*PCN ends 3/31/19*				
Pop Type:	**Medicaid**								
Eligible Member Months		70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost	$	48.97	5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure				$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults									
Pop Type:	**Medicaid**						*Anticipated start date of 4/1/21*		
Eligible Member Months		159	4.9%	167	175	184	176	180	
PMPM Cost	$	68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 10,702	$ 11,237	$ 11,799	$ 204,780	$ 221,024	$ 459,540
Targeted Adults						*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months			2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults									
Pop Type:	**Expansion**				*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months			2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Total Expenditure			$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	412,361	412,361	412,361	398,181	393,600	
PMPM Cost		3.0%	$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure			$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months		2.5%	-	-	54,000	156,300	160,208	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		13.5%	-	-	-	25	50	
PMPM Cost		5.0%	$ -	$ -	$ -	$ 18,671.00	$ 19,606.55	
Total Expenditure			$ -	$ -	$ -	$ 466,775	$ 980,328	$ 1,447,103
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/2021*		
Eligible Member Months		1.75%	-	-	-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/2021*		
Eligible Member Months		2.50%	-	-	-	8,418	17,256	
PMPM Cost		5.3%	-	-	-	$ 13,526.99	$ 14,243.92	
Total Expenditure				$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Expansion Parents <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure			$ -	$ -	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure			-	$ -	$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	$ -	$ -	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure			$ -	$ -	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	-	$ -	$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure			-	$ -	$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
								$ 6,632,904,348

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

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children				*PCN ends 3/31/19*					
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children							*Anticipated start date of 4/1/21*		
Pop Type:	**Hypothetical**								
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 23,415,350	$ 33,251,572	$ 62,403,693
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							*Anticipated start date of 4/1/21*		
Pop Type:	**Medicaid**								
Eligible Member Months		159	4.9%	167	175	184	176	180	
PMPM Cost	$	68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 10,702	$ 11,237	$ 11,799	$ 204,780	$ 221,024	$ 459,540
Former Targeted Adults						*Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding new managed care directed payments.* *PMPM will decrease due to removing the housing support benefit, and for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months			2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,281.14	$ 1,349.04	$ 1,420.54	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 155,909,778	$ 220,402,517	$ 237,885,946	$ 771,054,298
Dental - Targeted Adults					*Started 3/1/19*				
Pop Type:	**Expansion**								
Eligible Member Months			2.5%	-	12,000	18,450			
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 687,556	$ -	$ -	$ 1,087,556
System of Care						*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**								
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	
Total Expenditure				$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled									

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	412,361	412,361	412,361	398,181	393,600	
PMPM Cost		3.0%	$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure			$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	-	-	54,000	156,300	160,208	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months			-	-	-	25	50	
PMPM Cost			$ -	$ -	$ -	$ 18,671.00	$ 19,606.55	
Total Expenditure			$ -	$ -	$ -	$ 466,775	$ 980,328	$ 1,447,103
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2020*		
Eligible Member Months		1.75%	-		-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2020*		
Eligible Member Months		2.50%	-	-	-	8,418	17,256	
PMPM Cost		5.30%	-	-	-	13,527	14,244	
Total Expenditure			$ -	$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 640.57	$ 674.52	$ 710.27	
Total Expenditure			$ -	$ -	$ 108,841,789	$ 234,951,327	$ 253,588,841	$ 597,381,956
Expansion Adults w/out Dependent Children <=100% FPL					*Assumes start date of 1/1/20*			

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 899.03	$ 946.68	$ 996.85	
Total Expenditure			-	$ -	$ 180,242,854	$ 389,081,237	$ 419,945,107	$ 989,269,198
Expansion Parents 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**							
Eligible Member Months		5.25%	-	-	53,048	111,667	117,529	
PMPM Cost		5.3%	$ -	$ -	$ 625.86	$ 659.03	$ 693.96	
Total Expenditure			$ -	$ -	$ 33,200,871	$ 73,591,888	$ 81,560,602	$ 188,353,362
Expansion Adults w/out Dependent Children 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		5.25%	-	-	167,879	353,386	371,939	
PMPM Cost		5.3%	-	$ -	$ 882.60	$ 929.37	$ 978.63	
Total Expenditure			-	$ -	$ 148,169,813	$ 328,428,021	$ 363,991,028	$ 840,588,862

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

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

ATTACHMENT 2

Public Notice Requirements

UTAH DEPARTMENT OF HEALTH MEDICAID

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

Deseret Nev

PROOF OF PUBLICATION **CUSTOMER'S COPY**

CUSTOMER NAME AND ADDRESS	ACCOUN
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME, CRAIG DEVASHRAYEE PO BOX 143102	9001

SALT LAKE CITY UT 84114

ACCOUNT NAME
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURS

TELEPHONE	ORDER # / INVOICE
8015386641	0001290028 /

PUBLICATION SCHEDULE
START 05/18/2020 END 05/18/2020

CUSTOMER REFERENCE NUMBER
QAZ: Amendments to Utah 1115 Waiver

CAPTION
PUBLIC NOTICE Utah 1115 Waiver Amendments The Utah Department of

SIZE		
68 LINES	3 COLUMN(S)	
TIMES	TOTAL COST	
3	347.72	

Utah

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 "Substance Use and Health Care Amendments" and House Bill 436 "Health and Human Services Amendments", which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)
- This amendment will allow the State to provide Medicaid coverage to "qualified inmates" for up to 30 days before release from a correctional facility.
- A "qualified inmate" is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)
- This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.
- If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendments. The dates and times are listed below. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing.
- Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.
  - o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv
  - o Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)
- Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.
  - o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc
  - o Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

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

1290028 UPAXLP

AFFIDAVIT OF PUBLICATION

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

PUBLISHED ON Start 05/18/2020 End 05/18/2020

DATE 5/21/2020 SIGNATURE LTapusoa

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 21ST DAY OF MAY IN THE YEAR 2020

BY LENEA TAPUSOA.

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

Lgudmundson
NOTARY PUBLIC SIGNATURE

Department of Health:
Medicaid Expansion Workgroup

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendments

Notice Type: Notice, Meeting

Event Start Date & Time: May 21, 2020 02:00 PM

Event End Date & Time: May 21, 2020 04:00 PM

Description/Agenda:

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 'Substance Use and Health Care Amendments' and House Bill 436 'Health and Human Services Amendments', which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)

This amendment will allow the State to provide Medicaid coverage to 'qualified inmates' for up to 30 days before release from a correctional facility.

A 'qualified inmate' is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)

This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.

If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:

Meeting Location:

Video Conference
Salt Lake City , 84116

Map this!

Contact Information:

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

Audio File Address

Subscription Options

Subscription options will send you alerts regarding future notices posted by this Body.

E-mail

Options

Add this notice to calendar
Printer Friendly
Email this to a Friend

Connect

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

Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/kyj-yrbk-cvv

Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.
Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/ctt-dxpy-nqc

Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:

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

Notice of Electronic or telephone participation:

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Other Information

This notice was posted on: May 18, 2020 02:50 PM
This notice was last edited on: May 18, 2020 03:09 PM
Deadline Date: May 21, 2020 04:00 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

Department of Health:
Medicaid Expansion Workgroup

Search again

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendments

Notice Type: Notice, Meeting

Event Start Date & Time: May 26, 2020 04:30 PM

Event End Date & Time: May 26, 2020 05:30 PM

Description/Agenda:

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 'Substance Use and Health Care Amendments' and House Bill 436 'Health and Human Services Amendments', which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)

This amendment will allow the State to provide Medicaid coverage to 'qualified inmates' for up to 30 days before release from a correctional facility.

A 'qualified inmate' is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)

This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.

If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:

Meeting Location:

Video Conference
Salt Lake City , 84116

Map this!

Contact Information:

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

Audio File Address

Subscription Options

Subscription options will send you alerts regarding future notices posted by this Body.

E-mail

Options

Add this notice to calendar
Printer Friendly
Email this to a Friend

Connect

Tweet

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

Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv

Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc

Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:

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

Notice of Electronic or telephone participation:

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m. Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Other Information

This notice was posted on: May 18, 2020 02:59 PM
This notice was last edited on: May 18, 2020 03:06 PM
Deadline Date: May 26, 2020 05:30 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

ATTACHMENT 3

Medical Care Advisory Committee

Public Hearing

Medical Care Advisory Committee

Minutes of May 21, 2020

Participants

Committee Members (via phone)

Dr. William Cosgrove (Chair), Jessie Mandle (Vice Chair) Jenifer Lloyd, Christine Evans, Muris Prses on behalf of Dale Ownby, Brian Monsen, Adam Cohen, Dr. Robert Baird, Stephanie Burdick, Mark Ward on behalf of Michael Hales, Pete Ziegler, Mike Jensen, Ginger Phillips on behalf of Adam Montgomery, and Mary Kuzel

Committee Members Absent

Sara Carbajal-Salisbury, Joey Hanna, Mark Brasher, Gina Tuttle, and Danny Harris.

DOH Staff (via phone)

Nate Checketts, Emma Chacon, Tonya Hales, Brian Roach, Michelle Smith, Jennifer Meyer-Smart, Craig Devashrayee, Krisann Bacon, , Greg Trollan, Dave Lewis, Kim Michelson, Sheila Walsh-McDonald, Tracy Barkley, Joel Hoffman, Jorge Fuentes, Sharon Steigerwalt, and Dorrie Reese.

Guest (via phone)

Allison Hefferman, Andrew Riggle, Dan Schuring, Daniel Cheung, Dave Gessel, David Killen, , Jeannie Peters, Joni Nebeker, Julie Ewing, Kelli Peterson, Leanne Peters, Matt Hansen , Matthew Mulligan, Randal Serr, Robert Felix, Russ Elbel, Rylee Curtis, Sattia Chozo Gonzales, Scott Horne, Scott Titensor, Stacy Standford, Todd Wood, Tracey Meeks, Tracy Wagner, and Val Radmall

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

Jennifer Meyer-Smart discussed the Public Hearing for 1115 Waiver Amendment.

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020 through June 17, 2020.

With this waiver amendment, DMHF is requesting authority to:

- Provide Medicaid coverage to an individual who is incarcerated in a correctional facility, has a chronic physical, or behavioral health condition; a mental illness, or an opioid use disorder
- Increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enroll per month, to $300 per enroll per month, if approved. We estimate approximate 210 UPP eligible adults would receive this benefit per month.

The document which was presented is embedded in this document

Utah 1115-Abbrv Public Notice-Justice I

Public Hearing Overview-UPP-Justice

Public Comment:

- Mark Ward asked a question: How does this square with the resolution the legislation passed asking agencies to curtail spending especially for the new and expansion items in light of the lending COVID-19 budget shortfall?

Emma Chacon response: We realize that this may not go forward, because of the action of the Executive Appropriations Committee, but the final decision has not been made, that resolution advised agencies that they should approach their to plan for their Fiscal year 2021 budget to be the same as their fiscal year 2020 budgets. If it turns out through the special session that all the funding for specific bills are rescinded then we won't go forward submitting these waivers to CMS, or if it has already been submitted than we will withdrawal it. But in the event that funding is not rescinded for any reason we will be ready to move forward.

- Ginger Phillips who is filling in for Adam Montgomery asked question: On the 1115 Waiver, people qualifying on adult expansion who are incarcerated in the jail or prison which one of those will receive dental services?

Emma Chacon response: Currently, the adult expansion members do not have a dental benefit with the exception of 19-20-year olds under the EPSDT.

- Gina Evans, Salt Lake County emailed question: Does the waiver for the criminal justice population start July 1, 2020, the handout states January 1, 2021?

Emma Chacon response: The bill directs the state to submit a waiver by July 1, 2020. We indicated a January 1, 2021 start because we are hoping that CMS will approve this waiver amendment by that date. The effective date is the date this waiver gets approved then we will need some lead time to change systems in order to get this up and running. This date could change if we receive a faster approval date or this date could be pushed out beyond January 1, 2021if CMS approval is delayed.

- Dr. Cosgrove asked a question: Emma can you clarify the start date if the waiver goes through for the Utah Premium Partnership?

Emma Chacon response: That would go into effect the first or second month after CMS approval.

Approval of Minutes

Dr. Robert Baird made the motion to approve the April 16, 2020 MCAC minutes. The group unanimously agreed.

New Rulemakings Information Rules/SPAs – Craig Devashrayee:

Craig Devashrayee discussed Rules/SPAs.

- R414-506: Hospital Provider Assessments (Five-Year Review)
- R414-60-5: Limitations
- R414-40: Private duty Nursing Service (Five-Year Review)
- R414-401-3: Assessment
- R414-506: Hospital Provider Assessments
- R414-517: Inpatient Hospital Provider Assessments
- R414-523: Medicaid Expansion Hospital Provider Assessments
- 20-0006-UT: COVID-19 Emergency Disaster Relief
- 20-0007-UT: Quality Improvement Incentives
- 20-0009-UT: Disaster Relief Testing Locations

The documents which were presented are embedded in this document

MCAC Rule Summary 5-21-20.pdf

MCAC SPA Summary 5-21-20.pdf

Comments:

- Mark Ward has a question on R414-523: Medicaid Expansion Hospital Provider Assessment- The statutory reference listed here 26-36b says that chapter for July 1,2020, you can only do a hospital assessment if the sales tax and savings offset aren't sufficient to pay the cost of the Medicaid expansion. Has the Department of Health conducted any kind of analysis or estimate to make that determination that those resources are not adequate?

Emma Chacon response: No the purpose of putting forth the rule is to outline the operational aspect of this assessment. We do not intend to implement this assessment in FY2020 or FY 2021. As Craig has said the 7/1/2020 date is the earliest possible effective date, let us take this back and look into this further.

- Dave Gessel: I am trying to understand that rule, and Mark makes a good point that this does not kick into effect until all the money of the sales tax are gone. Have you been directed by the legislature or have you done this on your own?

Emma Chacon response: The rule? . We have not been directed by the legislature. I think this rule needs some clarification to say that it would not go into effect until it meets that criteria in the statute, we will amend that rule to make it clear.

- Dave Gessel: Just a quick question on the earlier assessments adding the penalties, I thought we had that in the statute or rule for a long time are you changing the penalties or amount that hospitals pay their assessments late, or is this kind of cleanup language that references whatever the normal penalties you already have?

Emma Chacon response: We have similar language in other provider assessment rules. Since we don't have this in rule for this assessment, we are not charging penalties. Currently we only have authority to put a hold on claims payments until the assessment payment is made. This is an attempt to make all our assessment rules consistent.

- Mark Ward: Technical question on the form the total fiscal benefit describes on the $24M, which includes $12M to State Government and $12M to other person that double counts the fiscal benefit that would be derived from this, because State Government would receive $12M additional, but the other person would receive the same amount whether it would pass inactive or not.

- Craig Devashrayee response: That was a broad figure that we used.

- Mark Ward: It would only be true if there was a plan to make a cut in that program that was going to replace the hospital assessment. Then the other persons would receive the $12M that otherwise would not receive.

- Emma Chacon response: Craig will make note of that, and he will follow-up with Mark Ward.

- Mark Ward: Note that what hospitals are doing supporting public health response to the coronavirus by setting up testing sites, clearing unit for COVID-19 patients, delaying visits, and elective procedures until we have protective equipment, capacity for COVID-19 patients. We are still in the middle of that response. With potential of re-opening and with the flu season, to have a surge later on. I am wondering how future tax increase supports the hospitals while they are in the middle of that response at a great expense and loss revenue that this results from?

Emma Chacon response: Mark I don't have an answer for your question, duly noted the point that you are making. We will take it back for further discussion.

- Stephanie Burdick: Do we have any information on how Utah compares to other states when it comes to how much hospital assessments? Are they requiring hospitals to contribute in comparison?

Emma Chacon response: We could probably do that, it would take some time, just as others are being impacted by everything that is going on right now, so are we. We can see whether NAMD (National Association of State Medicaid Directors) group might already have that information that we can try to access. Every state financing structure for their programs are a little bit different. We will see what we can do. We will certainly see if that information is out there, and if we can get our hands on it to share with the group. It will be interesting for us to see that information as well.

Eligibility Enrollment Update – Michelle Smith/Muris Prses:

Michelle Smith and Muris Prses gave a presentation from both DOH and DWS regarding eligibility: The impact eligibility has had from the downturn of the economy, changes to the system to comply with the families first act/not closing cases, etc. and DWS application process timeframe, backlog?

The document which was presented is embedded in this document.

Medicaid Trends.pdf MCAC Data.pptx

Medicaid Expansion Report – Jennifer Meyer-Smart:

Jennifer Meyer-Smart gave an update on the Medicaid Expansion Report.

The document which was presented is embedded in this document.

Expansion Report

ACO's Outreach Campaign – Brian Monsen

Brian Monsen gave an update on the ACOs Outreach Campaign program. The campaign goes through the end of May.

Legislative Updates & Appropriations – Emma Chacon:

Emma Chacon gave an update on the Legislative bills and appropriations.

Executive Appropriations met and voted to reverse all additional appropriations that were not in the base budget bill. In addition agencies were asked to identify 2%, 5% and 10% reductions to their budgets. The budget deficit for state fiscal year 2012 is between $587 million and 1.2billion. . There has been discussion legislative fiscal analyst. We have made a conceded effort to identify areas where we are already having policy changes in the works that will save money.

Next week, Tuesday, May 26th at 1:00 and on Friday, May 29th at 8:00 Social Service Committee meeting that is when they will look at all of the proposed cuts for the Department of Workforce Services, Department of Human Services, and the Department of Health.

During the first week of June another Medicaid Consensus meeting will take place to consider the impact of COVID-19 and the downturn of the economy on the Medicaid enrollment

Sometime in June there will be a special session to address any changes to appropriations for fiscal year 2021 which starts July 1, 2020. State agencies have been asked to look at 2%, 5% and 10% reductions. The maintenance of effort requirement to receive enhanced federal financial participation, limits what type of cuts that the state can make. We cannot make any changes to eligibility requirements or benefits that were in place as of January 1, 2020

Director's Report

COVID-19: - Nate Checketts

Nate Checketts discussed COVID-19. The State is moving forward with different risks levels, between orange and yellow, as we look at the COVID-19 moving forward, our numbers have been level over the past couple weeks. As you look at the number of new cases what you are seeing hospitalization and other areas. We are obviously moving into two different phases across the State of relaxing stay at home requirements and moving to less restrictive requirements where we will be watching the data very carefully for number of positive tests that are coming back with the number of cases we are finding. There are metrics built in these proposals as we move forward there are certain things move that will trigger flags if the cases start to climb again. There's a hope that across the State as we move to warmer times and people are spending more time outdoors that the state can relax at the overall rules that we are asking people to comply with. Overall the State has not had a high level of infection across these last couple of months. As we look at the return of the flu season in the fall, we have heard that it is likely less than 5% of Utahns have been infected to date with the COVID virus, so as we come back to another potential infection 95% have not been infected.

One of the initiatives we are pursuing is to provide additional training and testing at the Nursing Facilities and Long-Term Care facilities. Although we've have had a significant number of deaths of individuals who reside in nursing facilities, the overall death total for the state is low. We think there is some additional work we can do there. Our Healthcare Associate infection team is going out and doing training at those facilities, another group is doing training on the appropriate use of personal protective equipment (PPE), and making sure facilities understand the best way to respond to an outbreak in their facilities.

We have pulled in staff from other areas in the Department to work specifically on the COVID response. Many of those staff will need to transition back to their previous position at some point.

Medicaid Disaster SPA:

Michelle Smith discussed the Medicaid Disaster SPA which was approved.
The SPA will allow COVID-19 testing both the nasal swab and the antibodies to uninsured individuals who are on Medicaid/CHIP. We are building the ability to accept applications through a portal for this new COVID-19 uninsured testing group. We have three different avenues where a member can apply for this coverage: eligibility portal hospitals, Medicaid Website, and COVID-19 testing site. Available June 1, 2020.

1135 Waiver:

On the 1135 Waiver, we continue to have discussions with CMS about some of the requests we made in the waiver. They tell us that at some point we will receive a letter from them letting us know which items have been approved, which ones are still on hold, or which ones that are not being approved. At this time, we have not received that letter, other than the initial letter which approved a handful of items similar to what they approved for other states.

Attachment K (HCBS):

Most of the request have been approved, we are moving forward on them.

Cares Act:

Funding to provide relief to provider groups from HHS distributing those funds to providers first through their Medicare Fee-for-Service volume. All States (Medicaid agencies) were asked to provide information on all payments made to providers for 18-19-year

old's, basically contact and direct deposit information for our providers, which we have passed onto CMS have sent to Health and Human Services (HHS). Another $20 Billion they plan on distributing to providers based on their Medicaid activity and to help cover the uninsured, those funds will go directly to the providers. CMS has been reluctant to approve additional payment arrangements through Medicaid to providers to help to mitigate the impact of COVID-19, until these other funds from the Cares Act have been distributed.

Public Hearing (1115 Waiver):

Next public hearing scheduled Tuesday, May 26th 4:30-5:30, Video Conference: Google Hangout Meeting (only works in the Chrome web browser meet.google.com/ctt-dxpy-nqc. Accept comments through online portal and email through June 17th

Other:

- Dr. Cosgrove: Governor's Early Childhood Commission. The Early Invention Program is having problem getting reimbursed for telephone visits rather than Telemedicine visits in their home visiting programs when they are trying to bill Medicaid.

Emma Chacon response: Emma had a conversation with Noel Taxin and pointed her to the Telemedicine guidance document that we have on our Medicaid website and reassured her that telephone only was acceptable and that provider group should submit those claims to Medicaid for payment.

Adjourn

Meeting was adjourned at 4:00 pm.

ATTACHMENT 4

Tribal Consultation

UTAH DEPARTMENT OF HEALTH MEDICAID

Utah Indian Health Advisory Board (UIHAB) Meeting

6/12/2020
8:30 AM –10 AM
Utah Department of Health
Salt Lake City, UT 84114
(801) 538-6771 or (801) 712-9346

Join with Google Meet
Meeting ID
meet.google.com/uwq-oeps-qzs

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Facilitator:	Melissa Zito **Meeting ID** **meet.google.com/uwq-oeps-qzs**
Note taker:	Dorrie Reese Call In **1-617-675-4444** passcode **2135005668460 #**
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM — **UIHAB Meeting**

Welcome & Introductions — Jessica Sutherland, Chair; Felecita FullBear, Vice Chair

8:40 AM — Committee Updates & Medicaid Waiver Presentation

- UT Medicaid Eligibility Policy SPA's Medicaid & CHIP — Jeff Nelson
- Medicaid Waivers — Jennifer Meyer-Smart
- Medicaid & CHIP State Plan Amendments (SPA) & Rules — Craig Devashrayee
- DWS Medicaid Eligibility Operations — Jacoy Richins
- MCAC & CHIP Advisory Committees — Mike Jensen & Ryan Ward
- COVID-19 Materials & Update — Melissa Zito
  UIHAB Retreat Updates
- GoodHealth TV update — Candace Muggerud
- Opioid Grant Update — Jeremy Taylor & Kassie John
  Materials Set for Printing

10:00 AM — Adjourn to join UDOH COVID-19 Coordination Call

Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/757833341

You can also dial in using your phone.
United States: +1 (408) 650-3123

Access Code: 757-833-341

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

Richard G. Saunders
Interim Executive Director

Division of Medicaid and Health Financing

Nate Checketts
Director, Division of Medicaid and Health Financing

December 30, 2020

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

Dear Administrator Verma:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the 1115 Primary Care Network (PCN) Demonstration Waiver. This amendment seeks approval to allow the State to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have one of the following conditions: Cystic fibrosis, spinal muscular atrophy, Morquio syndrome, myotonic dystrophy, or sickle cell anemia.

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

Respectfully,

Emma Chacon

Emma Chacon
Operations Director
Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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

Utah 1115 Primary Care Network Demonstration Waiver

Amendment Request

In Vitro Fertilization and Genetic Testing

for Qualified Conditions

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

Contents

State of Utah

Section 1115 Demonstration Amendment

In Vitro Fertilization and Genetic Testing for Qualified Conditions

Section I. Program Description and Objectives

During the 2020 General Session of the Utah State Legislature, House Bill 214 “Insurance Coverage Modifications'' was passed, and signed into law by Governor Herbert. This legislation requires the Utah Department of Health, Division of Medicaid and Health Financing (DMHF) to seek 1115 waiver approval from the Centers for Medicare and Medicaid Services (CMS) to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have specific qualified conditions. These qualified conditions include:

- Cystic fibrosis
- Spinal muscular atrophy
- Morquio syndrome
- Myotonic dystrophy
- Sickle cell anemia

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 this demonstration is likely to promote the objectives of Medicaid by improving health outcomes for Medicaid populations and reducing Medicaid costs to ensure the sustainability of Medicaid.

Providing these services will make it possible for Medicaid eligible individuals who have, or who carry serious inherited disorders to decrease the risk of passing the disorder on to their child.

Operation and Proposed Timeline

The demonstration will operate statewide. The State intends to implement the proposed benefit as soon as possible after approval. The State requests to operate the demonstration through the end of the current waiver approval period, which is June 30, 2022.

Demonstration Hypotheses and Evaluation

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

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

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
This demonstration will decrease Medicaid expenditures associated with the conditions identified in this demonstration	• Total Medicaid expenditures associated with these conditions	Claims data	Independent evaluator will design quantitative and qualitative measures to include experimental or quasi-experimental comparisons

Section II. Demonstration Eligibility

Individuals eligible under this demonstration must be Medicaid eligible individuals who meet all of the following requirements:

1. Be age 18 through 35
2. Has been diagnosed by a physician as having a genetic trait associated with a qualified condition listed below:
    a. Cystic fibrosis
    b. Spinal muscular atrophy
    c. Morquio Syndrome
    d. Myotonic dystrophy, or
    e. Sickle cell anemia; and,
3. Intends to get pregnant with a partner who has been diagnosed by a physician as having a genetic trait associated with the same qualified condition as the individual.

Projected Enrollment

The projected enrollment for the demonstration population is approximately 50 individuals per year.

Section III. Demonstration Benefits and Cost Sharing Requirements

If approved under this demonstration, qualified Medicaid members will be eligible to receive the following services:

1. Preimplantation genetic diagnosis to test embryos for specific genetic disorders prior to transfer to the uterus; and
2. In vitro fertilization services.

Qualified Medicaid members may receive these services once per lifetime.

Cost sharing requirements will not differ from those provided under the state plan.

Section IV. Delivery System

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

Section V. Enrollment in Demonstration

Eligible individuals will be enrolled in the demonstration as of the implementation date of this amendment.

Section VI. Demonstration Financing and Budget Neutrality

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

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

	DY20 (SFY 22)
Enrollment	50
Expenditures	$860,000

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authority to operate the demonstration.

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services provided to individuals in the demonstration group.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for the population affected by this demonstration.

Expenditure Authority

The State requests expenditure authority to provide in vitro fertilization and genetic testing services for qualified Medicaid members.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

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

Two public hearings to take public comment on this request were held. The first public hearing was held on December 14, 2020 from 4:00 p.m. to 5:00 p.m. The second public hearing was held on December 17, 2020 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. Due to

the COVID-19 public health emergency and state social distancing guidelines, both public hearings were held via video and teleconferencing. Two comments in support of this amendment were submitted during the public hearings. No issues or concerns were submitted.

Public Comment

The public comment period was held November 25, 2020 through December 25, 2020. No additional public comments were submitted during the public comment period.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, DMHF began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on December 11, 2020 to present this demonstration amendment. Members of the board expressed support for this amendment. No issues or concerns were raised.

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 IX. Demonstration Administration

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

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

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	$ 184.52	$ 194.30	
Total Expenditure					$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
Demo Pop I - PCN Childless Adults					*PCN ends 3/31/19*					
Pop Type:	**Medicaid**									
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure					$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	159	0		2.5%	163	167	171	176	180	
PMPM Cost	68.45	0		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					*Started 11/1/17*		*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**						*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		0	0	2.5%	78,000	78,000	$ 126,000	172,200	176,505	
PMPM Cost		0	$ -	5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure					$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults					*Started 3/1/19*		*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Pop Type:	**Expansion**									
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure					$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*			
Eligible Member Months		0			-		720	1,440	1,440	

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
PMPM Cost	5.3%	0		5.3%	$ -		$ 2,100.00	$2,211.30	$2,328.50	
Total Expenditure					$ -		$ 1,512,000	$ 3,184,272	$ 3,353,038	$ 8,049,310
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**							*Anticipated start date of 1/1/21*		
Eligible Member Months	2.5%	0			412,361	412,361	412,361	398,181	393,600	
PMPM Cost	5.3%	0			$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure					$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
							21.50674765			
Dental - Aged										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months	2.5%	0	108,000				54,000	156,300	160,208	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment										
Pop Type:	**Hypothetical**							*Anticipated start date of 1/1/21*		
Eligible Member Months	13.5%	0	126					63	143	
PMPM Cost	5.0%	0						$ 18,671.00	$ 19,606.55	
Total Expenditure					$ -	$ -	$ -	$ 1,176,273	$ 2,803,737	$ 3,980,010
Former Foster										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	24			10	10	10	10	10	
PMPM Cost	4.8%	24			$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure					$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)										
Pop Type:	**Hypothetical**									
Eligible Member Months	6.9%	18	36,913	6.9%	39,456.31	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Started 5/1/19*				
Eligible Member Months	0.0%	0	4,018	0.0%		670	4,018	4,018	4,018	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations										
Pop Type:	**Hypothetical**							*Assumes start date of 7/1/20*		
Eligible Member Months	1.75%		3,200	1.75%	-			38,400	39,072	
PMPM Cost	3.0%			3.0%	-		$ -	$ 520.00	$ 535.60	
Total Expenditure					-		$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)										
Pop Type:	**Hypothetical**							*Assumes start date of 1/1/21*		

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
Eligible Member Months	2.5%		16,835	2.5%	-			8,418	17,256	
PMPM Cost	5.3%			5.3%	-		$ -	$ 13,527	$ 14,244	
Total Expenditure					-		$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		339,828	2.5%		-	169,914	348,324	357,032	
PMPM Cost	5.3%			5.3%	$	-	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure					$	-	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		400,973	2.5%	-		200,487	410,997	421,272	
PMPM Cost	5.3%			5.3%	-		$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure					-		$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								10,292	10,832	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		121,473	5.25%		-	58,671	123,503	129,987	
PMPM Cost	5.3%			5.3%	$	-	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure					$	-	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								32,570	34,280	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		384,418	5.25%	-		185,674	390,844	411,363	
PMPM Cost	5.3%			5.3%	-		$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure					-		$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
										$ 6,584,798,337

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

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**								
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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						*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months			2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults									
Pop Type:	**Expansion**				*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months			2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Total Expenditure			$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	412,361	412,361	412,361	398,181	393,600	
PMPM Cost		3.0%	$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure			$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months		2.5%	-	-	54,000	156,300	160,208	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		13.5%	-	-	-	25	50	
PMPM Cost		5.0%	$ -	$ -	$ -	$ 18,671.00	$ 19,606.55	
Total Expenditure			$ -	$ -	$ -	$ 466,775	$ 980,328	$ 1,447,103
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/2021*		
Eligible Member Months		1.75%	-	-	-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/2021*		
Eligible Member Months		2.50%	-	-	-	8,418	17,256	
PMPM Cost		5.3%	-	-	-	$ 13,526.99	$ 14,243.92	
Total Expenditure				$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Expansion Parents <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure			$ -	$ -	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure			-	$ -	$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	$ -	$ -	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure			$ -	$ -	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	-	$ -	$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure			-	$ -	$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
								$ 6,584,798,337

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

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children				*PCN ends 3/31/19*					
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**								
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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
Former Targeted Adults						*Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding new managed care directed payments.* *PMPM will decrease due to removing the housing support benefit, and for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months			2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,281.14	$ 1,349.04	$ 1,420.54	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 155,909,778	$ 220,402,517	$ 237,885,946	$ 771,054,298
Dental - Targeted Adults									
Pop Type:	**Expansion**				*Started 3/1/19*				
Eligible Member Months			2.5%	-	12,000	18,450			
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 687,556	$ -	$ -	$ 1,087,556
System of Care									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	
Total Expenditure				$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled									

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	412,361	412,361	412,361	398,181	393,600	
PMPM Cost		3.0%	$ 18.42	$ 19.40	$ 20.42	$ 25.49	$ 34.10	
Total Expenditure			$ 7,595,690	$ 7,998,261	$ 8,422,169	$ 10,149,621	$ 13,420,241	$ 47,585,981
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*	*Anticipated start date of 1/1/21*		
Eligible Member Months		0%	-	-	54,000	156,300	160,208	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 5,060,955	$ 5,462,415	$ 12,183,870
IVF Treatment								
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/21*		
Eligible Member Months			-	-	-	25	50	
PMPM Cost			$ -	$ -	$ -	$ 18,671.00	$ 19,606.55	
Total Expenditure			$ -	$ -	$ -	$ 466,775	$ 980,328	$ 1,447,103
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2020*		
Eligible Member Months		1.75%	-		-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**					*Assumes start date of 71/2020*		
Eligible Member Months		2.50%	-	-	-	8,418	17,256	
PMPM Cost		5.30%	-	-	-	13,527	14,244	
Total Expenditure			$ -	$ -	$ -	$ 113,866,796	$ 245,798,558	$ 359,665,354
Expansion Parents <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 640.57	$ 674.52	$ 710.27	
Total Expenditure			$ -	$ -	$ 108,841,789	$ 234,951,327	$ 253,588,841	$ 597,381,956
Expansion Adults w/out Dependent Children <=100% FPL					*Assumes start date of 1/1/20*			

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 899.03	$ 946.68	$ 996.85	
Total Expenditure			-	$ -	$ 180,242,854	$ 389,081,237	$ 419,945,107	$ 989,269,198
Expansion Parents 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**							
Eligible Member Months		5.25%	-	-	53,048	111,667	117,529	
PMPM Cost		5.3%	$ -	$ -	$ 625.86	$ 659.03	$ 693.96	
Total Expenditure			$ -	$ -	$ 33,200,871	$ 73,591,888	$ 81,560,602	$ 188,353,362
Expansion Adults w/out Dependent Children 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		5.25%	-	-	167,879	353,386	371,939	
PMPM Cost		5.3%	-	$ -	$ 882.60	$ 929.37	$ 978.63	
Total Expenditure			-	$ -	$ 148,169,813	$ 328,428,021	$ 363,991,028	$ 840,588,862

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

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

Assumes start date of 7/1/20 (SFY21)

Anticipated start date of 1/1/21 (SFY21); increase in member months due to approx 7,600 clients moving over from Dental - Blind/Disabled; PMPM increase due to coverage of porcelains and crowns

Anticipated start date of 1/1/21 (SFY21); decrease in member months as 7,600 clients move out of Dental - Aged

ATTACHMENT 2

Public Notice Requirements

UTAH DEPARTMENT OF HEALTH MEDICAID

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject:	Medicaid
Notice Title:	Utah 1115 Waiver Amendment
Meeting Location:	Video/Teleconference Salt Lake City UT
Event Date & Time:	December 14, 2020 December 14, 2020 04:00 PM - December 14, 2020 05:00 PM
Description/Agenda:	PUBLIC NOTICE Utah 1115 Waiver Amendment The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss an amendment to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding the demonstration amendment during the 30-day public comment period from November 25, 2020, through December 25, 2020. The DMHF is requesting authority to implement provisions of House Bill 214 'Insurance Coverage Modifications', which passed during the 2020 Utah Legislative General Session. This amendment seeks approval from the Centers for Medicare and Medicaid Services (CMS) to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have specific qualified conditions. These qualified conditions include: Cystic fibrosis Spinal muscular atrophy Morquio Syndrome Myotonic dystrophy Sickle cell anemia Public Hearings: The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Due to the COVID-19 public health emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing. Monday, December 14, 2020, from 4:00 to 5:00 p.m. o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yqr-syem-wcz o Or join by phone: 1-904-580-8215 (PIN: 205 297 331#)

Thursday, December 17, 2020, from 2:00 to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting
o Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/ujg-crxv-utn

o Or join by phone: 1-513-816-0805 (PIN: 136 946 939 #)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4725 by 5:00 p.m. on Thursday, December 10, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from November 25, 2020, through December 25, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:	In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Jennifer Meyer-Smart at 385-215-4725.
Notice of Electronic or telephone participation:	Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yqr-syem-wcz Or join by phone: 1-904-580-8215 (PIN: 205 297 331#)
Other information:	
Contact Information:	Jennifer Meyer-Smart (801)538-6338 jmeyersmart@utah.gov
Posted on:	November 23, 2020 10:26 AM
Last edited on:	November 25, 2020 07:23 AM

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject:	Medicaid
Notice Title:	Utah 1115 Waiver Amendment
Meeting Location:	Video/Teleconference Salt Lake City UT
Event Date & Time:	December 17, 2020 December 17, 2020 02:00 PM - December 17, 2020 04:00 PM
Description/Agenda:	PUBLIC NOTICE Utah 1115 Waiver Amendment The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss an amendment to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding the demonstration amendment during the 30-day public comment period from November 25, 2020, through December 25, 2020. The DMHF is requesting authority to implement provisions of House Bill 214 'Insurance Coverage Modifications', which passed during the 2020 Utah Legislative General Session. This amendment seeks approval from the Centers for Medicare and Medicaid Services (CMS) to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have specific qualified conditions. These qualified conditions include: Cystic fibrosis Spinal muscular atrophy Morquio Syndrome Myotonic dystrophy Sickle cell anemia Public Hearings: The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Due to the COVID-19 public health emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing. Monday, December 14, 2020, from 4:00 to 5:00 p.m. o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yqr-syem-wcz o Or join by phone: 1-904-580-8215 (PIN: 205 297 331#) Thursday, December 17, 2020, from 2:00 to 4:00 p.m.,

during the Medical Care Advisory Committee (MCAC) meeting
o Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/ujg-crxv-utn

o Or join by phone: 1-513-816-0805 (PIN: 136 946 939 #)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4725 by 5:00 p.m. on Thursday, December 10, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from November 25, 2020, through December 25, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:	In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Jennifer Meyer-Smart at 385-215-4725.
Notice of Electronic or telephone participation:	Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ujg-crxv-utn Or join by phone: 1-513-816-0805 (PIN: 136 946 939 #)
Other information:	
Contact Information:	Jennifer Meyer-Smart (801)538-6338 jmeyersmart@utah.gov
Posted on:	November 23, 2020 01:06 PM
Last edited on:	November 25, 2020 07:22 AM

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

Deseret News

Utah Media Group

PROOF OF PUBLICATION **CUSTOMER'S COPY**

CUSTOMER NAME AND ADDRESS	ACCOUNT NUMBER
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME, CRAIG DEVASHRAYEE PO BOX 143102 SALT LAKE CITY UT 84114	9001406923
	DATE: 11/28/2020

ACCOUNT NAME

UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME,

TELEPHONE	ORDER # / INVOICE NUMBER
8015386641	0001304432 /

PUBLICATION SCHEDULE

START 11/25/2020 END 11/25/2020

CUSTOMER REFERENCE NUMBER

QAZ: 1115 Waiver Amendment

CAPTION

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

SIZE

75 LINES 2 COLUMN(S)

TIMES	TOTAL COST
3	257.00

PUBLIC NOTICE
Utah 1115 Waiver Amendment

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss an amendment to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding the demonstration amendment during the 30-day public comment period from November 25, 2020, through December 25, 2020.

The DMHF is requesting authority to implement provisions of House Bill 214 "Insurance Coverage Modifications", which passed during the 2020 Utah Legislative General Session. This amendment seeks approval from the Centers for Medicare and Medicaid Services (CMS) to provide in vitro fertilization services and genetic testing for Medicaid eligible individuals who have specific qualified conditions. These qualified conditions include:

- Cystic fibrosis
- Spinal muscular atrophy
- Morquio Syndrome
- Myotonic dystrophy
- Sickle cell anemia

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

- Monday, December 14, 2020, from 4:00 to 5:00 p.m.
- Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yqr-syem-wcz
- Or join by phone: 1-904-580-8215 (PIN: 205 297 331#)
- Thursday, December 17, 2020, from 2:00 to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting
- Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ujg-crxv-utn
- Or join by phone: 1-513-816-0805 (PIN: 136 946 939?#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4725 by 5:00 p.m. on Thursday, December 10, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from November 25, 2020, through December 25, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

1304432 UPAXLP

AFFIDAVIT OF PUBLICATION

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

PUBLISHED ON Start 11/25/2020 End 11/25/2020

DATE 11/28/2020

SIGNATURE Lud mundson

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 28TH DAY OF NOVEMBER IN THE YEAR 2020

BY LORAINE GUDMUNDSON.

LENEA TAPUSOA
NOTARY PUBLIC-STATE OF UTAH
COMMISSION# 712892
COMM. EXP. 07-06-2024

L Tapusoa

NOTARY PUBLIC SIGNATURE

ATTACHMENT 3

Medical Care Advisory Committee

Public Hearing

UTAH DEPARTMENT OF HEALTH

Medical Care Advisory Committee Agenda

Meeting:	Medical Care Advisory Committee
Date:	December 17, 2020
Start Time:	2:00 p.m.
End Time:	4:00 p.m.
Location:	Google Hangout Meeting (only works in the Chrome web browser)
	meet.google.com/ujg-crxv-utn
	Or join by phone 1-513-816-0805 PIN: 136 946 939#

Agenda

1.	Welcome • Approve Minutes for November 2020 MCAC*	Jessie Mandle	2:00 / 5 min
2.	Public Hearing on the 1115 Waiver Amendment for In Vitro Fertilization & Genetic Testing for Qualified Conditions**	Jennifer Meyer-Smart/ Members of the Public	2:05 / 10 min
3.	Update on Managed Care	Greg Trollan	2:15 / 10 min
4.	HEDIS and CAHPS Measures	Greg Trollan	2:25 / 20 min
5.	Vote on Updated MCAC By-laws* Update on MCAC Meeting Structure Subcommittee	Jessie Mandle	2:45 / 10 min
6.	Governor's Budget Update	Nate Checketts/ Emma Chacon	2:55 / 10 min
7.	Director's Report • COVID-19 Update • COVID Vaccine Update • Legislative Updates	Nate Checketts / Emma Chacon	3:05 / 20 min
8.	Eligibility Enrollment Update**	Jeff Nelson	3:25 / 10 min
9.	Medicaid Expansion Report**	Jennifer Meyer-Smart	3:35 / 10 min
10.	Rule Summary**	Craig Devashrayee	3:45 / 5 min

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

Next Meeting: January 21, 2020
2:00 p.m. – 4:00 p.m.

Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

ATTACHMENT 4

Tribal Consultation

UTAH DEPARTMENT OF HEALTH MEDICAID

Utah Indian Health Advisory Board (UIHAB) Meeting

12/11/2020
8:30 AM –11:30 AM

Utah Department of Health
Google Meeting Format Web Link:
meet.google.com/krh-kvdf-svj

Salt Lake City, UT 84114
(801) 712-9346

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Facilitator:	Melissa Zito
Note taker:	Dorrie Reese Call In: **1-617-675-4444 PIN: 760 419 415 5523#**
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM	**UIHAB Meeting** Welcome & Introductions	Jessica Sutherland, Chair Felecita FoolBear, Vice Chair
8:40 AM	Committee Updates & Discussion	
	▪ UT Medicaid Eligibility Policy SPA's Medicaid & CHIP	Jeff Nelson
	▪ Medicaid & CHIP State Plan Amendments (SPA) & Rules	Craig Devashrayee
	▪ DWS Medicaid Eligibility Operations	Jacoy Richins
	▪ DPS/DEM	Anna Boynton
	▪ Federal and State Health Policy Impacting I/T/U	Melissa Zito
	▪ MCAC & CHIP Advisory Committees	Mike Jensen & Ryan Ward
	▪ Opioid Grant Updates Resiliency/Graphics	Jeremy Taylor
9:30 AM	**Medicaid Presentations** ▪ Medicaid Fertility Waiver	Jennifer Meyer-Smart
10:00 AM	**Diabetes Prevention Program Project**	Candace Muggerud, CEO GoodHealth TV
10:20 AM	**Murdered & Missing Indigenous Women & Girls Task Force Update**	Tamara Borchardt-Slayton Chairwoman, PITU
10:40 AM	**Flu Vaccination Flyer/Poster**	Jeremy Taylor & Kassie John
10:50 AM	**UIHAB Representative Self Care & Stress Management** ▪ Mental Health Care Tips and Mindful Breathing Exercise ▪ Celebration of our success this year! (Stories)	Kristina Groves, LCSW, UICSL BH Pro. Dir, and Allyson Shaw, CSW, UICSL UIHAB
11:30 AM	**ADJOURN**	

State of Utah

GARY R. HERBERT
Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

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

Division of Medicaid and Health Financing

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

June 29, 2020

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

Dear Administrator Verma:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the 1115 Primary Care Network (PCN) Demonstration Waiver. This amendment is a result of House Bill 38 "Substance Use and Health Care Amendments", which passed during the 2020 General Session of the Utah State Legislature. Approval of this amendment will allow the State of Utah to provide Medicaid coverage for qualified justice-involved individuals in the 30-day period immediately prior to the release of the incarcerated individual from a correctional facility. To qualify, these justice-involved individuals must have a chronic physical or behavioral health condition, a mental illness as defined by Section 62A-15-602 of Utah State Code, or an opioid use disorder.

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

Respectfully,

Emma Chacon
Emma Chacon (Jun 26, 2020 16:12 MDT)

Emma Chacon
Operations Director
Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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

Utah 1115 Primary Care Network Demonstration Waiver

Amendment Request

Medicaid Coverage for Justice-Involved Populations

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

Contents

State of Utah
Section 1115 Demonstration Amendment
Medicaid Coverage for Justice-Involved Populations

Section I. Program Description and Objectives

As a result of the 2020 General Session of the Utah Legislative Session, House Bill 38 "Substance Use and Health Care Amendments", passed and was signed into law. This legislation directs 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 provide Medicaid coverage for qualified justice-involved individuals. These individuals must have a chronic physical or behavioral health condition, a mental illness as defined by Section 62A-15-602 of Utah State Code, or an opioid use disorder. If approved, Medicaid coverage will be provided in the 30-day period immediately prior to release of the incarcerated individual from a correctional facility.

Background

In October 2018, Congress passed the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "Support Act") in response to the imperative to implement concrete changes to address the opioid epidemic. Per the SUPPORT Act, Congress requires the Department of Health and Human Services (HHS) to convene a stakeholder group to develop best practices for ensuring continuity of coverage and relevant social services for individuals who are incarcerated and transitioning to the community. The legislation also directs HHS to work with states to develop innovative strategies to help such individuals enroll in Medicaid and to, within a year of enactment, issue a State Medicaid Director (SMD) letter regarding opportunities to design section 1115 demonstration projects to improve care transitions to the community for incarcerated individuals who are eligible for Medicaid. Utah is seeking to collaborate with HHS to develop an innovative demonstration that will help to ensure continuity of care when justice-involved populations transition from incarceration to the community and that could inform the development of the SMD letter required by the SUPPORT Act.

National data has shown that the justice-involved population contains a disproportionate number of persons with behavioral health conditions (i.e., substance use disorders and mental health disorders), as well as HIV and other chronic diseases. Nationally, an estimated 80 percent of individuals released from prison in the United States each year have a substance use disorder or chronic medical or psychiatric condition.[1] In 2011-2012, half of people in state and federal prison and local jails reported ever having a chronic condition. [2] Twenty one percent of people in prison and 14 percent of people in jail reported

[1] Shira Shavit et al., "Transitions Clinic Network: Challenges and Lessons in Primary Care for People Released from Prison," Health Affairs 36, no. 6 (June 2017): 1006–15

[2] L. Maruschak, M. Bersofsky, and J. Unangst. Medical Problems of State and Federal Prisoners and Jail Inmates. Bureau of Justice Statistics Special Report (NCJ 248491), U.S. Department of Justice, February 2015

ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases, compared with 4.8 percent of the general population.[3]

In addition, according to the Bureau of Justice Statistics, 53 percent of all state prisoners and 45 percent of all federal prisoners met the DSM-IV criteria for drug dependence.[4] Estimates for the jail population indicate 47 percent have issues with alcohol use and 53 percent suffer from drug dependency or abuse.[5]

The justice-involved population also suffers from mental and behavioral health issues. According to the Bureau of Justice Statistics, in 2005, 56 percent of people in state prison, 45 percent of people in federal prison, and 64 percent of people in jail reported symptoms of a mental health disorder. [6]

The available data in Utah mirrors federal statistics. In Utah, the rate of mental illness in jails is 30 percent, which is six times higher than the general public.[7] In a jail survey from Davis, Weber, Tooele and Washington Counties, all jails reported that the number of inmates with a serious mental illness had increased over the past two years, and the average percentage of inmates with a serious mental illness in the jails at the time of the survey was 28 percent.[8]

Utah data also indicates that nearly 49 percent of justice-involved individuals screened during the statewide risk and needs screening process indicated the need for further assessment for substance use disorder, and 40 percent needed further mental health assessment. Roughly one-third needed further assessment for both. [9]

Utah believes uninterrupted health coverage is imperative to ensure this high-risk, high-need population receives much needed care as they transition back to their communities. To help facilitate this transition, Utah implemented suspension of benefits for all Medicaid programs as of December 1, 2019. If it is reported that an individual is incarcerated, the State will suspend Medicaid benefits until the individual is no longer incarcerated. If approved, this specific demonstration will allow the State to supplement suspension of benefits, and more seamlessly transition incarcerated individuals to the appropriate Medicaid program during the 30-day period prior to release from incarceration.

---

[3] *Ibid*

[4] Mumola, C. and Karberg, J. Drug Use and Dependence, State and Federal Prisoners, 2004. Bureau of Justice Statistics Special Report (NCJ213530), U.S. Department of Justice, October 2006

[5] Karberg, K. C., James, D. J. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. Bureau of Justice Statistics Special Report (NCJ 209588), U.S. Department of Justice, July 2005.

[6] 2 James, D. and Glaze, L. Mental Health Problems of Prison and Jail Inmates. Bureau of Justice Statistics Special Report (NCJ 213600), U.S. Department of Justice, September 2006. Available at: http://www.bjs.gov/index.cfm?ty_pbdetail&iid_789

[7] Utah Commission on Criminal and Juvenile Justice. Mentally Ill Offender Initiative, September 2008.

[8] *Ibid*

[9] Peterson, B., Nystrom, S. and Weyland, D. Utah Justice Reinvestment Initiative 2017 Annual Report, October 2017.

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 this demonstration is likely to promote the objectives of Medicaid by providing transitional services in order to ensure high-risk justice-involved populations have critical supports in place when released from incarceration.

The goal and objective of this demonstration is to ensure high-risk justice-involved individuals receive needed coverage, access, and continuity of care prior to release. The State believes this will lead to a reduction in emergency department use, hospitalizations, and other medical expenses associated with release, as well as improvement in health outcomes. The State also believes it will promote continuity of Medication Assisted Treatment for individuals with an opioid use disorder, as well as continuity of antipsychotic medication for individuals receiving that pharmaceutical treatment.

Under this demonstration, the State will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release, thereby improving the chances individuals with a history of substance use, serious mental illness and/or chronic diseases receive stable and continuous care.

Operation and Proposed Timeline

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

Demonstration Hypotheses and Evaluation

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

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

By providing Medicaid coverage prior to an individual's release from incarceration, the State will be able to bridge relationships between community-based Medicaid providers and justice-involved populations prior to release thereby improving the chances individuals with a history of substance use, serious mental illness and/or chronic diseases receive stable and continuous care. The following hypotheses will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
This demonstration will promote continuity of Medication Assisted Treatment for individuals with an Opioid Use Disorder.	• Number of MAT prescriptions	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
This demonstration will promote continuity of Antipsychotic medication for individuals receiving that pharmaceutical treatment.	• Number of antipsychotic prescriptions	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

Table 1

Section II. Demonstration Eligibility

To be eligible for this demonstration an individual must be a "qualified inmate", which is defined as an individual who:

1. Is incarcerated in a correctional facility with 30 days or less before release; and has
    a. a chronic physical or behavioral health condition; or
    b. a mental illness as defined in Utah State Code Section 62A-15-602, which states:
        i. "Mental illness" means:
            (a) *a psychiatric disorder that substantially impairs an individual's mental, emotional, behavioral, or related functioning; or*
            (b) *the same as that term is defined in:*
            (i) the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or
            (ii) the current edition of the International Statistical Classification of Diseases and Related Health Problems; or
    c. an opioid use disorder.

Individuals deemed a "qualified inmate" will have eligibility determined for the appropriate Medicaid program for which they meet eligibility requirements. For example, if a "qualified inmate" meets the eligibility criteria for the Adult Expansion Medicaid program, they will receive this specific Medicaid program. Possible Medicaid programs include, but are not limited to:

- Aged Medicaid
- Blind or Disabled Medicaid
- Pregnant Woman
- Adult Expansion Medicaid

- Targeted Adult Medicaid
- Child Medicaid

A "qualified inmate" must meet general Medicaid program requirements. These include:

1. Must be a Utah resident;
2. Must be a U.S. Citizen or qualified alien;
    a. Non-qualified non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
3. Must meet the income and asset standards for the applicable Medicaid program.

The table below indicates estimates of the incarcerated population in the State of Utah that may be impacted by this demonstration.

Aggregate Site	Average Daily Population	Average Monthly Releases
Utah Department of Corrections (State Prison System)	6,500	300
Salt Lake County Jail	2,200	2,656
Total Statewide Jail System (includes Salt Lake County Jail)	5,700	6,852

Table 2

Section III. Demonstration Benefits and Cost Sharing Requirements

Individuals eligible under this demonstration will receive the benefit plan applicable to the program they are eligible to receive. Below are the benefit plans for each Medicaid program/group.

Eligibility Group	Benefit Package
Adults with Dependent Children	● Non-Traditional Benefits (see description below)
Adults without Dependent Children	● State Plan Benefits
Medically Frail	● Adults with Dependent Children normally receive non-traditional benefits, but may choose traditional state plan benefits
Targeted Adults	● State Plan Benefits ● State plan dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms & Conditions of the 1115 Demonstration Waiver)

	• 12-months continuous eligibility
Aged Medicaid	• State Plan Benefits, including Dental (as approved in the State's 1115 waiver)
Blind and Disabled Medicaid	• State Plan Benefits, including Dental (as approved in the State's 1115 waiver)
Child Medicaid	• State Plan Benefits, including Dental
Pregnant Woman	• State Plan Benefits, including Dental

Table 3

Non-Traditional Benefit Package

Adults with dependent children receive the State's non-traditional benefit package, authorized under the State's 1115 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 4 below.

Table 4- 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 requirements will not differ from those provided under the state plan. Individuals eligible for Targeted Adult Medicaid are exempt from cost sharing.

Section IV. Delivery System

Delivery of services will be determined by the Medicaid program the individual is eligible to receive.

Adult Expansion Medicaid

Services for the Adult Expansion Population will be provided through a fee for service (FFS) delivery system during the month of application and potentially the following month depending on the date of approval. In addition, Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the FFS network. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates. Adult Expansion beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. Individuals living in Utah's five largest counties will be enrolled in integrated plans that provide access to both physical health and behavioral health services through a single managed care entity. In the remaining counties, beneficiaries will be enrolled in a pre-paid mental health plan for their behavioral health services.

Targeted Adult Medicaid

Services for Targeted Adult Medicaid eligible individuals will be provided through the FFS delivery system.

All other Medicaid Programs

Services for other Medicaid programs will be provided through a fee for service (FFS) delivery system during the month of application and potentially the following month depending on the date of approval. Individuals living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid. Individuals living in non-mandatory counties may choose a managed care plan or may choose FFS. They will also be enrolled in a Pre-paid Mental Health Plan for their behavioral health services.

Section V. Implementation and Enrollment in Demonstration

The State intends to initially implement the demonstration with the Utah Department of Corrections (state prison system), as a process is already in place to process medical applications of state prison individuals within 30-days of their release date. There is also more certainty around release dates for these individuals, as well as existing data exchange agreements. The State will phase in the demonstration with county jails once processes and any needed agreements are put in place.

Upon release from incarceration, any changes to the individual's household situation must be reported. Any changes reported may require a re-determination of eligibility for the appropriate Medicaid program.

Section VI. Demonstration Financing and Budget Neutrality

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

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

Medicaid for Justice-Involved	DY 20 (SFY 22)
Enrollment	3,200
Expenditures	$19,900,000

Section VII. Proposed Waiver and Expenditure Authority

The State seeks such waiver authority as necessary under the demonstration to receive federal match on costs not otherwise matchable for services rendered to individuals who are incarcerated 30-days prior to their release. The specific additional waivers, if any that would be needed will be identified in collaboration with CMS.

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

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services provided to individuals in the demonstration group.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for the population affected by this demonstration.

Expenditure Authority

The State requests expenditure authority to provide Medicaid benefits to demonstration eligible individuals.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

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

Two public hearings to take public comment on this request were held. The first public hearing was held on May 21, 2020 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing was held on May 26, 2020 from 4:30 p.m. to 5:30 p.m. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings were held via video and teleconferencing. The MCAC meeting minutes can be found in Attachment 3.

No comments were provided during the public hearings. However, three individuals asked questions regarding benefits for Adult Expansion beneficiaries, the effective date of the amendment, and budget concerns due to the COVID-19 emergency. The questions asked did not require any changes to the amendment.

Public Comment

The public comment period was held May 18, 2020 through June 17, 2020. No public comments were submitted to the State.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions impacting Indian Tribes in the State of Utah. DMHF notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, DMHF began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on June 12, 2020 to present this demonstration amendment. No feedback or concerns were provided. Members of UIHAB voiced support for this amendment. The UIHAB meeting agenda can be found in Attachment 4.

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 IX. Demonstration Administration

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

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

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	$ 184.52	$ 194.30	
Total Expenditure					$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
Demo Pop I - PCN Childless Adults						*PCN ends 3/31/19*				
Pop Type:	**Medicaid**									
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure					$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	159	0		2.5%	163	167	171	176	180	
PMPM Cost	68.45	0		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							*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**				*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		0	0	2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost		0	$ -	5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure					$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults										
Pop Type:	**Expansion**					*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure					$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*			
Eligible Member Months		0			-		720	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	$ -		$ 2,100.00	$2,211.30	$2,328.50	
Total Expenditure					$ -		$ 1,512,000	$ 3,184,272	$ 3,353,038	$ 8,049,310
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure					$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*			
Eligible Member Months	2.5%	0	108,000				54,000	110,700	113,468	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
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**									
Eligible Member Months	6.9%	18	36,913	6.9%	39,456.31	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Started 5/1/19*				
Eligible Member Months	0.0%	0	4,018	0.0%		670	4,018	4,018	4,018	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations										
Pop Type:	**Hypothetical**							*Assumes start date of 7/1/21*		
Eligible Member Months	1.75%		3,200	1.75%	-			38,400	39,072	
PMPM Cost	3.0%			3.0%	-		$ -	$ 520.00	$ 535.60	
Total Expenditure					-		$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Expansion Parents <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		339,828	2.5%	-		169,914	348,324	357,032	
PMPM Cost	5.3%			5.3%	$ -		$ 671.61	$ 707.21	$ 744.69	
Total Expenditure					$ -		$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL										
Pop Type:	**Expansion**						*Assumes start date of 1/1/20*			
Eligible Member Months	2.5%		400,973	2.5%	-		200,487	410,997	421,272	
PMPM Cost	5.3%			5.3%	-		$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure					-		$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								10,292	10,832	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		121,473	5.25%	-		58,671	123,503	129,987	
PMPM Cost	5.3%			5.3%	$ -		$ 656.90	$ 691.72	$ 728.38	
Total Expenditure					$ -		$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								32,570	34,280	
Pop Type:	**Expansion**						*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months	5.25%		384,418	5.25%	-		185,674	390,844	411,363	
PMPM Cost	5.3%			5.3%	-		$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure					-		$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715

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

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

Assumes start date of 7/1/21 (SFY21)

$ 6,574,468,745

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$	949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$	46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure				$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**								
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$	150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure				$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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						*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**			*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months			2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults									
Pop Type:	**Expansion**				*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months			2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost			5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure				$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care									
Pop Type:	**Hypothetical**					*Anticipated start date of 1/1/20*			
Eligible Member Months				-		720	1,440	1,440	
PMPM Cost			5.3%	$ -		2,100	2,211	2,328	
Total Expenditure				$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled									
Pop Type:	**Hypothetical**								
Eligible Member Months			0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost			3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure				$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*			
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**					*Assumes start date of 7/1/2021*		
Eligible Member Months		1.75%	-	-	-	38,400	39,072	
PMPM Cost		3.0%	-	$ -	$ -	$ 520.00	$ 535.60	
Total Expenditure				$ -	$ -	$ 19,968,000	$ 20,926,963	$ 40,894,963
Expansion Parents <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure			$ -	$ -	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure			-	$ -	$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	$ -	$ -	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure			$ -	$ -	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	-	$ -	$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure			-	$ -	$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
								$ 6,574,468,745

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

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

Assumes start date of 7/1/2021 (SFY21)

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles			*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure			$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children				*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**							
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure			$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure			$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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
Former Targeted Adults					*Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility.*			
					PMPM will increase due to adding new managed care directed payments.			
Pop Type:	**Expansion**		*Started 11/1/17*		*PMPM will decrease due to removing the housing support benefit, and for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost		5.3%	$ 979.53	$ 1,031.45	$ 1,281.14	$ 1,349.04	$ 1,420.54	
Total Expenditure			$ 76,403,340	$ 80,452,717	$ 155,909,778	$ 220,402,517	$ 237,885,946	$ 771,054,298
Dental - Targeted Adults				*Started 3/1/19*				
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	12,000	18,450			
PMPM Cost		5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure			$ -	$ 400,000	$ 687,556	$ -	$ -	$ 1,087,556
System of Care					*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**							
Eligible Member Months			-		720	1,440	1,440	
PMPM Cost		5.3%	$ -		2,100	2,211	2,328	
Total Expenditure			$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure			$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged					*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
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

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

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

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

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

Assumes start date of 7/1/2021 (SFY21)

ATTACHMENT 2

Public Notice Requirements

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

Deseret Nev

PROOF OF PUBLICATION **CUSTOMER'S COPY**

CUSTOMER NAME AND ADDRESS	ACCOUN
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME, CRAIG DEVASHRAYEE PO BOX 143102 SALT LAKE CITY UT 84114	9001

ACCOUNT NAME
UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURS

TELEPHONE	ORDER # / INVOICE
8015386641	0001290028 /

PUBLICATION SCHEDULE
START 05/18/2020 END 05/18/2020

CUSTOMER REFERENCE NUMBER
QAZ: Amendments to Utah 1115 Waiver

CAPTION
PUBLIC NOTICE Utah 1115 Waiver Amendments The Utah Department of

SIZE		
68	LINES	3 COLUMN(S)

TIMES	TOTAL COST
3	347.72

Utah

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 "Substance Use and Health Care Amendments" and House Bill 436 "Health and Human Services Amendments", which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)
- This amendment will allow the State to provide Medicaid coverage to "qualified inmates" for up to 30 days before release from a correctional facility.
- A "qualified inmate" is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)
- This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.
- If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendments. The dates and times are listed below. Due to the COVID-19 emergency and state social distancing guidelines, both public hearings will be held via video and teleconferencing.
- Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.
  - o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv
  - o Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)
- Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.
  - o Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc
  - o Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

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

1290028 UPAXLP

AFFIDAVIT OF PUBLICATION

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

PUBLISHED ON Start 05/18/2020 End 05/18/2020

DATE 5/21/2020 SIGNATURE LTapusoa

STATE OF UTAH)

COUNTY OF SALT LAKE)

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 21ST DAY OF MAY IN THE YEAR 2020

BY LENEA TAPUSOA.

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

LGudmundson
NOTARY PUBLIC SIGNATURE

Department of Health:
Medicaid Expansion Workgroup

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendments

Notice Type: Notice, Meeting

Event Start Date & Time: May 21, 2020 02:00 PM

Event End Date & Time: May 21, 2020 04:00 PM

Description/Agenda:

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 'Substance Use and Health Care Amendments' and House Bill 436 'Health and Human Services Amendments', which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)

This amendment will allow the State to provide Medicaid coverage to 'qualified inmates' for up to 30 days before release from a correctional facility.

A 'qualified inmate' is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)

This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.

If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:

Meeting Location:

Video Conference
Salt Lake City , 84116

Map this!

Contact Information:

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

Audio File Address

Subscription Options

Subscription options will send you alerts regarding future notices posted by this Body.

E-mail

Options

Add this notice to calendar
Printer Friendly
Email this to a Friend

Connect

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

Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/kyj-yrbk-cvv

Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.
Video Conference: Google Hangout Meeting (only works in the Chrome web browser)
meet.google.com/ctt-dxpy-nqc

Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:

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

Notice of Electronic or telephone participation:

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Other Information

This notice was posted on: May 18, 2020 02:50 PM
This notice was last edited on: May 18, 2020 03:09 PM
Deadline Date: May 21, 2020 04:00 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

Department of Health:
Medicaid Expansion Workgroup

Entity: Department of Health

Body: Medicaid Expansion Workgroup

Subject: Medicaid Health Care

Notice Title: Utah 1115 Waiver Amendments

Notice Type: Notice, Meeting

Event Start Date & Time: May 26, 2020 04:30 PM

Event End Date & Time: May 26, 2020 05:30 PM

Description/Agenda:

PUBLIC NOTICE
Utah 1115 Waiver Amendments

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020, through June 17, 2020.

DMHF is requesting authority to implement provisions of House Bill 38 'Substance Use and Health Care Amendments' and House Bill 436 'Health and Human Services Amendments', which passed during the 2020 Utah Legislative Session. The amendment requests include the following provisions:

Medicaid Coverage for Justice-Involved Populations (HB 38)

This amendment will allow the State to provide Medicaid coverage to 'qualified inmates' for up to 30 days before release from a correctional facility.

A 'qualified inmate' is an individual who is incarcerated in a correctional facility and has a chronic physical or behavioral health condition, a mental illness as defined in Utah State Code Section 62A-15-602, or an opioid use disorder.

Utah's Premium Partnership for Health Insurance (UPP) Premium Reimbursement Increase (HB 436)

This amendment request will allow the State to increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enrollee per month, to a higher amount through the state administrative rulemaking process, rather than by waiver amendment.

If approved, initially the maximum UPP reimbursement amount for adults will be $300 per enrollee per month.

Public Hearings:

Meeting Location:

Video Conference
Salt Lake City , 84116

Map this!

Contact Information:

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

Audio File Address

Subscription Options

Subscription options will send you alerts regarding future notices posted by this Body.

E-mail

Options

Add this notice to calendar
Printer Friendly
Email this to a Friend

Connect

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

Thursday, May 21, 2020, from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/kyj-yrbk-cvv

Or join by phone: 1-413-233-4024 (PIN: 746 045 310#)

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m.

Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc

Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at jmeyersmart@utah.gov or 385-215-4735 by 5:00 p.m. on Monday, May 18, 2020.

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 18, 2020, through June 17, 2020.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

Notice of Special Accommodations:

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

Notice of Electronic or telephone participation:

Tuesday, May 26, 2020, from 4:30 p.m. to 5:30 p.m. Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/ctt-dxpy-nqc Or join by phone: 1-318-612-0038 (PIN: 268 779 416#)

Other Information

This notice was posted on: May 18, 2020 02:59 PM
This notice was last edited on: May 18, 2020 03:06 PM
Deadline Date: May 26, 2020 05:30 PM

Board/Committee Contacts

Member	Email	Phone

Please give us feedback

ATTACHMENT 3

Medical Care Advisory Committee

Public Hearing

Medical Care Advisory Committee

Minutes of May 21, 2020

Participants

Committee Members (via phone)

Dr. William Cosgrove (Chair), Jessie Mandle (Vice Chair) Jenifer Lloyd, Christine Evans, Muris Prses on behalf of Dale Ownby, Brian Monsen, Adam Cohen, Dr. Robert Baird, Stephanie Burdick, Mark Ward on behalf of Michael Hales, Pete Ziegler, Mike Jensen, Ginger Phillips on behalf of Adam Montgomery, and Mary Kuzel

Committee Members Absent

Sara Carbajal-Salisbury, Joey Hanna, Mark Brasher, Gina Tuttle, and Danny Harris.

DOH Staff (via phone)

Nate Checketts, Emma Chacon, Tonya Hales, Brian Roach, Michelle Smith, Jennifer Meyer-Smart, Craig Devashrayee, Krisann Bacon, , Greg Trollan, Dave Lewis, Kim Michelson, Sheila Walsh-McDonald, Tracy Barkley, Joel Hoffman, Jorge Fuentes, Sharon Steigerwalt, and Dorrie Reese.

Guest (via phone)

Allison Hefferman, Andrew Riggle, Dan Schuring, Daniel Cheung, Dave Gessel, David Killen, , Jeannie Peters, Joni Nebeker, Julie Ewing, Kelli Peterson, Leanne Peters, Matt Hansen , Matthew Mulligan, Randal Serr, Robert Felix, Russ Elbel, Rylee Curtis, Sattia Chozo Gonzales, Scott Horne, Scott Titensor, Stacy Standford, Todd Wood, Tracey Meeks, Tracy Wagner, and Val Radmall

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

Jennifer Meyer-Smart discussed the Public Hearing for 1115 Waiver Amendment.

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss amendments to the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding these demonstration amendments during the 30-day public comment period from May 18, 2020 through June 17, 2020.

With this waiver amendment, DMHF is requesting authority to:

- Provide Medicaid coverage to an individual who is incarcerated in a correctional facility, has a chronic physical, or behavioral health condition; a mental illness, or an opioid use disorder
- Increase the maximum UPP reimbursement amount for adults (age 19 through 64), from $150 per enroll per month, to $300 per enroll per month, if approved. We estimate approximate 210 UPP eligible adults would receive this benefit per month.

The document which was presented is embedded in this document

Utah 1115-Abbrv Public Notice-Justice I

Public Hearing Overview-UPP-Justice

Public Comment:

- Mark Ward asked a question: How does this square with the resolution the legislation passed asking agencies to curtail spending especially for the new and expansion items in light of the lending COVID-19 budget shortfall?

Emma Chacon response: We realize that this may not go forward, because of the action of the Executive Appropriations Committee, but the final decision has not been made, that resolution advised agencies that they should approach their to plan for their Fiscal year 2021 budget to be the same as their fiscal year 2020 budgets. If it turns out through the special session that all the funding for specific bills are rescinded then we won't go forward submitting these waivers to CMS, or if it has already been submitted than we will withdrawal it. But in the event that funding is not rescinded for any reason we will be ready to move forward.

- Ginger Phillips who is filling in for Adam Montgomery asked question: On the 1115 Waiver, people qualifying on adult expansion who are incarcerated in the jail or prison which one of those will receive dental services?

Emma Chacon response: Currently, the adult expansion members do not have a dental benefit with the exception of 19-20-year olds under the EPSDT.

- Gina Evans, Salt Lake County emailed question: Does the waiver for the criminal justice population start July 1, 2020, the handout states January 1, 2021?

Emma Chacon response: The bill directs the state to submit a waiver by July 1, 2020. We indicated a January 1, 2021 start because we are hoping that CMS will approve this waiver amendment by that date. The effective date is the date this waiver gets approved then we will need some lead time to change systems in order to get this up and running. This date could change if we receive a faster approval date or this date could be pushed out beyond January 1, 2021if CMS approval is delayed.

- Dr. Cosgrove asked a question: Emma can you clarify the start date if the waiver goes through for the Utah Premium Partnership?

Emma Chacon response: That would go into effect the first or second month after CMS approval.

Approval of Minutes

Dr. Robert Baird made the motion to approve the April 16, 2020 MCAC minutes. The group unanimously agreed.

New Rulemakings Information Rules/SPAs – Craig Devashrayee:

Craig Devashrayee discussed Rules/SPAs.

- R414-506: Hospital Provider Assessments (Five-Year Review)
- R414-60-5: Limitations
- R414-40: Private duty Nursing Service (Five-Year Review)
- R414-401-3: Assessment
- R414-506: Hospital Provider Assessments
- R414-517: Inpatient Hospital Provider Assessments
- R414-523: Medicaid Expansion Hospital Provider Assessments
- 20-0006-UT: COVID-19 Emergency Disaster Relief
- 20-0007-UT: Quality Improvement Incentives
- 20-0009-UT: Disaster Relief Testing Locations

The documents which were presented are embedded in this document

MCAC Rule Summary 5-21-20.pdf

MCAC SPA Summary 5-21-20.pdf

Comments:

- Mark Ward has a question on R414-523: Medicaid Expansion Hospital Provider Assessment- The statutory reference listed here 26-36b says that chapter for July 1,2020, you can only do a hospital assessment if the sales tax and savings offset aren't sufficient to pay the cost of the Medicaid expansion. Has the Department of Health conducted any kind of analysis or estimate to make that determination that those resources are not adequate?

Emma Chacon response: No the purpose of putting forth the rule is to outline the operational aspect of this assessment. We do not intend to implement this assessment in FY2020 or FY 2021. As Craig has said the 7/1/2020 date is the earliest possible effective date, let us take this back and look into this further.

- Dave Gessel: I am trying to understand that rule, and Mark makes a good point that this does not kick into effect until all the money of the sales tax are gone. Have you been directed by the legislature or have you done this on your own?

Emma Chacon response: The rule? . We have not been directed by the legislature. I think this rule needs some clarification to say that it would not go into effect until it meets that criteria in the statute, we will amend that rule to make it clear.

- Dave Gessel: Just a quick question on the earlier assessments adding the penalties, I thought we had that in the statute or rule for a long time are you changing the penalties or amount that hospitals pay their assessments late, or is this kind of cleanup language that references whatever the normal penalties you already have?

Emma Chacon response: We have similar language in other provider assessment rules. Since we don't have this in rule for this assessment, we are not charging penalties. Currently we only have authority to put a hold on claims payments until the assessment payment is made. This is an attempt to make all our assessment rules consistent.

- Mark Ward: Technical question on the form the total fiscal benefit describes on the $24M, which includes $12M to State Government and $12M to other person that double counts the fiscal benefit that would be derived from this, because State Government would receive $12M additional, but the other person would receive the same amount whether it would pass inactive or not.

- Craig Devashrayee response: That was a broad figure that we used.

- Mark Ward: It would only be true if there was a plan to make a cut in that program that was going to replace the hospital assessment. Then the other persons would receive the $12M that otherwise would not receive.

- Emma Chacon response: Craig will make note of that, and he will follow-up with Mark Ward.

- Mark Ward: Note that what hospitals are doing supporting public health response to the coronavirus by setting up testing sites, clearing unit for COVID-19 patients, delaying visits, and elective procedures until we have protective equipment, capacity for COVID-19 patients. We are still in the middle of that response. With potential of re-opening and with the flu season, to have a surge later on. I am wondering how future tax increase supports the hospitals while they are in the middle of that response at a great expense and loss revenue that this results from?

Emma Chacon response: Mark I don't have an answer for your question, duly noted the point that you are making. We will take it back for further discussion.

- Stephanie Burdick: Do we have any information on how Utah compares to other states when it comes to how much hospital assessments? Are they requiring hospitals to contribute in comparison?

Emma Chacon response: We could probably do that, it would take some time, just as others are being impacted by everything that is going on right now, so are we. We can see whether NAMD (National Association of State Medicaid Directors) group might already have that information that we can try to access. Every state financing structure for their programs are a little bit different. We will see what we can do. We will certainly see if that information is out there, and if we can get our hands on it to share with the group. It will be interesting for us to see that information as well.

Eligibility Enrollment Update – Michelle Smith/Muris Prses:

Michelle Smith and Muris Prses gave a presentation from both DOH and DWS regarding eligibility: The impact eligibility has had from the downturn of the economy, changes to the system to comply with the families first act/not closing cases, etc. and DWS application process timeframe, backlog?

The document which was presented is embedded in this document.


Medicaid Trends.pdf


MCAC Data.pptx

Medicaid Expansion Report – Jennifer Meyer-Smart:

Jennifer Meyer-Smart gave an update on the Medicaid Expansion Report.

The document which was presented is embedded in this document.


Expansion Report

ACO's Outreach Campaign – Brian Monsen

Brian Monsen gave an update on the ACOs Outreach Campaign program. The campaign goes through the end of May.

Legislative Updates & Appropriations – Emma Chacon:

Emma Chacon gave an update on the Legislative bills and appropriations.

Executive Appropriations met and voted to reverse all additional appropriations that were not in the base budget bill. In addition agencies were asked to identify 2%, 5% and 10% reductions to their budgets. The budget deficit for state fiscal year 2012 is between $587 million and 1.2billion. . There has been discussion legislative fiscal analyst. We have made a conceded effort to identify areas where we are already having policy changes in the works that will save money.

Next week, Tuesday, May 26th at 1:00 and on Friday, May 29th at 8:00 Social Service Committee meeting that is when they will look at all of the proposed cuts for the Department of Workforce Services, Department of Human Services, and the Department of Health.

During the first week of June another Medicaid Consensus meeting will take place to consider the impact of COVID-19 and the downturn of the economy on the Medicaid enrollment

Sometime in June there will be a special session to address any changes to appropriations for fiscal year 2021 which starts July 1, 2020. State agencies have been asked to look at 2%, 5% and 10% reductions. The maintenance of effort requirement to receive enhanced federal financial participation, limits what type of cuts that the state can make. We cannot make any changes to eligibility requirements or benefits that were in place as of January 1, 2020

Director's Report

COVID-19: - Nate Checketts

Nate Checketts discussed COVID-19. The State is moving forward with different risks levels, between orange and yellow, as we look at the COVID-19 moving forward, our numbers have been level over the past couple weeks. As you look at the number of new cases what you are seeing hospitalization and other areas. We are obviously moving into two different phases across the State of relaxing stay at home requirements and moving to less restrictive requirements where we will be watching the data very carefully for number of positive tests that are coming back with the number of cases we are finding. There are metrics built in these proposals as we move forward there are certain things move that will trigger flags if the cases start to climb again. There's a hope that across the State as we move to warmer times and people are spending more time outdoors that the state can relax at the overall rules that we are asking people to comply with. Overall the State has not had a high level of infection across these last couple of months. As we look at the return of the flu season in the fall, we have heard that it is likely less than 5% of Utahns have been infected to date with the COVID virus, so as we come back to another potential infection 95% have not been infected.

One of the initiatives we are pursuing is to provide additional training and testing at the Nursing Facilities and Long-Term Care facilities. Although we've have had a significant number of deaths of individuals who reside in nursing facilities, the overall death total for the state is low. We think there is some additional work we can do there. Our Healthcare Associate infection team is going out and doing training at those facilities, another group is doing training on the appropriate use of personal protective equipment (PPE), and making sure facilities understand the best way to respond to an outbreak in their facilities.

We have pulled in staff from other areas in the Department to work specifically on the COVID response. Many of those staff will need to transition back to their previous position at some point.

Medicaid Disaster SPA:

Michelle Smith discussed the Medicaid Disaster SPA which was approved.
The SPA will allow COVID-19 testing both the nasal swab and the antibodies to uninsured individuals who are on Medicaid/CHIP. We are building the ability to accept applications through a portal for this new COVID-19 uninsured testing group. We have three different avenues where a member can apply for this coverage: eligibility portal hospitals, Medicaid Website, and COVID-19 testing site. Available June 1, 2020.

1135 Waiver:

On the 1135 Waiver, we continue to have discussions with CMS about some of the requests we made in the waiver. They tell us that at some point we will receive a letter from them letting us know which items have been approved, which ones are still on hold, or which ones that are not being approved. At this time, we have not received that letter, other than the initial letter which approved a handful of items similar to what they approved for other states.

Attachment K (HCBS):

Most of the request have been approved, we are moving forward on them.

Cares Act:

Funding to provide relief to provider groups from HHS distributing those funds to providers first through their Medicare Fee-for-Service volume. All States (Medicaid agencies) were asked to provide information on all payments made to providers for 18-19-year

old's, basically contact and direct deposit information for our providers, which we have passed onto CMS have sent to Health and Human Services (HHS). Another $20 Billion they plan on distributing to providers based on their Medicaid activity and to help cover the uninsured, those funds will go directly to the providers. CMS has been reluctant to approve additional payment arrangements through Medicaid to providers to help to mitigate the impact of COVID-19, until these other funds from the Cares Act have been distributed.

Public Hearing (1115 Waiver):

Next public hearing scheduled Tuesday, May 26th 4:30-5:30, Video Conference: Google Hangout Meeting (only works in the Chrome web browser meet.google.com/ctt-dxpy-nqc. Accept comments through online portal and email through June 17th

Other:

- Dr. Cosgrove: Governor's Early Childhood Commission. The Early Invention Program is having problem getting reimbursed for telephone visits rather than Telemedicine visits in their home visiting programs when they are trying to bill Medicaid.

Emma Chacon response: Emma had a conversation with Noel Taxin and pointed her to the Telemedicine guidance document that we have on our Medicaid website and reassured her that telephone only was acceptable and that provider group should submit those claims to Medicaid for payment.

Adjourn

Meeting was adjourned at 4:00 pm.

ATTACHMENT 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

6/12/2020
8:30 AM –10 AM
Utah Department of Health
Salt Lake City, UT 84114
(801) 538-6771 or (801) 712-9346

Join with Google Meet
Meeting ID
meet.google.com/uwq-oeps-qzs

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Facilitator:	Melissa Zito **Meeting ID** **meet.google.com/uwq-oeps-qzs**
Note taker:	Dorrie Reese Call In **1-617-675-4444** passcode **2135005668460 #**
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM — **UIHAB Meeting**

Welcome & Introductions — Jessica Sutherland, Chair; Felecita FullBear, Vice Chair

8:40 AM — Committee Updates & Medicaid Waiver Presentation

- UT Medicaid Eligibility Policy SPA's Medicaid & CHIP — Jeff Nelson
- Medicaid Waivers — Jennifer Meyer-Smart
- Medicaid & CHIP State Plan Amendments (SPA) & Rules — Craig Devashrayee
- DWS Medicaid Eligibility Operations — Jacoy Richins
- MCAC & CHIP Advisory Committees — Mike Jensen & Ryan Ward
- COVID-19 Materials & Update — Melissa Zito
  UIHAB Retreat Updates
- GoodHealth TV update — Candace Muggerud
- Opioid Grant Update — Jeremy Taylor & Kassie John
  Materials Set for Printing

10:00 AM — Adjourn to join UDOH COVID-19 Coordination Call

Please join my meeting from your computer, tablet or smartphone.
https://global.gotomeeting.com/join/757833341

You can also dial in using your phone.
United States: +1 (408) 650-3123

Access Code: 757-833-341

STATE OF UTAH

GARY R. HERBERT
GOVERNOR

OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

SPENCER J. COX
LIEUTENANT GOVERNOR

November 1, 2019

Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Azar:

My State has worked over many years to develop a Medicaid expansion proposal that would cover adults in the Affordable Care Act (ACA) coverage gap while providing financial protections for the State so that Medicaid expenditures are not allowed to monopolize and cannibalize other important social service spending. I appreciated your suggestions and guidance when we met in Washington earlier this year. Therefore, I am pleased to submit the State of Utah's request for an amendment to its 1115 demonstration waiver. This waiver amendment is a result of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 General Session of the Utah State Legislature.

This waiver request seeks to provide 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 the State have a balanced budget and 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 and other infrastructure, public health and other social services, law enforcement and public safety, along with general government operations all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's General Fund expenditures as a share of General Fund revenues 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 included additional adults with dependent children and adults without dependent children historically not 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 as a share of available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a reliable long term funding source for the program absent additional budgetary flexibilities. 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.
On July 27, 2019, the Centers for Medicare and Medicaid Services (CMS) released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely that you will use your authority at this time to allow enhanced funding for an expansion that includes an enrollment cap, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

First, the landscape regarding Medicaid expansion may change. Most notably, the U.S. Court of Appeals for the 5th Circuit will be issuing a decision in the *Texas v. U.S.*, litigation challenging the ACA. Comments attributed to administration officials in news articles regarding CMS's

position on partial expansion and enrollment caps seem to tie this administration's position to a hope that *Texas v. U.S.* will overturn the ACA. However, as shown by the Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012), court decisions are not entirely predictable. Therefore, in light of the possibility that the legal situation regarding the ACA may change (or may not) in the near future, the State is submitting its entire request for your review.

Second, the State's waiver request contains many other program features beyond the request for enhanced match for expansion with an enrollment cap. The State believes the other components of its waiver request can be approved and are important to operating an efficient and effective Medicaid Expansion program.

This waiver request includes the following proposals for Utah's Medicaid Expansion:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including Adult Expansion and Targeted Adult Populations
- Lock-out from the Medicaid Expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports for groups within Medicaid Expansion
- Not allowing hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a $10 surcharge for each non-emergent use of the emergency department after having received a warning for inappropriate use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP).

The State is also requesting to continue the following components for the Adult Expansion demonstration group, which are currently authorized under the State's 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

The State of Utah appreciates your consideration of this waiver request. The State has worked with CMS for over a year on specific expansion proposals seeking to find areas where the federal government and the State are aligned in their visions for Medicaid Expansion. Earlier this year, Utah invested a significant amount of time and energy in pursuit of a Per Capita Cap waiver. CMS ultimately rejected that request which pushed the State to this "Fallback" waiver request. We are now again in the position of submitting another waiver request seeking your approval to operate Medicaid Expansion in an efficient and effective manner. It is time for CMS to approve the State's requests and allow the State to begin receiving enhanced match for this coverage; therefore, we are seeking approval of this request by December 31, 2019. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Expansion program.

Respectfully,

Gary R. Herbert

Gary R. Herbert
Governor

Utah 1115 Demonstration Waiver Amendment

November 1, 2019

Contents

Utah Section 1115 Demonstration Waiver

Amendment

Medicaid Expansion

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 to seek 1115 waiver approval from the Centers for Medicare and Medicaid Services (CMS) to implement specific proposals. Some of these proposals were approved by CMS on March 29, 2019, as part of the State's "Bridge Plan" for Medicaid expansion.

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

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL), to 133 percent FPL, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including the Adult Expansion demonstration group and the Targeted Adult demonstration group
- Lock-out from the Medicaid expansion for committing an intentional program violation
- Federal expenditure authority to provide housing related services and supports (HRSS) for groups within Medicaid Expansion
- Not allow hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a $10 surcharge for each non-emergent use of the emergency department after having received a warning for inappropriate use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid.
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP)

The State is also requesting to continue the following components for the Adult Expansion demonstration group which are currently authorized under the State's 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance (ESI) to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

The proposals included in this request will apply to the Medicaid Expansion population described in Section II. "Program Overview and Demonstration Eligibility" below, unless otherwise noted. With this application, the State is requesting the authority to operate a Medicaid Expansion program consisting of both the Targeted Adult demonstration group and the Adult Expansion demonstration group.

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 provisions 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 ESI by encouraging community engagement and providing premium reimbursement for ESI plans
- Providing continuity of coverage for individuals

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 housing supports and services, while encouraging individuals to obtain or sustain employment.

B. Operation and Proposed Timeframe

The Demonstration will operate statewide. The State intends to implement the Demonstration effective January 1, 2020.

Section II. Program Overview and Demonstration Eligibility

A. Approved Demonstration Populations and Components

As stated above, the State is requesting approval to continue the following components and programs with this amendment for the expanded Adult Expansion demonstration group, which are currently authorized under the State's 1115 Demonstration Waiver.

1. Community Engagement through a Self Sufficiency Requirement

With this waiver amendment, the State proposes to continue to administer the community engagement requirement for individuals eligible for the Adult Expansion demonstration group. The community engagement requirement was originally approved for this population, as part of the expansion authorized in the March 29, 2019 amendment to the State's 1115 Demonstration Waiver. The community engagement requirement applies to Adult Expansion beneficiaries who do not 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 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 those individuals required to 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 other 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 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 the 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 ;

[1] Karsten 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.

6. A member of a federally recognized tribe;

7. Has applied for and is awaiting an eligibility determination for unemployment insurance benefits, or is currently receiving unemployment insurance benefits, and has registered for work at the Department of Workforce Services (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 or do not show good cause 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 access 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 the provision of support services necessary to participate is unavailable, where participation is otherwise 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 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.

2. Enrollment Limits

As directed by Senate Bill 96, the State requests to continue to apply enrollment limits to the Adult Expansion and Targeted Adult Populations under this amendment. Enrollment limits for these populations are currently approved under the State's 1115 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 suspended, 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 Medicaid Expansion, eligibility will be denied. The State will not maintain 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 suspended 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 Medicaid Expansion at the time enrollment is suspended will remain enrolled.

3. ESI Reimbursement

As approved on March 29, 2019, under the State's 1115 Demonstration waiver, the State proposes to require individuals who are eligible for the Adult Expansion demonstration group, and have access to ESI, to purchase their ESI plan. 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. The State requests flexibility to exempt certain groups from disenrollment if they fail to enroll. Under the authority granted to the State through this waiver, the State will implement this closure policy through its administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes to exempt certain income groups from the ESI requirement.

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. Under the authority granted to the State through this waiver, 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 qualified plan would likely follow similar criteria to that already established through state administrative rule for the 1115 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.

Exemption

Members of federally recognized tribes will be exempt from the requirement to purchase ESI coverage. However, if they choose to enroll in a qualified ESI health plan, they may be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified plan

Impact to Beneficiaries

The State estimates that approximately 14,000-19,000 individuals under this demonstration will be eligible for an ESI plan and will enroll in that plan. The State estimates 100-200 members per year will lose Medicaid eligibility due to failure to enroll in ESI coverage.

4. Early and Periodic Screening, Diagnostic, and Treatment

Through the State's 1115 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 Populations. The State requests to continue this authority for these populations.

B. New Demonstration Waiver Requests

As stated previously, with this amendment the State is seeking approval to implement the following proposals as directed by Senate Bill 96.

1. Income Limit Increase for Adult Expansion Population

The State proposes to increase the income limit from 95 percent FPL, to 133 percent FPL for the Adult Expansion Population, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion, which includes both the Adult Expansion and the Targeted Adult demonstration groups. If the allowable enhanced FMAP is ever reduced to below 90 percent, the State will sunset the Adult Expansion demonstration group no later than July 1 after the date on which the FMAP is reduced.

The Adult Expansion Population is defined as individuals who 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
- Not pregnant

- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 133 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
- Not enrolled in the Targeted Adult demonstration group
- Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.

As a result of expanding the Adult Expansion demonstration group to individuals with household income up to 133 percent FPL, the State will change the income range for demonstration populations III, V and Current Eligible CHIP Children (referred to as Utah's Premium Partnership for Health Insurance or UPP). The income range criteria for the UPP program will change to; household income above 133 percent through 200 percent FPL.

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 entire Medicaid Expansion, including both the Adult Expansion and Targeted Adults populations.

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 determined by a district court as a result of a 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 UDOH to claim undue hardship.
    b. UDOH must receive verification of the reason the undue hardship exists.
    c. UDOH will make the determination of whether to grant a hardship exemption.
    d. If a hardship exemption is granted, UDOH 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 Medicaid Expansion if enrollment is suspended. The individual will have to wait for an open enrollment period to become eligible again for Medicaid Expansion. However, they may apply and have eligibility determined for other Medicaid programs for which they may be eligible.

Impact to Beneficiaries

The implementation of this proposal may cause approximately 750 individuals per year to lose eligibility for six-months as a result of committing an IPV. The State anticipates this may deter individuals from committing an IPV. Currently, the State does not impose a lock-out as a result of committing an IPV for any Medicaid program.

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 Medicaid Expansion. 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 (HRSS)

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 Medicaid Expansion.

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 Medicaid Expansion. Under the authority granted to the State through this waiver, 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. 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 to provide these evidence-based services and supports to the Targeted Adult Population. The State's efforts to reduce barriers that impact individuals' health will focus on providing HRSS to eligible populations. Participation in HRSS will be voluntary. Individuals' ongoing need for HRSS will be verified every six months.

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. Services include:

    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

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

Eligibility Criteria for HRSS		
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 1

2. The following table identifies populations eligible for individual HRSS.

Populations Eligible for Individual HRSS		
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 1	All individuals must meet at least one of the needs-based criteria identified in Table 1	All individuals must meet at least one of the needs-based criteria identified in Table1

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 2

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

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.,***

[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.

2016, p. 21). 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 HRSS 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 HRSS 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

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. 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 Medicaid Expansion. 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

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 500-750 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. Approximately 54 percent of individuals approved for hospital presumptive eligibility are ultimately approved for ongoing Medicaid.

5. Targeted Adult Medicaid Eligibility Definitions

With this amendment, the State is requesting to expand its eligibility criteria definitions for two of the Targeted Adult subgroups. This will allow the State to increase the number of individuals who are eligible for the Targeted Adult Population, allowing more individuals to receive the additional benefits of 12-months continuous eligibility (and dental benefits if they are actively receiving substance use disorder treatment).

Currently, individuals must meet the following criteria to be eligible for the Targeted Adult Population:

- 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.

With this amendment, the State proposes to add or change the following for each subgroup below:

- Chronically Homeless subgroup:
    - Add “an individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter”.
    - Move the following group from the subgroup “Needing substance abuse or mental health treatment” to the “Chronically Homeless” subgroup; “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”.
- Involved in the justice system and in need of substance use or mental health treatment subgroup:
    - Add “an individual who is court ordered to receive substance abuse or mental health treatment through a district court or Tribal court”.
    - Add “an individual on probation or parole with serious mental illness and/or serious substance use disorder”.

The State currently has authority through its 1115 Demonstration Waiver to suspend enrollment for the three subgroups of the Targeted Adult Population. Under the authority granted to the State through this waiver, the State is requesting the ability to suspend enrollment for the subsets within the three subgroups (ie. individuals living in supportive housing, individuals receiving General Assistance, etc.) through its administrative

rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. 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. If enrollment is suspended for a specific subgroup, the State will develop a transition plan to move individuals currently eligible for the specific Targeted Adult Population subgroup to the Adult Expansion Population.

Impact to Beneficiaries

The State estimates an additional 7,000 individuals will become eligible for Targeted Adult Medicaid by expanding the criteria.

6. Flexibility to Make Changes through the State Administrative Rulemaking Process

Under the authority granted to the State through this waiver, the State requests the ability to make the changes listed below for the Medicaid Expansion through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

These changes include the following:

- Begin enrollment the first of the month after application for Adult Expansion beneficiaries with income over 100 percent FPL (prospective enrollment)

  Impact to beneficiaries - The State estimates one month out of twelve will be removed from a beneficiary's eligibility span. This would reduce total beneficiary months by 8.3% for this group.

- Not allow retroactive eligibility for Adult Expansion beneficiaries with income over 100 percent FPL

  Impact to beneficiaries - The State estimates a reduction of 1.4% beneficiary months for this group due to not allowing retroactive eligibility.

- Change the benefit package for Adult Expansion and Targeted Adult demonstration groups (excluding medically frail) to the State's non-traditional benefit package

  Impact to beneficiaries - The State estimates a reduction in demonstration expenditures for the Adults without Dependent Children and Targeted Adults equaling $8.06 per beneficiary per month.

- Exempt certain groups from the ESI requirement

  Impact to beneficiaries - The State estimates that 50% of beneficiaries with access to employer-sponsored insurance will not enroll in that insurance if exempted from the requirement.

- Suspend housing supports

  Impact to beneficiaries - The State estimates a reduction in demonstration expenditures for Targeted Adults equaling $234.56 per beneficiary per month. The State also estimates a reduction in demonstration expenditures for Adult Expansion equaling $31.04 per beneficiary per month.

- Make enrollment in an integrated plan or other managed care mandatory or optional for different adult expansion groups

  Impact to beneficiaries - The State estimates no difference in enrollment or cost due to this change.

- Open or suspend enrollment for each population group within Targeted Adult Medicaid

  Impact to beneficiaries - Beneficiaries formerly enrolled in the Targeted Adult demonstration will no longer have access to 12-month continuous eligibility. The State estimates this will reduce total beneficiary months by 5.4%. Beneficiaries formerly enrolled in the Targeted Adult demonstration who also had a substance use disorder will lose access to dental benefits. Currently there are approximately 250 beneficiaries accessing the dental benefit.

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 3 below, during the Demonstration period:

Table 3 - Waiver Hypotheses

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
Medicaid 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	• Number of prescriptions	Claims/encounter data	Independent evaluator will design quantitative and qualitative

individuals by increasing access to primary care and improving appropriate utilization of emergency department (ED) services by the Medicaid Expansion Population.	● Number of non-emergent ED visits ● Number of cancer screenings ● Number of well-care visits		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 individuals in enrolling in ESI plans in a cost effective manner.	● Overall cost of care for ESI-enrolled individuals compared to comparable non-ESI enrollees.	Claims/encounter data	Independent evaluator will design quantitative and qualitative 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	● Number of prescriptions	Claims/encounter data	Independent evaluator will design quantitative

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 non-emergent ED visits ● Number of cancer screenings ● Number of well-care visits		and qualitative measures to include quasi-experimental comparisons
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	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
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- eREP Eligibility System 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
Not Allowing Presumptive Eligibility			
The demonstration will allow individuals to enroll retroactively covering unforeseen hospital expenses at a rate equivalent to hospital presumptive eligibility pre-demonstration.	● Pre-demonstration, proportion of enrollees enrolling through hospital presumptive eligibility plus retroactive enrollment. ● Post demonstration, proportion of enrollees enrolling through retroactive enrollment.	Medicaid Data Warehouse eRep Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Premiums			
Individuals sharing in the total cost of care by paying premiums will access preventive services at a rate equivalent or greater than individuals who do not pay premiums.	● 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
Non-emergent Use of the Emergency Room			

Charging a surcharge for this service will decrease inappropriate use of the emergency room without impacting other health measures	● Number of prescriptions ● Number of non-emergent ED visits ● Number of cancer screenings ● Number of well-care visit	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

The State will test the following hypothesis if the relevant provisions of the waiver are activated by the State.

Prospective Enrollment			
The implementation of the proposal will generate cost savings over the term of the waiver.	● Average cost per member in month of application for comparison group ● Average cost per member in the first three eligible months after application for demonstration group and comparison group	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	● 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
Elimination of Retroactive Eligibility			
The implementation of the proposal will generate cost savings over the term of the waiver.	● Average cost per member in retro months prior to application for comparison group ● Average cost per member in the	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

	first three eligible months after application for demonstration group and comparison group		
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	● 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

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 4 below. Note that the housing related supports and services will be available to specific waiver populations, as outlined in the "Housing Related Supports and Services" section above.

Table 4- Eligibility Group and Benefit Package

Eligibility Group	Benefit Package
Adults with Dependent Children	● Non-Traditional Benefits (see description below)
Adults without Dependent Children	● State Plan Benefits
ESI Eligible Adults with Dependent Children	● Premium Reimbursement with Non-Traditional Benefit Wrap-around
ESI Eligible Adults without Dependent Children	● Premium Reimbursement with State Plan Benefit Wrap-around
Medically Frail	● Adults with Dependent Children normally receive non-traditional benefits, but may choose traditional state plan benefits
Targeted Adults	● State Plan Benefits ● State plan dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special

	Terms & Conditions of the 1115 Demonstration Waiver) ● 12-months continuous eligibility
Housing Related Services and Supports for Individuals Meeting Needs Based Criteria	● Tenancy Support Services ● Community Transition Services ● Supportive Living/Housing Services

Non-Traditional Benefit Package

Adults with dependent children will receive the State's non-traditional benefit package, authorized under the State's 1115 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 5 below.

Table 5- 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.

Medically Frail

As stated above, Adult Expansion beneficiaries will receive either traditional state plan Medicaid benefits if they do not have a dependent child living in the home, or they will receive non-traditional Medicaid benefits if they do have a dependent child living in the home. However, if an Adult Expansion beneficiary with a dependent child at home is identified as medically frail, as defined by 42 CFR 440.315, they may choose between traditional state plan Medicaid benefits or non-traditional Medicaid benefits, as authorized under the State's 1115 Demonstration Waiver.

An individual is medically frail, as defined by 42 CFR 440.315, if the individual has a:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
- Disability determination based on Social Security criteria

Premiums

With this amendment, the State is proposing to implement monthly premiums for individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL. Monthly premiums will be set at the following amounts regardless of household size or household income.

- $20 per month for a single individual
- $30 per month for a married couple

Under the authority granted to the State through this waiver, the State requests the ability to raise these premium amounts to mirror annual increases in the federal poverty level through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

Premiums will not be charged for the month of application or any months of retroactive coverage. Premiums must be paid in the month prior to the month of eligibility to avoid disenrollment. Failure to pay the required premium will result in loss of eligibility for Adult Expansion Medicaid.

Premium Exemptions

The following individuals are exempt from paying premiums:

- Individuals with verified membership in a federally recognized tribe
- Individuals identified as medically frail, as described in 42 CFR 440.315

Individuals who receive ESI reimbursements will have premiums deducted from their ESI reimbursement amount.

The total of the individual's or couple's premium amount and any applicable copayments will not exceed 5 percent of the household's income, per 42 CFR 447.56(f).

Payment of Past Due Premiums after Losing Eligibility

Individuals who have been disenrolled for failure to pay premiums will be required to pay any past due premiums in order to reinstate Medicaid. However, if it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

Impact to Beneficiaries

The State estimates approximately 40,000 individuals will be required to pay a monthly premium to receive Adult Expansion Medicaid. Based on other State's experiences with premiums, the State estimates approximately three percent of these individuals will lose eligibility due to failure to pay the monthly premium.

Surcharge for Non-Emergent Use of the Emergency Department

In order to discourage inappropriate use of the emergency department, Utah is proposing to apply a surcharge directly to the individual's premium, rather than increasing the copay for non-emergent use of the emergency department as originally suggested in the draft waiver proposal released in September 2019. Because emergency room copays are implemented as a reimbursement decrease to hospitals and it is unclear whether or not hospitals would collect these enhanced copays from individuals, the State determined that a premium surcharge for inappropriate use of the emergency room would be a better way to implement this provision. The State is proposing a $10 surcharge for each non-emergent use of the emergency department, up to a maximum of $30 per quarter, per individual. This surcharge will only apply to individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL.

After the State identifies the first occurrence of non-emergent use of the emergency department, the individual will be sent notification regarding improper use. They will be informed that improper use has occurred, provided with education on appropriate usage of the emergency department, and notified of the

surcharges that will follow if improper use continues. They will be informed that future non-emergent visits to the emergency department will incur a $10 surcharge (up to a maximum of $30 per quarter, per individual).

If a future inappropriate visit is identified, a $10 surcharge per occurrence will be added to their premium amount with their next premium invoice. They will again receive notification of their improper use of the emergency department, as well as education on how to correctly utilize their Medicaid benefits.

All notices sent to the individual will include the right to appeal the surcharge. All hearings in regards to the surcharge will be conducted by the UDOH administrative law judges, rather than the Department of Workforce Services eligibility hearing officers.

Individuals with five or more occurrences of non-emergent use of the emergency department within the most recent twelve months will be referred to the Medicaid Restriction Program. The Restriction Program may take additional action, including limitations on where an individual may receive services. This restriction process is already in place for Medicaid members today.

Surcharge Exemptions:

This surcharge will not apply to the following:

1. An individual identified as medically frail
2. An individual receiving ESI reimbursement
3. A member of a federally recognized tribe

If an individual's eligibility ends or the individual moves to another program, the surcharge will be forgiven after 90 days. If the eligibility is ended for failure to pay premiums, the member must pay any outstanding premiums including any surcharges, before eligibility may be re-established.

Impact to Beneficiaries

The State estimates approximately 1,500 to 2,000 individuals per month will be required to pay a surcharge for non-emergent use of the emergency department.

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 the Adult Expansion Population will be provided through FFS during the month of application and potentially the following month depending on the date of approval. In addition, Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the FFS network. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

Adult Expansion beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. In addition, in Utah's five 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. In the remaining counties, beneficiaries will be enrolled in a pre-paid mental health plan for their behavioral health services.

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 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 ninety (90) days prior to the contract /rate period. 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 its managed care contracts for the populations covered under this waiver. The State will submit its initial contract to CMS for review and approval ninety (90) days prior to the contract /rate period. 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 ninety (90) days prior to the contract /rate period. 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 enrolled in the Adult Expansion Population under Utah's 1115 Demonstration waiver will remain as the Adult Expansion Population under the new demonstration. These 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 ESI Reimbursement

As approved in the March 29, 2019, amendment to Utah's 1115 Demonstration waiver, Adult Expansion beneficiaries that 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.

Individuals Currently Enrolled in the Federal Marketplace

When the State has expanded to 133 percent of FPL, individuals enrolled in Federal Marketplace coverage will need to request a Medicaid determination through the Federal Marketplace or apply directly with the State for Medicaid coverage. Individuals enrolled in the Federal Marketplace at that time will not be automatically moved or assessed for Medicaid eligibility until their coverage is renewed, the individual requests a Medicaid determination, or applies directly with the State. Once eligible for Medicaid the individual should terminate their marketplace plan within 30 days.

Until such time that the Federal Marketplace can update their systems to automate the assessment of Utah eligibility standards and transfer accounts to the State directly, Utahns applying for health coverage through the Federal Marketplace will also have to apply directly for Medicaid with the State. Once the federal system changes have been made, new marketplace applicants may be assessed as eligible for Medicaid and their applications will be automatically referred to the State for processing eligibility.

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 6 shows the projected demonstration enrollees in each demonstration year (DY). These enrollment projections include members in the demonstrations included in this amendment.

Enrollment	**DY 18[4]**	**DY 19**	**DY 20**
Targeted Adults	14,000	14,350	14,709
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	9,779	10,292	10,832
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	30,946	32,570	34,280
Annual Total	**116,458**	**120,489**	**124,680**

Table 6

Table 7 shows the projected demonstration expenditures in each demonstration year (DY). These amounts are calculated by applying the estimated per member per month estimates in the Budget Neutrality attachment to the enrollment figures from Table 6.

Expenditures (Total Fund)	**DY 18[5]**	**DY 19**	**DY 20**
Targeted Adults	$127,914,000	$276,122,000	$298,026,000
Expansion Parents up to 100% FPL	$114,116,000	$246,336,000	$265,877,000

[4]Reflects anticipated average enrollment January 2020 through June 2020

[5] Reflects anticipated total expenditures January 2020 through June 2020

Expansion Parents above 100% FPL up to 133% FPL	$38,541,000	$85,430,000	$94,680,000
Expansion Adults without Children up to 100% FPL	$187,889,000	$405,586,000	$437,759,000
Expansion Adults without Children above 100% FPL up to 133% FPL	$170,956,000	$378,934,000	$419,966,000
Annual Total	**$639,416,000**	**$1,392,408,000**	**$1,516,308,000**

Table 7

Table 8 shows the projected enrollees under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

Enrollment	**DY 18[6]**	**DY 19**	**DY 20**
Former Targeted Adults	13,283	13,615	13,955
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	8,841	9,306	9,794
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	27,980	29,449	30,995
Annual Total	**111,837**	**115,647**	**119,603**

Table 8

Table 9 shows the projected expenditures under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

Expenditures (Total Fund)	**DY 18[7]**	**DY 19**	**DY 20**
Targeted Adults	$102,102,000	$220,403,000	$237,886,000
Expansion Parents up to 100% FPL	$108,842,000	$234,951,000	$253,589,000
Expansion Parents above 100% FPL up to 133% FPL	$33,201,000	$73,592,000	$81,561,000
Expansion Adults without Children up to 100% FPL	$180,244,000	$389,083,000	$419,947,000
Expansion Adults without Children above 100% FPL up to 133% FPL	$148,170,000	$328,428,000	$363,991,000
Annual Total	**$572,559,000**	**$1,246,457,000**	**$1,356,974,000**

Table 9

Section VIII. Proposed Waivers and Expenditure Authorities

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

[6]Reflects anticipated average enrollment January 2020 through June 2020

[7] Reflects anticipated total expenditures January 2020 through June 2020

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 Medicaid Expansion 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 Medicaid Expansion beneficiaries compared to the benefits available to individuals eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration in order to provide 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)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	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. 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.
Section 1902(a)(14) insofar as it incorporates Sections 1916 and 1916A	To the extent necessary to enable the State to require monthly premiums for individuals in the Adult Expansion Population who have household income above 100 up to and including 133 percent of the FPL.

Table 10

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

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

The State certifies that two public hearings to take public comment on this request were held. The first public hearing was held on October 7, 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. The second public hearing was held on October 10, 2019, from 2:00 p.m. to 4:00 p.m. during the Medical Care Advisory Committee (MCAC) meeting, at the Cannon Health Building located at 288 N 1460 W, Salt Lake City, UT. Telephonic conferencing was available for both public hearings.

Public Comment

The State accepted public comment during a 30-day public comment period, which was held September 27, 2019 through October 27, 2019. The State received comments from 99 individuals and agencies. This includes comments provided during both public hearings, email and online portal comments, and mailed comments. The State reviewed and considered all public comments received.

The majority of commenters did not agree with the State's request to implement most components of the amendment. They expressed concerns with the impacts of the following proposals, including; intentional program violation lock-out, community engagement requirement, enrollment limits, waiving the EPSDT requirement for 19 and 20 year olds, and not allowing hospitals to make presumptive eligibility determinations. They believe these components will lead to a loss of coverage for individuals who would otherwise be eligible for Medicaid benefits or assistance, if not for these provisions.

Commenters were generally supportive of providing housing supports and services.

Commenters also expressed concerns regarding the State's proposed hypotheses for evaluating and monitoring the demonstration. They believed the proposed waiver hypotheses and evaluation framework fail to address the impact of several significant risks and potential changes to Utah's Medicaid program. In response to this concern, the State will work with the independent evaluator with whom the State contracts, to refine or possibly amend the proposed hypotheses, and to develop an evaluation plan. The State has also committed to engage the MCAC in the evaluation process.

In response to concerns regarding the $25 copay for non-emergent use of the emergency department, the State is removing this request from the amendment. However, the State is proposing to apply a $10 surcharge per occurrence to the individual's premium amount (up to a maximum of $30 per quarter, per individual), for individuals who improperly use the emergency department. Information regarding this proposal can be found in section IV.

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. The State notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, the State began the tribal consultation process by attending the Utah Indian Health Affairs Board (UIHAB) meeting on October 11, 2019, to present this demonstration amendment.

The Navajo Nation submitted a letter during the public comment period that contained several concerns and requests. They are as follows:

Tribal Consultation

The Navajo Nation states that the Tribal consultation with the Tribal Leaders is occurring in November, after the waiver is submitted.

Response: As stated above, 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. Tribal Consultation policy can be found at http://health.utah.gov/indianh/pdfs/2017ConsultationPolicy.pdf. The State complied with the consultation policy in developing this waiver request. The State began the Tribal consultation process by presenting an overview of the waiver amendment to the UIHAB on October 11, 2019. After reviewing this proposal with the UIHAB and answering questions, Nate Checketts, Utah Medicaid Director, offered to provide additional Tribal consultation prior to the anticipated submission date at the end of October 2019. It was explained that the public comment period and waiver submission date do not always align with Tribal meetings. Members of the UIHAB gave no indication that additional consultation was needed prior to waiver submission. The UIHAB moved to have Nate Checketts participate in a Tribal Leader meeting on November 8th to present the waiver amendment. Nate Checketts agreed to participate in this meeting.

Exemption Requests

The Navajo Nation recommends the requested exemption for members of a federally recognized Tribe from the community engagement requirement, enrollment limit, and ESI requirement, also apply to all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

Response: During the State's discussion with CMS regarding allowing an exemption, it was brought to the State's attention that the Office of Civil Rights has concerns with the exemption applying to all AI/AN persons, as it could raise civil rights concerns. This concern was also stated in a CMS letter to Tribal Leaders dated January 17, 2018. Based on this, the State proposed allowing the exemption for members of federally recognized tribes, which CMS has found to be consistent with the tribes' status as political entities. This request was approved by CMS for the community engagement requirement. As such, the State is requesting this same exemption apply to the request for an enrollment limit and the ESI requirement.

Increase in Income Limit

The Navajo Nation recommends the increase to 138 percent at a minimum, but should further increase to 200 percent FPL, and it should apply for all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

Response: Under the Affordable Care Act, the State can only increase the income to 133 percent of the FPL, which the State intends to do. Senate Bill 96 also limits the FPL that UDOH can request in this waiver.

Housing Related Services and Supports (HRSS)
The Navajo Nation recommends clarity of the rulemaking process and any changes should not be at the expense of other services approved and proposed in the amendment for the targeted adult group.

Response: Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all Medicaid rulemaking during the monthly UIHAB meeting, as well as the MCAC, which are both open to the public.

Targeted Adult Medicaid Subgroups
The Navajo Nation recommends continuous coverage for 12 months; however, they oppose the ability for the state to suspend enrollment.

Response: The State currently has approval to suspend enrollment for Targeted Adult Medicaid. The State is requesting to continue this authority, and to apply this authority to the individual subgroups. If an individual is ineligible for the Targeted Adult Medicaid program due to enrollment being suspended, eligibility for Adult Expansion Medicaid will be determined.

Flexibility to Make Changes through the State Administrative Rulemaking Process
The Navajo Nation recommends the state to conduct timely and proper Tribal Consultation to Tribal leaders in Utah. They recommend the State remove these provisions prior to submission to CMS.

Response: The State intends to follow the consultation process during the rulemaking process for any policy changes. This is currently the State's process, and this will continue.

Managed Care Delivery:
The Navajo Nation recommends an exemption for federally recognized Tribes regardless of where the beneficiaries reside and it should apply to all AI/AN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Navajos commute between non-mandatory and mandatory counties; therefore, increasing access to ACOs and/or non-ACOs is recommended based on existing health care access challenges.

Response: Services provided at an I/T/U are exempt (carved out) from managed care. All services provided by an I/T/U are billed directly to State Medicaid. An AI/AN individual can be enrolled in managed care and still receive services at an I/T/U. The I/T/U does not have to be on an ACOs network,

Tribal Consultation Policy
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

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

ATTACHMENT 1

Compliance with Budget Neutrality Requirements

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	$ 184.52	$ 194.30	
Total Expenditure					$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
Demo Pop I - PCN Childless Adults						*PCN ends 3/31/19*				
Pop Type:	**Medicaid**									
Eligible Member Months		0		2.5%	73,812	58,293	-	-	-	
PMPM Cost		0		5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure					$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	159	0		2.5%	163	167	171	176	180	
PMPM Cost	68.45	0		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							*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**				*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		0	0	2.5%	78,000	78,000	$ 126,000	172,200	176,505	
PMPM Cost		0	$ -	5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure					$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults										
Pop Type:	**Expansion**					*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Eligible Member Months		0		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost	5.3%	0		5.3%	$ -	$33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure					$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*			
Eligible Member Months		0			-		720	1,440	1,440	
PMPM Cost	5.3%	0		5.3%	$ -		$ 2,100.00	$2,211.30	$2,328.50	
Total Expenditure					$ -		$ 1,512,000	$ 3,184,272	$ 3,353,038	$ 8,049,310
Dental - Blind/Disabled										
Pop Type:	**Hypothetical**									
Eligible Member Months	0.0%	0			412,361	412,361	412,361	412,361	412,361	
PMPM Cost	3.0%	0			$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure					$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged										
Pop Type:	**Hypothetical**						*Anticipated start date of 1/1/20*			
Eligible Member Months	2.5%	0	108,000				54,000	110,700	113,468	
PMPM Cost	5.3%	0					$ 30.75	$ 32.38	$ 34.10	
Total Expenditure					$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
Former Foster										
Pop Type:	**Hypothetical**									

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

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

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

$ 6,533,573,782

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles			*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure			$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children				*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**							
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure			$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure			$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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					*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*			
Pop Type:	**Expansion**		*Started 11/1/17*		*PMPM will increase due to adding the housing support benefit and new managed care directed payments*			
Eligible Member Months		2.5%	78,000	78,000	126,000	172,200	176,505	
PMPM Cost		5.3%	$ 979.53	$ 1,031.45	$ 1,522.79	$ 1,603.50	$ 1,688.48	
Total Expenditure			$ 76,403,340	$ 80,452,717	$ 191,871,540	$ 276,122,333	$ 298,025,737	$ 922,875,668
Dental - Targeted Adults				*Started 3/1/19*	*Porcelain crowns anticipated start date of 1/1/20 increases PMPM*			
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	12,000	36,900	37,823	38,768	
PMPM Cost		5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure			$ -	$ 400,000	$ 1,375,111	$ 1,484,192	$ 1,601,925	$ 4,861,228
System of Care					*Anticipated start date of 1/1/20*			
Pop Type:	**Hypothetical**							
Eligible Member Months			-		720	1,440	1,440	
PMPM Cost		5.3%	$ -		2,100	2,211	2,328	
Total Expenditure			$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure			$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged								

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*			
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Expansion Parents <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 671.61	$ 707.21	$ 744.69	
Total Expenditure			$ -	$ -	$ 114,115,918	$ 246,336,326	$ 265,876,956	$ 626,329,200
Expansion Adults w/out Dependent Children <=100% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 937.16	$ 986.83	$ 1,039.13	
Total Expenditure			-	$ -	$ 187,887,968	$ 405,584,361	$ 437,757,341	$ 1,031,229,669
Expansion Parents 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	58,671	123,503	129,987	
PMPM Cost		5.3%	$ -	$ -	$ 656.90	$ 691.72	$ 728.38	
Total Expenditure			$ -	$ -	$ 38,541,205	$ 85,429,087	$ 94,679,562	$ 218,649,854
Expansion Adults w/out Dependent Children 101-133% FPL								
Pop Type:	**Expansion**				*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums*			
Eligible Member Months		5.25%	-	-	185,674	390,844	411,363	
PMPM Cost		5.3%	-	$ -	$ 920.73	$ 969.53	$ 1,020.91	
Total Expenditure			-	$ -	$ 170,955,560	$ 378,934,111	$ 419,966,044	$ 969,855,715
								$ 6,533,573,782

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

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

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles			*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost	$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.07	$ 1,166.79	$ 1,228.63	
Total Expenditure			$ 377,612,830	$ 383,420,334	$ 355,641,571	$ 372,830,227	$ 390,798,881	$ 1,880,303,842
Demo Pop I - PCN Adults w/Children			*PCN ends 3/31/19*					
Pop Type:	**Hypothetical**							
Eligible Member Months	104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost	$ 46.18	5.3%	$ 48.63	$ 51.21	$ 53.92	$ 56.78	$ 59.79	
Total Expenditure			$ 5,399,987	$ 4,517,106	$ -	$ -	$ -	$ 9,917,093
Demo Pop III/V - UPP Adults with Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost	$ 150.08	5.3%	$ 158.03	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure			$ 1,293,029	$ 1,836,200	$ 2,607,542	$ 3,702,908	$ 5,258,410	$ 14,698,089
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
Former Targeted Adults					*Member months will increase when the criteria is expanded to include victims of domestic violence, individuals with court ordered treatment and certain individuals on probation or parole. Also, member months will decrease due to the removal of continuous eligibility.*			
Pop Type:	**Expansion**		*Started 11/1/17*		*PMPM will increase due to adding new managed care directed payments. PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	78,000	78,000	121,696	163,378	167,462	
PMPM Cost		5.3%	$ 979.53	$ 1,031.45	$ 1,281.14	$ 1,349.04	$ 1,420.54	
Total Expenditure			$ 76,403,340	$ 80,452,717	$ 155,909,778	$ 220,402,517	$ 237,885,946	$ 771,054,298
Dental - Targeted Adults								
Pop Type:	**Expansion**			*Started 3/1/19*				
Eligible Member Months		2.5%	-	12,000	18,450			
PMPM Cost		5.3%	$ -	$ 33.33	$ 37.27	$ 39.24	$ 41.32	
Total Expenditure			$ -	$ 400,000	$ 687,556	$ -	$ -	$ 1,087,556
System of Care								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*			
Eligible Member Months			-		720	1,440	1,440	
PMPM Cost		5.3%	$ -		2,100	2,211	2,328	
Total Expenditure			$ -		1,512,000	3,184,272	3,353,038	$ 8,049,310
Dental - Blind/Disabled								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	412,361	412,361	412,361	412,361	412,361	
PMPM Cost		3.0%	$ 18.42	$ 18.97	$ 19.54	$ 20.13	$ 20.73	
Total Expenditure			$ 7,595,690	$ 7,823,560	$ 8,058,267	$ 8,300,015	$ 8,549,016	$ 40,326,548
Dental - Aged								
Pop Type:	**Hypothetical**				*Anticipated start date of 1/1/20*			

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Eligible Member Months		0%	-	-	54,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 1,660,500	$ 3,584,438	$ 3,868,774	$ 9,113,712
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Started 5/1/19*				
Eligible Member Months		0.0%	-	670	4,018	4,018	4,018	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 2,953,046	$ 3,100,699	$ 3,255,733	$ 9,778,216
Expansion Parents <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	-	-	169,914	348,324	357,032	
PMPM Cost		5.3%	$ -	$ -	$ 640.57	$ 674.52	$ 710.27	
Total Expenditure			$ -	$ -	$ 108,841,789	$ 234,951,327	$ 253,588,841	$ 597,381,956
Expansion Adults w/out Dependent Children <=100% FPL					*Assumes start date of 1/1/20*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		2.5%	-	-	200,487	410,997	421,272	
PMPM Cost		5.3%	-	$ -	$ 899.03	$ 946.68	$ 996.85	
Total Expenditure			-	$ -	$ 180,242,854	$ 389,081,237	$ 419,945,107	$ 989,269,198
Expansion Parents 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**							
Eligible Member Months		5.25%	-	-	53,048	111,667	117,529	
PMPM Cost		5.3%	$ -	$ -	$ 625.86	$ 659.03	$ 693.96	
Total Expenditure			$ -	$ -	$ 33,200,871	$ 73,591,888	$ 81,560,602	$ 188,353,362
Expansion Adults w/out Dependent Children 101-133% FPL					*Assumes start date of 1/1/20 and a 3.4% reduction in member months as an estimate for nonpayment of premiums. Further reduction of 8.3% to account for premium payment required prior to enrollment. Further reduction of 1.4% to account for removal of retroactive enrollment.*			
Pop Type:	**Expansion**				*PMPM will decrease for non-medically frail individuals removing certain benefits from the traditional package.*			
Eligible Member Months		5.25%	-	-	167,879	353,386	371,939	
PMPM Cost		5.3%	-	$ -	$ 882.60	$ 929.37	$ 978.63	
Total Expenditure			-	$ -	$ 148,169,813	$ 328,428,021	$ 363,991,028	$ 840,588,862

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

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

ATTACHMENT 2

Public Notice Requirements

Deseret News | Utah Media Group | The Salt Lake Tribune

Remit to:
Utah Media Group
4770 S 5600 W
West Valley City, UT 84118

Order Confirmation for 0001268486

Client	UTAH DEPARTMENT OF HEALTH BUREAU OF COVERAGE/REIMBURSEME		
Client Phone	8015386641	Account #	9001406923
Address	PO BOX 143102	Ordered By	Suzanne
	SALT LAKE CITY UT 841143103	Account Exec	ltapusoa2
		PO Number	QAZ: Public Notice for U
Email	cdevashrayee@utah.gov		

Total Amount	**$473.72**
Payment Amt	**$0.00**
Amount Due	**$473.72**

Text: QAZ: Public Notice for Utah 1115 Waiver Amendment -"Fallback" Plan

Ad Number	0001268486-01	**Ad Type**	Legal Liner
Ad Size	3 X 93 li	**Color**	

WYSIWYG Content

PUBLIC NOTICE
Utah 1115 Waiver Amendment - "Fallback" Plan

The Utah Department of Health will hold public hearings to discuss an amendment to the 1115 Primary Care Network Demonstration. The Department will accept public comment regarding this demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

The Department is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. The request includes the following provisions:
- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult members
- Implement a Medicaid lock-out period for committing an intentional program violation
- Provide housing related services and supports
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion members
- Allow for certain flexibilities in operating managed care
- Require premiums for Adult Expansion members with income over 100 percent FPL
- Require a $25 copayment for non-emergent use of the emergency department for Adult Expansion members with income over 100 percent FPL through 133 percent FPL
- Expand the definitions for Targeted Adult Medicaid to include additional adults
- Obtain authority through this waiver amendment to potentially implement defined flexibility and cost savings provisions through the state administrative rulemaking process:
    - Require that Adult Expansion members with income over 100% FPL pay their monthly premium prior to receiving Medicaid for the eligible month
    - Not allow retroactive eligibility for Adult Expansion members with in come over 100% FPL and enroll these adults prospectively in Medicaid
    - Change the benefit package for all adults on Medicaid expansion (including Targeted Adults, but excluding medically frail) to the State's non-traditional benefit package
    - Exempt certain groups from the mandatory employer sponsored insurance (ESI) requirement
    - Suspend housing supports
    - Make enrollment in an integrated plan or other managed care mandatory or options for different groups on Medicaid expansion
    - Open or suspend enrollment for each population group or subgroup within Targeted Adult Medicaid

In addition, the Department will also request to continue the following approved programs and provisions from Utah's current 1115 Primary Care Network Demonstration:

- Enrollment limits for the Adult Expansion and Targeted Adult members
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement for Adult Expansion members
- Provide premium reimbursement and wrap-around Medicaid coverage, to eligible Adult Expansion members who have access to ESI

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019 from 4:00 p.m. to 6:00 p.m., in room 1020C of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.

- Thursday, October 10, 2019 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.

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

The public may comment on the proposed application request during the 30-day public comment period from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

1268486 **UPAXLP**

Product	Placement	Position
Salt Lake Tribune	Legal Liner Notice	998
Scheduled Date(s):	09/27/2019	
utahlegals.com	utahlegals.com	utahlegals.com
Scheduled Date(s):	09/27/2019	
Deseret News	Legal Liner Notice	998
Scheduled Date(s):	09/27/2019	

Full Public Notice

Utah 1115 Demonstration Amendment

Fallback Plan

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF) intends to submit a request to the Centers for Medicare and Medicaid Services (CMS) to amend its 1115 Demonstration Waiver as a result of Senate Bill 96- "Medicaid Expansion Amendments", which passed during the 2019 Utah Legislative Session. DMHF will hold two public hearings to discuss the amendment. In addition, DMHF will accept public comment regarding the demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

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

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion including Adult Expansion and Targeted Adult Populations
- Lock-out from the Medicaid Expansion for committing an Intentional Program Violation
- Federal expenditure authority to provide housing related services and supports for groups within Medicaid Expansion
- Not allowing hospitals to make presumptive eligibility determinations for the Medicaid Expansion
- Additional flexibility for providing services through managed care for all Medicaid members
- Require premiums for Adult Expansion beneficiaries with income over 100 percent through 133 percent of the FPL
- Require a $25 copayment for non-emergent use of the emergency department for Adult Expansion beneficiaries with income over 100 percent FPL through 133 percent FPL
- Expand the subgroup definitions for the Targeted Adult demonstration group to include additional groups of individuals that may receive Targeted Adult Medicaid.
- Implement defined flexibilities and cost savings provisions for the Medicaid Expansion through the state administrative rulemaking process within the parameters defined by this waiver amendment
- Change the income range for Utah's Premium Partnership for Health Insurance (UPP)

The State is also requesting to continue the following components for the Adult Expansion demonstration group which are currently authorized under the State's 1115 Demonstration Waiver:

- Implementing a community engagement requirement for the Adult Expansion demonstration group
- Authorizing the ability for the State to impose an enrollment cap for the Medicaid Expansion
- Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults for the Medicaid Expansion
- Requiring Adult Expansion Medicaid beneficiaries with access to employer-sponsored insurance (ESI) to enroll in the available insurance, with the flexibility to exempt certain income groups from disenrollment if they fail to enroll

I. Program Description:

The waiver populations defined below will be impacted by this demonstration amendment:

1. Adult Expansion Population, defined as:
    - Adults ages 19 through 64
    - A U.S. Citizen or qualified alien
        - Non-citizens will receive the Emergency Only program pursuant to 42 CFR § 435.139
    - A resident of Utah
    - Not pregnant
    - Residents of a public institution are not eligible unless furloughed for an inpatient stay
    - Have a household income at or below 133 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
    - Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.

2. Targeted Adult Population, defined as:
    - Adults age 19 through 64, without a dependent child
    - A U.S. Citizen or qualified alien
    - A resident of Utah
    - Residents of a public institution are not eligible unless furloughed for an inpatient stay
    - 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
        - Involved in the justice system and in need of substance use or mental health treatment
        - Needing substance use or mental health treatment

Overview of New Proposals:

The State is requesting to implement the following components with this amendment:

1. Income Limit Increase for Adult Expansion Population

The State proposes to increase the income limit for the Adult Expansion Population from 95 percent FPL, to 133 percent FPL, in order to receive the increased Federal Medical Assistance Percentages (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Medicaid Expansion, which includes both the Adult Expansion and the Targeted Adult demonstration groups. If the allowable enhanced FMAP is ever reduced to below 90 percent, the State will sunset the Adult Expansion demonstration group no later than July 1 after the date on which the FMAP is reduced.

The Adult Expansion Population is defined as individuals who 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
- Not pregnant
- Residents of a public institution are not eligible unless furloughed for an inpatient stay
- Have a household income at or below 133 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
- Their dependent child(ren) are covered by Medicaid, CHIP or Minimal Essential Coverage (MEC) as defined by 42 CFR § 435.4.

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. This request applies to the Medicaid Expansion, which includes both the Adult Expansion Population and Targeted Adults.

3. Housing Related Services and Supports

The State proposes to offer housing related services and supports (HRSS) to the Medicaid Expansion, who meet needs-based criteria. HRSS includes; tenancy support services, community transition services and supportive living/supportive housing services.

4. 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.

5. Flexibility to Make Changes through the State Administrative Rulemaking Process

Under the authority granted to the State through this waiver, the State requests the ability to make the changes listed below for the Medicaid Expansion through the state administrative rulemaking process

pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

These changes include the following:

- Begin enrollment the first of the month after application for Adult Expansion Medicaid beneficiaries with income over 100 percent FPL (prospective eligibility)
- Not allowing three months of retroactive coverage for Adult Expansion Medicaid beneficiaries who have income over 100 percent FPL
- Change the benefit package for Adult Expansion and Targeted Adult demonstration groups (excluding medically frail) to the State's non-traditional benefit package
- Exempt certain groups from the employer sponsored insurance requirement
- Make enrollment in an integrated plan or other managed care mandatory or optional for different adult expansion groups
- Suspending housing related services and supports in order to stay within appropriations for this provision.
- Suspend enrollment for the subsets within the three subgroups on Targeted Adult Medicaid

6. Expanding Targeted Adult Medicaid Eligibility Definitions

With amendment, the State is requesting to expand its eligibility criteria definitions for the three Targeted Adult subgroups. This will allow the State to increase the number of individuals who are eligible for the Targeted Adult Population, allowing more individuals to receive the added benefits of 12-months continuous eligibility (and dental benefits, if they are actively receiving substance use disorder treatment).

Currently, individuals must meet the following criteria to be eligible for the Targeted Adult Population:

- 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:
    - Be chronically homeless
    - Involved in the justice system AND in need of substance abuse or mental health treatment
    - In need of substance abuse or mental health treatment

The State proposes to add or change the following for each criteria subgroup:

- Chronically Homeless
    - Add "an individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter""
    - Move the following group from the subgroup "Needing substance abuse or mental health treatment" to the "Chronically Homeless" subgroup; "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"

- Involved in the justice system and in need of substance use or mental health treatment
    - Changing the criteria of "an individual involved in a Drug Court or Mental Health Court, including Tribal courts", to "an individual who is court ordered to receive substance abuse or mental health treatment through a district court or Tribal court, or involved in a Drug Court or Mental Health Court".
    - Add "an individual on probation or parole with serious mental illness and/or serious substance use disorder".

7. Require premiums for Adult Expansion Medicaid beneficiaries with income over 100 percent through 133 percent of the FPL

Information regarding premiums is provided in section "IV. Benefits and Cost Sharing Requirements" below.

8. Require a $25 copayment for non-emergent use of the emergency department for Adult Expansion Medicaid beneficiaries with income over 100 percent FPL through 133 percent FPL

Information regarding the $25 copayment is provided in section "IV. Benefits and Cost Sharing Requirements" below.

Overview of Continuing Programs and Benefits:

The State is also requesting to continue the following components and programs with this amendment for the expanded Adult Expansion Population, which are currently authorized under the State's 1115 Demonstration Waiver:

1. Enrollment Limits

The State requests to continue to apply enrollment limits to the Adult Expansion and Targeted Adult Populations under this demonstration amendment. Enrollment limits for these populations are currently approved under the State's 1115 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 suspended, 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 suspended will remain enrolled.

3. Community Engagement through a Self Sufficiency Requirement

With this waiver amendment, 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 Demonstration Waiver.

4. Employer Sponsored Insurance (ESI Reimbursement)

As approved on March 29, 2019 under the State's 1115 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.

5. Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

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 amendment.

II.Demonstration Goal/Objective:

The goals and objectives of the demonstration are to:

- Provide health care coverage for low-income and other vulnerable Utahns that would not otherwise have access to, or be able to afford health care coverage
- Improve participant health outcomes and quality of life
- Lower the uninsured rate of low income Utahns
- Support the use of employer-sponsored insurance by encouraging community engagement and providing premium reimbursement for employer-sponsored health plans
- Provide continuity of coverage for individuals

III. Proposed Delivery System:

Services for the Adult Expansion Population will be provided through FFS during the month of application and potentially the following month depending on the date of approval. In addition, Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the FFS network. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

Adult Expansion beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. In addition, in Utah's five 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. In the remaining counties, beneficiaries will be enrolled in a pre-paid mental health plan for their behavioral health services.

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.

Managed Care Flexibilities

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
- Flexibility in managed care contract review
- Demonstration of directed payment compliance
- Access to care and availability of services

IV. Benefits and Cost Sharing Requirements:

Individuals eligible under this demonstration will receive benefits as listed in the table below.

Eligibility Group and Benefit Package

Eligibility Group	Benefit Package
Adults with Dependent Children	● Non-Traditional Benefits (see description below)
Adults without Dependent Children	● State Plan Benefits
ESI Eligible Adults with Dependent Children	● Premium Reimbursement with Non-Traditional Benefit Wrap-around
ESI Eligible Adults without Dependent Children	● Premium Reimbursement with State Plan Benefit Wrap-around
Medically Frail	● Adults with Dependent Children normally receive non-traditional benefits, but may choose traditional state plan benefits
Targeted Adults	● State Plan Benefits, and dental benefits for individuals receiving Substance Use Disorder Treatment (as defined in the Special Terms & Conditions #23(h)) of the 1115 Demonstration Waiver ● 12-months continuous eligibility

Housing Related Services and Supports for Individuals Meeting Needs Based Criteria	● Tenancy Support Services ● Community Transition Services ● Supportive Living/Housing Services

Non-Traditional Benefit Package

Adults with dependent children will receive the State's non-traditional benefit package, authorized under the State's 1115 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 below.

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.

Medically Frail

As stated above, Adult Expansion beneficiaries will receive either traditional state plan Medicaid benefits if they do not have a dependent child living in the home, or they will receive non-traditional Medicaid benefits if they do have a dependent child living in the home. However, if an Adult Expansion beneficiary is identified as medically frail, as defined by 42 CFR 440.315, they may choose between traditional state plan Medicaid benefits or non-traditional Medicaid benefits, as authorized under the State's 1115 Demonstration Waiver.

An individual is medically frail, as defined by 42 CFR 440.315, if the individual has a:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical condition
- Physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living
- Disability determination based on Social Security criteria

Premiums

With this amendment, the State is proposing to implement monthly premiums for individuals in the Adult Expansion Population who have household income above 100 percent of the FPL through 133 percent FPL . Monthly premiums will be set at the following amounts regardless of household size or household income.

- $20 per month for a single individual
- $30 per month for a couple

Under the authority granted to the State through this waiver, the State requests the ability to raise these premium amounts to mirror annual increases in the federal poverty level through the state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. In conjunction with its rulemaking process, the State would provide notice to the public and to CMS regarding any intended changes.

Premiums will not be charged for the month of application or any months of retroactive coverage. Premiums must be paid in the month prior to the month of eligibility to avoid disenrollment. Failure to pay the required premium will result in loss of eligibility for Adult Expansion Medicaid.

Premium Exemptions
The following individuals are exempt from paying premiums:

- Individuals with verified membership in a federally recognized tribe
- Individuals identified as medically frail, as described in 42 CFR 440.315

Individuals who receive employer sponsored insurance reimbursements will have premiums deducted from their ESI reimbursement amount.

The total of the individual's or couple's premium amount and any applicable copayments will not exceed 5 percent of the household's income, per 42 CFR 447.56(f).

Payment of Past Due Premiums after Losing Eligibility
Individuals who have been disenrolled for failure to pay premiums will be required to pay any past due premiums in order to reinstate Medicaid. However, if it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

Cost Sharing

Copayment for Non-Emergent Use of the Emergency Department
In accordance with Section 1916(f) of the Social Security Act, the State proposes to require a $25 copayment for non-emergent use of the emergency department for individuals in the Adult Expansion Population who have household income above 100 percent FPL through 133 percent FPL. Members of federally recognized tribes will be exempt from this provision.

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.

V. Annual Enrollment and Expenditures:

The table below shows the projected demonstration enrollees in each demonstration year (DY).

Enrollment	DY 18[1]	DY 19	DY 20
Targeted Adults	14,000	14,350	14,709

[1]Reflects anticipated average enrollment January 2020 through June 2020

Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	9,779	10,292	10,832
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	30,946	32,570	34,280
Annual Total	**116,458**	**120,489**	**124,680**

The table below shows the projected expenditures for each demonstration year (DY).

Expenditures (Total Fund)	**DY 18[2]**	**DY 19**	**DY 20**
Targeted Adults	$127,914,000	$276,122,000	$298,026,000
Expansion Parents up to 100% FPL	$114,116,000	$246,336,000	$265,877,000
Expansion Parents above 100% FPL up to 133% FPL	$38,541,000	$85,430,000	$94,680,000
Expansion Adults without Children up to 100% FPL	$187,889,000	$405,586,000	$437,759,000
Expansion Adults without Children above 100% FPL up to 133% FPL	$170,956,000	$378,934,000	$419,966,000
Annual Total	**$639,416,000**	**$1,392,408,000**	**$1,516,308,000**

The table below shows the projected enrollees under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

Enrollment	**DY 18[3]**	**DY 19**	**DY 20**
Former Targeted Adults	13,283	13,615	13,955
Expansion Parents up to 100% FPL	28,319	29,027	29,753
Expansion Parents above 100% FPL up to 133% FPL	8,841	9,306	9,794
Expansion Adults without Children up to 100% FPL	33,414	34,250	35,106
Expansion Adults without Children above 100% FPL up to 133% FPL	27,980	29,449	30,995
Annual Total	**111,837**	**115,647**	**119,603**

Table 8

The table below shows the projected expenditures under the scenario that the State implements all of the additional flexibilities and cost controls requested in this demonstration.

[2] Reflects anticipated total expenditures January 2020 through June 2020

[3]Reflects anticipated average enrollment January 2020 through June 2020

Expenditures (Total Fund)	DY 18[4]	DY 19	DY 20
Targeted Adults	$102,102,000	$220,403,000	$237,886,000
Expansion Parents up to 100% FPL	$108,842,000	$234,951,000	$253,589,000
Expansion Parents above 100% FPL up to 133% FPL	$33,201,000	$73,592,000	$81,561,000
Expansion Adults without Children up to 100% FPL	$180,244,000	$389,083,000	$419,947,000
Expansion Adults without Children above 100% FPL up to 133% FPL	$148,170,000	$328,428,000	$363,991,000
Annual Total	**$572,559,000**	**$1,246,457,000**	**$1,356,974,000**

VI. Waivers and Expenditure Authorities:

The State will request the following waivers and expenditure authorities in order to administer this 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)(14) insofar as it incorporates Sections 1916 and 1916A	To the extent necessary to enable the State to require monthly premiums for individuals in the Adult Expansion Population who have household income above 100 up to and including 133 percent of the FPL.
Section 1902(a)(8) and (a)(10)- Eligibility and Provision of Medical Assistance	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

[4] Reflects anticipated total expenditures January 2020 through June 2020

	described in the STCs, unless the beneficiary is exempted, or demonstrates good cause, as described in the STCs. 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.

Expenditure Authority

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.

VII. Hypotheses and Evaluation Parameters of the Demonstration:

During the approved demonstration period, the State will test the hypotheses indicated in the table below. The State intends to contract with an independent evaluator to develop a plan for evaluating these 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	• 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

department (ED) services by Adult Expansion members.			
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 purchasing employer sponsored insurance to help reduce the number of uninsured adults.	● Number of enrolled members with employer-sponsored insurance	Enrollment data	Independent evaluator will design quantitative and qualitative 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	● Number of prescriptions ● Number of non-emergent ED visits ● Number of cancer screenings	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

subject to the requirements, compared to Medicaid beneficiaries not subject to the requirements.	● Number of well-care visits		
Community engagement requirements will increase the likelihood that Medicaid beneficiaries transition to commercial health insurance after separating from Medicaid, compared to Medicaid beneficiaries not subject to the requirements.	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
Premiums			
Individuals sharing in the total cost of care by paying premiums will access preventive services at a rate equivalent or greater than individuals who do not pay premiums.	● 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
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
Not Allowing Presumptive Eligibility			
The demonstration will allow individuals to enroll retroactively covering unforeseen hospital expenses at a rate equivalent to hospital presumptive eligibility pre-demonstration.	Pre-demonstration, proportion of enrollees enrolling through hospital presumptive eligibility plus retroactive enrollment. Post demonstration, proportion of enrollees enrolling through retroactive enrollment.	Medicaid Data Warehouse eRep Eligibility System Data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
Non-emergent Use of the Emergency Room			
Charging a higher copay for this service will decrease inappropriate use of the emergency	● Number of prescriptions ● Number of non-emergent ED visits	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include

room without impacting other health measures	● Number of cancer screenings Number of well-care visit		quasi-experimental comparisons

The State will test the following hypothesis if the relevant provisions of the waiver are activated by the State.

Prospective Enrollment			
The implementation of the proposal will generate cost savings over the term of the waiver.	● Average cost per member in month of application for comparison group ● Average cost per member in the first three eligible months after application for demonstration group and comparison group	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	● 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
Elimination of Retroactive Eligibility			

The implementation of the proposal will generate cost savings over the term of the waiver.	● Average cost per member in retro months prior to application for comparison group ● Average cost per member in the first three eligible months after application for demonstration group and comparison group	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons
The implementation of this proposal will not adversely impact health outcomes of demonstration individuals.	● 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

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.

VIII. Review of Documents and Submission of Comments

Location and Internet Address of Demonstration Amendment for Public Comment and Review:

A copy of the DMHF's proposed demonstration amendment is available for review online at: https://medicaid.utah.gov/1115-waiver.

A copy of the DMHF's proposed demonstration amendment may be requested in writing from:
Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

Submitting Public Comments:
The public may comment on the proposed demonstration amendment during the 30-day public comment period, from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver.

Email: Medicaid1115waiver@utah.gov

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

Public Hearings:
The DMHF will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019
  4:00 p.m. to 6:00 p.m.
  Multi-Agency State Office Building
  195 N 1950 W, Salt Lake City, Utah
  Room 1020C

- Thursday, October 10, 2019
  2:00 p.m. to 4:00 p.m. (Medical Care Advisory Committee (MCAC) meeting)
  Cannon Health Building
  288 N 1460 W, Salt Lake City, Utah
  Room 125

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.

PUBLIC NOTICE

Utah 1115 Waiver Amendment - "Fallback" Plan

The Utah Department of Health will hold public hearings to discuss an amendment to the 1115 Primary Care Network Demonstration. The Department will accept public comment regarding this demonstration amendment during the 30-day public comment period from September 27, 2019 through October 27, 2019.

The Department is requesting authority to implement the provisions of Senate Bill 96 "Medicaid Expansion Adjustments", which passed during the 2019 Utah Legislative Session. The request includes the following provisions:

- Increase the income limit for the Adult Expansion demonstration group from 95 percent of the federal poverty level (FPL) to 133 percent FPL, in order to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult members
- Implement a Medicaid lock-out period for committing an intentional program violation
- Provide housing related services and supports
- Not allow hospitals to make presumptive eligibility determinations for the Adult Expansion members
- Allow for certain flexibilities in operating managed care
- Require premiums for Adult Expansion members with income over 100 percent FPL
- Require a $25 copayment for non-emergent use of the emergency department for Adult Expansion members with income over 100 percent FPL through 133 percent FPL
- Expand the definitions for Targeted Adult Medicaid to include additional adults
- Obtain authority through this waiver amendment to potentially implement defined flexibility and cost savings provisions through the state administrative rulemaking process:
    - Require that Adult Expansion members with income over 100% FPL pay their monthly premium prior to receiving Medicaid for the eligible month
    - Not allow retroactive eligibility for Adult Expansion members with income over 100% FPL and enroll these adults prospectively in Medicaid
    - Change the benefit package for all adults on Medicaid expansion (including Targeted Adults, but excluding medically frail) to the State's non-traditional benefit package
    - Exempt certain groups from the mandatory employer sponsored insurance (ESI) requirement
    - Suspend housing supports
    - Make enrollment in an integrated plan or other managed care mandatory or options for different groups on Medicaid expansion
    - Open or suspend enrollment for each population group or subgroup within Targeted Adult Medicaid

In addition, the Department will also request to continue the following approved programs and provisions from Utah's current 1115 Primary Care Network Demonstration:

- Enrollment limits for the Adult Expansion and Targeted Adult members
- Waiver of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Implement a community engagement requirement for Adult Expansion members
- Provide premium reimbursement and wrap-around Medicaid coverage, to eligible Adult Expansion members who have access to ESI

Public Hearings:

The Department will conduct two public hearings to discuss the demonstration amendment. The dates, times and locations are listed below:

- Monday, October 7, 2019 from 4:00 p.m. to 6:00 p.m., in room 1020C of the Multi-Agency State Office Building located at 195 N 1950 W, Salt Lake City, Utah.

- Thursday, October 10, 2019 from 2:00 p.m. to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting. This meeting will be held in room 125 of the Cannon Health Building located at 288 N 1460 W, Salt Lake City, Utah.

A conference line is available for both public hearings for those who would like to participate by phone: 1-877-820-7831, passcode 378804#.

Individuals requiring an accommodation to fully participate in either meeting may contact Jennifer Meyer-Smart at 801-538-6338 by 5:00 p.m. on Thursday, October 3, 2019.

Public Comment:

A copy of the full public notice and proposed application is available online at https://medicaid.utah.gov/1115-waiver.

The public may comment on the proposed application request during the 30-day public comment period from September 27, 2019 through October 27, 2019.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

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

ATTACHMENT 3

Public Comments and State Responses

UTAH DEPARTMENT OF HEALTH MEDICAID

Summary of Public Comments and State Responses

1115 Waiver Amendment
Medicaid Expansion

The State received comments from 99 individuals, advocacy groups and other community partners. The State appreciates all comments and feedback submitted regarding this waiver application. A summary of the comments submitted related to the waiver amendment and the State's responses to those comments are detailed below. Some comments were outside the scope of the waiver application and are not addressed in the State's responses.

General Comments

1. Many commenters stated they believe this proposal is contrary to the purpose of the Medicaid program and it would be illegal for the Secretary of Health and Human Services to approve the State's request. They also stated the State should expedite the implementation of full expansion by requesting it through a State Plan Amendment without any restrictions. They do not believe the State should wait for approval of the 1115 waiver amendment.

Response: In November 2018, Utah voters approved Proposition 3. The proposition expanded Medicaid to 133 percent of the federal poverty level (FPL) for adults ages 19-64, mandated an annual inflationary increase for all Medicaid providers across the entire Medicaid program (both in and out of expansion), and raised the State's sales tax. In February 2019, the Utah Legislature passed and Governor Herbert signed Senate Bill 96 citing concerns that Proposition 3's sales tax was insufficient to cover both the expansion and the mandatory provider rate increases and that growth in the Medicaid program might not be sustainable for the State in the long term. Senate Bill 96 directed the Utah Department of Health (UDOH) to seek a series of waivers that, if approved, would expand Medicaid up to 133 percent FPL, obtain enhanced match (90 percent federal/10 percent state), and implement other provisions designed to create an expansion program that closed the coverage gap while putting in place program integrity requirements and fiscal circuit breakers. Senate Bill 96 outlines a Medicaid expansion proposal that the Utah Legislature and Governor Herbert believe is feasible for Utah.

Section 1901 of Title XIX of the Social Security Act defines the purpose of the Medicaid program as follows:

> *For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of*

necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title.

Many commenters stated that the purpose of the Medicaid program was to furnish medical assistance; however, they did not acknowledge the phrase that immediately preceded it. The Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. In Utah, the State Constitution requires that income taxes be spent on education and that the State must have a balanced budget. As a result, the sales tax is the primary source of funding for the State's General Fund. Medicaid, transportation and other infrastructure, public health and other social services, law enforcement and public safety, along with general government operations, all vie for funding from the State's General Fund. Over the last 19 years (1998 to 2017), Medicaid's General Fund expenditures as a share of General Fund revenues 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 included additional adults with dependent children and adults without dependent children who historically have not been served by Medicaid. While the State 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 as a share of the available General Fund revenue nor to expect that higher sales tax rates on a narrowing tax base will serve as a reliable long term funding source for the program absent additional budgetary flexibilities. This waiver proposal requests that the Secretary of Health and Human Services approve this waiver to furnish medical assistance to Utahns ages 19-64 in a way deemed practicable by the Utah Legislature and Governor Herbert as defined through Senate Bill 96.

Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act:

(a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of title I, X, XIV, XVI, or XIX, or part A or D of title IV, in a State or States—

(1) the Secretary may waive compliance with any of the requirements of section 2, 402, 454, 1002, 1402, 1602, or 1902, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section 3, 455, 1003, 1403, 1603, or 1903, as the case may be, and which are not included as part of the costs of projects under section 1110, shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans, as may be appropriate,

Both under this administration and under President Obama's administration, the Centers for Medicare and Medicaid Services (CMS), has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking. It is not uncommon for CMS's interpretation of its authorities to evolve. As CMS Administrator Seema Verma said to state Medicaid directors in November 2017, "So now it is up to you, the states, to put your innovative ideas into practice. We very much look forward to your proposals and helping you implement successful initiatives that improve the health and lives of the diverse set of beneficiaries you serve." The State believes that the combination of the Secretary's authority to waive compliance with certain sections of Title XIX and to approve expenditures not otherwise matchable is sufficient to approve this waiver proposal, which will improve the health and lives of an estimated 120,000 to 140,000 Utahns.

On July 27, 2019, CMS released a statement saying, "...a number of states have asked CMS for permission to cover only a portion of the adult expansion group and still access the enhanced federal funding available through Obamacare. Unfortunately, this would invite continued reliance on a broken and unsustainable Obamacare system. While we have carefully considered these requests, CMS will continue to only approve demonstrations that comply with the current policy." While this statement indicates it is unlikely the Secretary will use his authority at this time to allow enhanced funding for an expansion that includes an enrollment cap, the State believes there are several important reasons for submitting this waiver request as originally envisioned by Senate Bill 96.

First, the landscape regarding Medicaid expansion may change. Most notably, the U.S. Court of Appeals for the 5th Circuit will be issuing a decision in the *Texas v. U.S.*, litigation challenging the Affordable Care Act (ACA). Comments attributed to administration officials in news articles regarding CMS's position on partial expansion seem to tie this administration's position to a hope that *Texas v. U.S.* will overturn the ACA. However, as shown by the Supreme Court decision in *National Federation of Independent Business v. Sebelius* (2012), court decisions are not entirely predictable. Therefore, in light of the possibility that the legal situation regarding the ACA may change (or may not) in the near future, the State is submitting its entire request for review by the Secretary.

Second, the State's waiver request contains many other program features beyond the request for enhanced match for expansion with an enrollment cap. The State believes the other components of its waiver request can be approved and are important to operating an efficient and effective Medicaid Expansion program.

Lock-Out from the Medicaid Expansion for Committing an Intentional Program Violation (IPV)

2. Many commenters stated that this request is not needed because fraud is already defined under state law and prosecuted accordingly. They would like to know how an IPV is different from a fraud

determination. In addition, they state the amendment already clearly indicates that individuals can be charged for overpayments while appealing an IPV.

Response: A determination of fraud is made through a judicial procedure. Section 76-8-1205 Utah Code Annotated, defines public assistance fraud.

76-8-1205 Public assistance fraud defined.

Each of the following persons, who intentionally, knowingly, or recklessly commits any of the following acts is guilty of public assistance fraud:
(1) a person who uses, transfers, acquires, traffics in, falsifies, or possesses SNAP benefits as defined in Section 35A-1-102, a SNAP identification card, a certificate of eligibility for medical services, a Medicaid identification card, a fund transfer instrument, a payment instrument, or a public assistance warrant in a manner not allowed by law;
(2) a person who fraudulently misappropriates funds exchanged for SNAP benefits as defined in Section 35A-1-102, or an identification card, certificate of eligibility for medical services, Medicaid identification card, or other public assistance with which the person has been entrusted or that has come into the person's possession in connection with the person's duties in administering a state or federally funded public assistance program;
(3) a person who receives an unauthorized payment as a result of acts described in this section;
(4) a provider who receives payment or a client who receives benefits after failing to comply with any applicable requirement in Sections 76-8-1203 and 76-8-1204;
(5) a provider who files a claim for payment under a state or federally funded public assistance program for goods or services not provided to or for a client of that program;
(6) a provider who files or falsifies a claim, report, or document required by state or federal law, rule, or provider agreement for goods or services not authorized under the state or federally funded public assistance program for which the goods or services were provided;
(7) a provider who fails to credit the state for payments received from other sources;
(8) a provider who bills a client or a client's family for goods or services not provided, or bills in an amount greater than allowed by law or rule;
(9) a client who, while receiving public assistance, acquires income or resources in excess of the amount the client previously reported to the state agency administering the public assistance, and fails to notify the state agency to which the client previously reported within 10 days after acquiring the excess income or resources;
(10) a person who fails to act as required under Section 76-8-1203 or 76-8-1204 with intent to obtain or help another obtain an "overpayment" as defined in Section 35A-3-102; and
(11) a person who obtains an overpayment by violation of Section 76-8-1203 or 76-8-1204.

The determination of an IPV has been part of policy for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid for many years. The determination of an IPV is made through an administrative adjudicative proceeding under the Utah Administrative Procedures Act. The burden of proof is with the State. The standard of evidence is clear and convincing in both an administrative or judicial proceeding. The determination of an IPV through an

administrative proceeding with the possibility of a lock out of the Medicaid program is less onerous than a conviction based on a judicial criminal proceeding that could result in a third or second degree felony.

3. Several commenters stated they believe beneficiaries will be confused by what they must report and will get caught up in “red tape” trying to provide information, therefore causing them to lose coverage.

Response: Members are informed of what is required to be reported and when they must report. Current policy requires Medicaid members to report changes that affect eligibility within 10 days from the date of the change. The waiver makes no change to current reporting requirements.

4. Several commenters stated that while they appreciate the attempt to prevent fraud and abuse, they believe that individuals who might lose coverage due to this proposal, should be allowed a swift and effective appeals process, so they do not lose coverage due to an administrative mistake.

Response: All federally mandated appeal rights will be in place, as they are today. After the State has investigated a case for an IPV, and the Administrative Law Judge has concurred with the decision, an individual may be locked out for 6 months of the Adult Expansion Medicaid Program. The individual will receive notice of the decision. The notice includes the right to appeal and would be reviewed through the current administrative hearing process at the Department of Workforce Services (DWS).

5. Several commenters stated they believe the lock-out provision will only divert money from providing care to administering this provision. They also believe it will increase the administrative burden on patients on the Medicaid program.

Response: The determination of an IPV is currently in Medicaid policy. This is not new nor is it a change. The DWS Investigation unit conducts the investigation. Therefore there is no significant change to the current administrative burden to the State or members.

6. Several commenters stated they believe this provision includes vague or broad descriptions of an IPV. They believe this will lead to subjective decisions which likely will be influenced by implicit biases, resulting in certain populations, likely people of color and other marginalized groups- being more apt to be found to commit an IPV.

Response: The determination of an IPV has been in place for at least two decades for the SNAP, TANF and Medicaid programs. The burden of proof rests with the State. The State complies with judicial standards of evidence. When fault is alleged, the State must prove by clear and convincing evidence that the overpayment was obtained intentionally, knowingly, recklessly as "intentionally, knowingly, and recklessly" are defined in Section 76-2-103, by false statement, misrepresentation, impersonation, or

other fraudulent means, including committing any of the acts or omissions described in Sections 76-8-1203, 76-8-1204, or 76-8-1205.

7. Several commenters stated the lock-out period is problematic when coupled with the enrollment limit. They stated if someone was subject to a lock-out and an enrollment limit was enacted, they would continue to be locked-out for a longer time frame.

Response: The lock-out period continues to run regardless of enrollment being open or closed. While possible that the enrollment closes during someone's lock-out period, the lock-out period only applies to the Adult Expansion Medicaid Program, and other programs may still be available. If other programs are not available, these adults can reapply when enrollment opens again.

8. Several commenters express concern for the IPV definition including "failure to report a required change within 10 days". They would like this specific piece of the IPV definition removed.

Response: An IPV is different from an inadvertent error. In order to be considered an IPV, an individual would have to knowingly not report 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. The burden of proof is on the State to prove this occurred. The "failure to report in 10 days" provision is currently included in the definition of an IPV. This is not a change to policy.

9. Several commenters stated an individual's socioeconomic status can influence an individual's ability to adhere to program rules. They believe this is a difficult requirement for any income level. They also stated that individuals could be confused as to what they need to report, which would result in losing coverage over bureaucracy.

Response: Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. The State is not proposing to change current reporting requirements or the definition of an IPV. The State is only proposing to apply a lock-out period if an IPV determination is made.

10. One commenter stated they will have to provide sliding fee scale services to individual's locked out and that this seems to be too harsh for what seems to be less serious offenses.

Response: An IPV is different from an inadvertent error. To be considered an IPV, the individual has to knowingly and intentionally make statements or withhold information to obtain benefits they are not or were entitled to receive. The State would not consider this as a "less serious offense", given the intent of the violation.

11. Several commenters stated that disenrollment policies reduce access to care, disrupt the continuity of care, and cause increased utilization of emergency departments. They believe this proposal will lead to these issues. They also believe locking individuals out of coverage does not achieve Medicaid objectives, and is not allowable under Section 1115 authority.

Response: The State currently has IPV policy in place. Medicaid policy currently includes specific reporting requirements, as well as the IPV definition included in the lock-out proposal. As stated in the response to Comment 1, the State must operate within the limits of its budget and therefore it is practical that only those individuals truly eligible for Medicaid should receive benefits. CMS will determine whether or not this and any other provision is allowable under this waiver authority.

12. One commenter stated the purported justification for Utah's Medicaid 1115 waiver is fiscal responsibility. However, implementation of the lock-out process would require Utah Medicaid to divert already thin administrative resources to oversee and conduct the program. They also state the potential dollar amount of savings that Utah Medicaid would achieve from locking low-income individuals out of Medicaid for 6-months is not provided, and input cannot be given without this.

Response: The State already has an IPV policy and process in place. IPV's are currently determined. The only change to the State's current process is the lock-out period. In response to the information regarding potential dollar savings, the State has met the transparency requirements found at 42 CFR 431.408. The waiver application and budget neutrality attachment reflect the required information.

13. One commenter stated the lock-out provision could have huge financial implications to individuals. They believe it is also not clear what overpayments a patient could be responsible for if the state determines an IPV occurred. For example, would an individual be forced to repay a capitation payment amount made to a managed care plan, even when they received no services?

Response: Under current Medicaid policy, if it is determined that an individual was not eligible to receive Medicaid, an overpayment is assessed for the months they were not eligible. The amount of the overpayment is based on claims paid on behalf of the individual as well as any capitation payments paid on behalf of the individual (if the individual was with a managed care plan). This will not change under the IPV lock-out policy. The only change under this proposal, is that if an individual has committed an IPV, they will have a 6-month lock-out period.

14. One commenter stated that charging individuals with overpayments for coverage received while awaiting an appeal decision could discourage individuals from appealing the decision, leading to unnecessary coverage losses and additional financial burdens.

Response: This proposed provision is consistent with current Medicaid regulation found in 42 CFR 230 which reads:

§431.230 Maintaining services.

(a) If the agency sends the 10-day or 5-day notice as required under §431.211 or §431.214 of this subpart, and the beneficiary requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the beneficiary in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, to the extent they were furnished solely by reason of this section.

Housing Related Services and Supports (HRSS)

15. Many commenters stated they are very supportive of the proposal to provide housing related services and supports. However, they believe it should be extended to all Adult Expansion members, not just the Targeted Adult Population. They believe providing to just a sub-group of the population contradicts the intent of Senate Bill 96.

Response: Based on the estimated cost to provide housing related services and the amount of funding designated for these services within overall Medicaid Expansion funding, the State determined to initially limit coverage to the Targeted Adult Population. Based on program flexibility the State is seeking to modify covered populations through administrative rule. After gaining additional cost and utilization experience, if funding is available, the State will consider covering housing related services for additional populations.

16. One commenter noted they strongly oppose the proposal to allow the State to make changes to this component through state administrative rulemaking, rather than the 1115 review and approval process. They believe this is contrary to transparency requirements.

Response: The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would

then use its administrative rulemaking process to activate the options approved in the waiver. The State believes the rulemaking process is transparent and would follow the process outlined under the Utah Administrative Rulemaking Act , Title 63G Chapter 3 Utah Code Annotated which provides for public input.

After passing through an internal review and approval process, UDOH files all proposed rules with the Division of Administrative Rules. The proposed rules are then published in the Utah State Bulletin, which the public can access at https://rules.utah.gov/ to review the proposed changes. Upon publication, the public has 30 days to review and comment on the proposed changes, and may send their written comments to the contact person listed. UDOH reviews all comments provided during the public comment period, and has seven days after the comment period to determine whether it will go forward to make the rule effective, change the proposed rule, or simply let the rule lapse. UDOH also presents all rules to its Medical Care Advisory Committee and the Utah Indian Health Advisory Board.

In accordance with the provisions of the rulemaking act, individuals may also petition UDOH for a public hearing to discuss the proposed rule. UDOH would then grant the request, appoint a hearing officer, and make appropriate arrangements to accommodate a public gathering.

UDOH may also initiate a public hearing to discuss the proposed changes if it feels the need is warranted and that the changes require further outreach. In this case, UDOH may arrange to publish notice of the hearing in the State Bulletin when it files the proposed rule, or may arrange to publish this notice in the bulletin or newspaper after the rule filing.

UDOH also has the option of sending proposed changes to Medicaid providers, advocacy groups, shareholders, or others in the healthcare industry during the rulemaking process. This action is usually based on certain issues surrounding the rulemaking, or where UDOH just wants further input and consultation with the aforementioned groups.

In regards to the waiver process, CMS is under no statutory obligation to review 1115 waiver amendments in a timely fashion. The State has had many experiences where waiver amendments have sat with CMS for months and even years before final action was taken. In full compliance with federal transparency requirements, the State is seeking for a limited, defined scope of authority from CMS where the State could modify certain rules related to the approved waiver criteria definitions using a more timely and locally responsive administrative rules process.

17. One commenter stated while they support any initiative designed to help Utah's extremely low-income populations, they believe Medicaid is medical insurance, not a housing program, and therefore they do not support this proposal. They believe precious resources should not be directed away from core functions of the Medicaid program.

Response: Language in Senate Bill 96 requires UDOH to seek CMS authority to provide housing supports for eligible Medicaid expansion enrollees. In addition to the statutory mandate, the State acknowledged that a growing body of empirical evidence shows that addressing social determinants of health such as housing supports, has the potential to reduce medical utilization and cost. For example, a health care utilization study conducted in Seattle by Mackelprang and colleagues (2014) examined EMS utilization before and after entering a single-site Housing First program. The 91 program participants had substance use disorders. The study did not monitor health outcomes, but examined and categorized the reasons for EMS calls through examination of administrative data, both for two years prior to enrollment in supported housing and two years following enrollment. The study found a 54 percent reduction in EMS calls for those who entered supportive housing.

Not Allowing Hospitals to Make Presumptive Eligibility Determinations for the Adult Expansion Demonstration Population

18. Many commenters stated they are opposed to this provision. They believe hospital presumptive eligibility is an important entry point for individuals to receive Medicaid. They believe approval of this proposal will lead to individuals facing significant out of pocket costs, and increased uncompensated care costs for providers. They also stated while they believe retroactive eligibility is an important safeguard they do not believe it is sufficient.

Response: Senate Bill 96 directs the state not to implement hospital presumptive eligibility for adults on the Adult Expansion Medicaid program. Most Medicaid programs (including Adult Expansion Medicaid program) offer retroactive eligibility for the three months prior to the month the application is received. Three months retroactive coverage is not a benefit available in the commercial, marketplace, or Medicare plans. Due to the availability of retroactive coverage, uncompensated care costs and individual out-of-pocket expenses will only occur when an individual was never eligible for Medicaid.

19. One commenter stated that because the State has already waived retroactive eligibility, this proposal will lead to hospitals not being reimbursed for low income uninsured patients. They also believe this will lead to crippling financial liabilities for patients.

Response: The State has not had retroactive eligibility waived for the Adult Medicaid Expansion. These adults can continue to request retroactive eligibility when applying for Medicaid.

If the State obtains authority to waive retroactive eligibility at a later date through an administrative rule process, then the public and the State will be able to discuss at that time how to balance the need of the State to reduce expenditures and the impact on members and hospitals.

20. One commenter stated the waiver does not address the gap between those who have qualified under presumptive eligibility and those who successfully complete the Medicaid application process. They believe this does not address the actual impact.

Response: The State believes it has addressed this in the waiver amendment. The amendment states that approximately 54 percent of individuals approved for hospital presumptive eligibility are ultimately approved for ongoing Medicaid.

21. One commenter stated that Senate Bill 96 does not require the State to eliminate presumptive eligibility, only to "limit". They also indicate this only applied to the per capita cap waiver, not the fallback plan.

Response: While Senate Bill 96 uses the term "limit" in conjunction with the Hospital Presumptive Eligibility (HPE) Program, UDOH has consistently stated that this means to eliminate this group from the larger HPE program which includes several eligibility groups There have not been any discussions about "limiting" which hospitals or providers may determine eligibility under the HPE program or allowing a limited quota of individuals to qualify at any one HPE approved site. The Senate Bill 96 provisions limiting HPE are included under both the 'Per Capita Cap' waiver request as well as the 'Fallback' waiver amendment.

Managed Care Flexibilities

22. One commenter stated they are extremely concerned that these changes would limit oversight over patient care provided through managed care. They believe these issues require significant oversight to ensure taxpayer funds are being spent appropriately.

Response: This change does not limit CMS oversight. This change only allows the State to implement new rates and contracts in a timely manner while minimizing risk of federal funds disallowance. CMS still retains all oversight authority they have by federal law and regulation.

23. One commenter stated they are concerned that the previous Per Capita Cap waiver application indicated the State intended to submit plan contracts and rates to CMS by October 1, 2019, which is almost four weeks after the closure of the waiver comment period. It is unknown whether the State has already provided this information to CMS. They request additional clarification.

Response: Federal regulations encourage states to submit proposed rates and contracts at least 90 days before the contract/rate period. Rates for the Medicaid expansion group have been submitted to CMS for their review. Contracts for the expansion group are still in draft but will be sent to CMS soon. Both rates and contracts are subject to the current CMS review process.

24. One commenter stated they are strongly opposed to the State's request to "implement contracts and rates prior to formal approval by CMCS and the Office of the Actuary" as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State's decisions. They believe this places the Medicaid program at increased financial risk, contrary to the waiver's global concern with making Medicaid a fiscally sustainable program.

Response: Under current regulations (42 CFR 438.806) a state must obtain prior approval of a managed care organization (MCO) (comprehensive risk) contract and rates. Prior approval by CMS is a condition for federal financial participation. All managed care rates are calculated under very specific rate setting guidance from CMS by the State's contracted actuarial firm, Milliman, Inc. The rates must be certified by the actuary as being actuarially sound. The current CMS process for rate approval takes months to complete. At the end of the process, CMS typically approves the rates originally submitted by the State.

The State waits until the rates are approved to reimburse the plan the current rate. This causes a delay in appropriate reimbursement and a significant administrative burden to the State and the plan when the State recoups and repays the plans the approved rates.

Under this waiver request, the State will still submit rates and contracts to CMS for final approval. The purpose of this waiver request is to allow the State to pay the current proposed rate and be assured federal financial participation pending CMS's review. This waiver will put the State at less risk by assuring federal match. If CMS requires any change to the rate or contract, the State will not be at risk of losing any federal match for the past period and will only be required to make changes prospectively resulting in far less administrative burden.

25. One commenter stated they are strongly opposed to the State's request for more flexibility in implementing contracts and rates prior to formal approval by CMS as this proposal leaves the State open to what could be significant financial losses or untenable contract situations should CMS not concur with the State's decisions.

Response: Please see the State's response to Comment 24.

26. One commenter stated they are strongly opposed to the State's request for more flexibility in implementing directed payments and rates prior to their formal approval by CMS as this proposal leaves the State open to what could be significant financial losses should CMS not concur with the State's decisions.

Response: Directed payments are part of the rate setting process. Please see the State's response to Comment 24.

27. One commenter stated they are strongly opposed to the State's proposal to "adopt an approach to network adequacy, access to care, and availability of services" without any firm definition of how those parameters would be established.

Response: Currently CMS does not provide any specific guidance or standards to states regarding network adequacy, access to care, and availability of services. The State is currently working to establish these standards and parameters in accordance with the requirements in federal regulation. The State intends to adopt these standards through administrative rule making allowing for full transparency and public comment.

Benefits

28. One commenter stated they are extremely disappointed that adults with dependent children receive fewer benefits than adults without children. They believe benefits should be the same.

Response: Currently, adults without dependent children (including Targeted Adult Medicaid members) receive traditional Medicaid benefits. Adults with dependent children receive non-traditional Medicaid benefits. This includes Parent Caretaker Relative Medicaid members. The State chose to keep benefits received by Adult Expansion Medicaid members consistent with the benefit packages offered today.

Demonstration Hypotheses and Evaluation

29. One commenter suggests there should be a comparison of how the people on ESI are doing health wise compared to those who receive regular Medicaid.

Response: As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The suggested hypotheses may be refined and/or amended after consulting with the evaluator.

30. One commenter stated they do not agree with the hypotheses for community engagement, which proposes to compare health outcomes of Medicaid beneficiaries subject to the requirement with those who are not. They believe these are biased comparisons because people who are subject to the requirement are, by virtue of the fact they do not qualify for an exemption, almost certain to be more healthy than those not subject to the requirement.

Response: As stated above, the State will work with an independent evaluator to develop an evaluation plan. However, the State will follow CMS guidance specific to community engagement initiatives, in

developing an evaluation plan. The evaluation plan also requires CMS approval prior to conducting the evaluation. The State will consider this concern in consultation with the independent evaluator.

31. One commenter stated they are concerned with how the waiver will be evaluated. They stated they are left to wonder how the impact or effectiveness in terms of increasing coverage or access, and improving quality and efficiency will be monitored and safeguarded.

Response: As stated in the waiver amendment, the State will work with an independent evaluator to develop an evaluation plan. The evaluation plan requires CMS approval prior to conducting the evaluation.

Enrollment Limit

32. Several commenters referred to CMS's August 16, 2019, letter to Utah, which denies Utah's request to implement an enrollment limit for the expansion population, as this would be akin to partial expansion, and would make the State ineligible for the requested 90/10 FMAP.

Response: CMS has officially responded to the State's Per Capita Cap waiver indicating it will not approve this provision at this time; however, Senate Bill 96 requires that the State request this program feature again in the 'Fallback' waiver amendment.

33. Many commenters stated an enrollment limit would leave many people without access to critical care. They believe anyone who is eligible should receive Medicaid, as it is an entitlement program. They believe this provision does not meet the objectives of Medicaid. They are also concerned that there will be no waitlist, which they believe creates barriers to individuals needing care.

Response: As stated in the response to Comment 1, the Social Security Act states that the purpose of the Medicaid program is to furnish medical assistance as far as practicable in each State. While the State understands the commenters' concerns, enrollment in this adult expansion population will be limited by the amount of the state tax collected and other funds appropriated by the Legislature to fund the state share of the cost to operate this Medicaid program. Current estimates place funded enrollment at 120,000-140,000.

As was done previously with the Primary Care Network (PCN) and the Targeted Adult Medicaid program, the State is requesting the ability to open and close enrollment for this program in order to stay within the budget. Once the budget limit has been reached, enrollment will be closed. Enrollment numbers will be evaluated periodically to determine if additional individuals can be covered. If additional individuals can be covered, enrollment will be opened and applications will be accepted. All

individuals applying during the open enrollment period will be reviewed for eligibility and enrolled in the program if eligible.

34. One commenter sought clarity on how the enrollment limit will work with retroactive eligibility.

Response: If an individual applies for Adult Expansion during an open enrollment period, and they request retroactive medical coverage, they will be allowed retroactive coverage (if otherwise eligible). This applies even if the retroactive months were during a closed enrollment period. However, if the individual applies when enrollment is closed (and is therefore not eligible), retroactive coverage will not be allowed, even if the retroactive months were during open enrollment. The individual must apply during an open enrollment period to receive retroactive coverage.

35. One commenter stated that enrollment limits would force health centers to supplement the Medicaid program in a way Congress did not intend to subsidize the care of those who are otherwise eligible.

Response: The State is operating its current "Bridge" expansion program with an enrollment limit. This waiver proposal is expected to continue coverage for an estimated 120,000 to 140,000 Utahns. Some of these are individuals who previously had no health care coverage, many of whom sought care through health centers. Continuation of this coverage for these adults helps relieve the financial burden of health centers for the care of the uninsured.

36. One commenter stated the State did not provide the required assessment to the impact on enrollment for this proposal.

Response: The State's estimates for impacts to enrollment are stated within the applicable waiver application sections. The budget neutrality documents require enrollment figures to be equivalent for "without waiver" and "with waiver." Budget neutrality is calculated at a per-member level and there are no calculated savings that result from reduced enrollment.

37. One commenter stated that the State cites "fiscal sustainability" as a reason for an enrollment limit. However, they add that it is hardly clear that Utah's Medicaid program faces a crisis of sustainability that necessitates a waiver of eligibility provision. They add that the waiver provides no evidence to suggest that the value of any potentially achievable sustainability would outweigh the potential negative effects of the waiver on coverage.

Response: As stated in the response to Comment 1, Medicaid's General Fund expenditures as a share of General Fund revenues has grown from 12.7 percent to 26.1 percent over the last 19 years. Senate Bill

96 directs the State to request approval of an enrollment limit to stay within the appropriations for this program.

Community Engagement Requirement

38. One commenter sought assurances that the State will follow fair hearing processes when applying the community engagement requirements.

Response: Individuals who become ineligible due to failure to comply with the work requirement will retain all federally mandated appeals rights. All decision notices sent to enrollees contain information on how to appeal decisions. The current process for appeals will be followed.

39. Many commenters stated they disapprove of the community engagement requirement, as it does not promote the objectives of Medicaid, as shown by recent court rulings.

Response: The State received approval to implement a community engagement requirement. As stated in the CMS approval letter dated March 29, 2019, "Utah and CMS will be able to evaluate the effectiveness of a policy that is designed to improve the health of Medicaid beneficiaries and promote their financial independence. Promoting beneficiary health and independence advances the objectives of the Medicaid program. Indeed, in 2012, HHS specifically encouraged states to develop demonstration projects "aimed at promoting healthy behaviors" and "individual ownership in health care decisions" as well as "accountability tied to improvement in health outcomes.""

40. Many commenters stated this requirement will increase the administrative burden on impacted individuals, likely decreasing the number of people with coverage. They cited Arkansas as an example of individuals losing coverage. They also believe the administrative cost to the State will be high.

Response: Utah's community engagement requirement is significantly less onerous than Arkansas's requirement. Utah is structuring its community engagement requirement to be similar to SNAP. Individuals who are meeting the SNAP requirement or who are already exempt under the SNAP requirement will meet the Medicaid community engagement requirement. In addition, due to similarity to SNAP, Utah already has the technology and the infrastructure to support a community engagement requirement for Medicaid. Therefore, the administrative cost to Utah will be minimal. Finally, due to the simplicity of Utah's community engagement requirement and the options for exemption or hardship, Utah's estimates on the impact on enrollment may differ from those estimated by other states.

41. Many commenters stated they believe the current exemptions will not capture all individuals who have, or at risk of serious and chronic health issues that prevent them from working.

Response: Many adults with chronic conditions are able to work and may want to do so. Any adult can access employment services or choose to participate. However, the State is developing a list of potential serious or chronic health conditions that would meet the definition of physically or mentally unable to work. The State is considering using these conditions to automatically exempt an adult with one of these conditions.

42. Several commenters stated concerns with the impact to children if their parents lose coverage due to the community engagement requirement and enrollment limit. They state that studies show that if parents do not have medical coverage, their children are less likely to have medical coverage.

Response: Children may be determined eligible for Medicaid independently from their parents. Many children receive Medicaid or CHIP even though their parents were not previously eligible for coverage or are currently not covered by Medicaid. Members will be provided with clear information on how to meet the community engagement requirement. In addition, the State has provided members with multiple pathways to meet an exemption or request a hardship waiver when one is warranted. The State intends to monitor and evaluate the implementation of the community engagement requirement to minimize any potential negative impact on children.

43. Several commenters requested exemptions for specific illnesses or diseases, such as cancer and HIV. They indicated Michigan and Arizona as states who have done so, by including these in the definition of medically frail.

Response: The State appreciates this feedback from commenters. The current exemptions proposed in the waiver are quite broad and are intended to cover any condition which prohibits an individual from participating in community engagement. In addition, the waiver also includes a request for a hardship exemption to address unique circumstances. The State is also considering creating a list of conditions that would automatically exempt an adult with one of these conditions.

44. One commenter stated the implementation and administrative costs will be high, as indicated by other states. They ask that the State include a projection of administrative costs associated with implementation be included in the waiver.

Response: Other states have designed their community engagement requirements very differently than what Utah has proposed. Some states designed entirely new systems to capture information for their community engagement program. Utah's program relies on existing resources at DWS that already provide job assessment, training, and search reporting for SNAP recipients. The State anticipates operating the community engagement requirement within its existing resources.

Waiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 and 20 year old adults

45. Many commenters are strongly opposed to the request to waive EPSDT. They state EPSDT is the backbone of the Medicaid program for children and young adults and ensures that all medically necessary services they are found to need are provided. They also state that this benefit is much needed due to the mental health and SUD crisis within this population. In addition, they state that dental care would be cut at a time when young adults are entering the job market, and it has been proven that dental issues impact an individual's ability to get employment.

Response: Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. In addition, as of November 2017, all adults on Utah Medicaid, including 19 and 20 year olds, receive the full array of behavioral health services.

Full dental services have not been available for most adults between 19-64 with or without dependent children (only disabled 19 and 20 year old adults receive full dental benefits). Budget estimates for Senate Bill 96 did not include dental coverage for 19 and 20 year old adults. Expanding dental benefits to these adults would require an additional appropriation.

46. One commenter stated the Secretary does not have the authority to waive EPSDT, both because Congress' intent with respect to EPSDT coverage is abundantly clear, and because the requirement is located outside of § 1396a. They also stated that without EPSDT these individuals will not receive medically necessary services, as Utah limits coverage of certain mental health services for adults enrolled in its 1115 PCN waiver.

Response: Previous Secretaries have approved and reauthorized Utah's current waiver of EPSDT. Utah's 1115 Primary Care Network demonstration waiver includes a waiver of EPSDT for 19-20 year Current Eligible (Non-Traditional parents 0-40 percent FPL). In addition, effective November 1, 2017, full mental health benefits were restored for all adults as a result of a waiver amendment to the PCN Waiver. Therefore there are no differences in behavioral health benefits for adults.

47. One commenter stated the EPSDT waiver should be rescinded because it was not included in Senate Bill 96 and was not requested by the state legislature.

Response: Utah has had a waiver of EPSDT for 19 and 20 year old adults since the approval of Utah's current 1115 Primary Care Network Waiver in 2002. This waiver continues to exist for parents whose income is between 0 to 40 percent FPL. Although not required by Senate Bill 96, the State is requesting the same waiver of EPSDT requirements for 19-20 year old adults with higher incomes as a matter of

equity in the adults with dependent children group. Senate Bill 96 authorizes UDOH to include additional flexibilities and cost controls in this waiver request beyond those specifically identified in the bill.

Employer-Sponsored Insurance (ESI) Requirement

48. Several commenters stated they are concerned that this proposal will divert funds that could be used for patient care to cover the administrative costs of coordinating benefits between the ESI provider and Medicaid. They do not believe this an efficient use of funds for such a small portion of the population. They also believe ESI creates administrative complexity.

Response: The State already has established processes for purchasing ESI and coordinating benefits and payments for members. As such, this process does not require significant new administrative infrastructure and is not expected to divert funds for patient care. ESI presents an opportunity for members to be covered with a commercial plan as their primary benefit as well as Medicaid as a secondary benefit while maintaining cost effectiveness.

49. One commenter stated they are concerned about the beneficiary communications around the wraparound benefit offered. They believe this will create unnecessary complexity and barriers to care for beneficiaries. They state national research shows states have not sufficiently explained the availability of wraparound services.

Response: For those beneficiaries that have access to ESI we will notify them in advance of the requirement to enroll and allow time for them to enroll in their coverage. After the ESI coverage is added, all future claims are processed by the ESI coverage first and the Medicaid coverage second. This is a routine and regular process for health insurance companies and Medicaid has years of experience in processing these types of claims. Some individuals may receive additional services if their health plan covers beyond the scope of Medicaid's services.

50. One commenter referred to concerns that remain from the previous waiver request for ESI. These concerns include: timeframe that the individual will be "locked-out" if they fail to enroll in ESI; how ESI coverage and premium amount will be verified; what safeguards will be in place to ensure someone does not lose coverage due to an individual or state error; what occurs if someone accidentally misses an enrollment period.

Response: The State is proposing to lock-out individuals from Medicaid when they miss the opportunity to enroll, up until such time that the person enrolls in their employer sponsored plan, lose access to their employer sponsored plan, or 12-months, whichever comes first. The State will be clear in its

communication to beneficiaries so they will know when this requirement applies to them. The State will validate the premium using all available verification methods except "customer statement", meaning that health plan enrollment may be validated electronically, through a collateral contact with the employer or insurance company, or by other paperwork turned in by the beneficiary. In order to protect beneficiaries, they always have the right to request a fair hearing if they believe they have been closed or denied in error.

51. One commenter stated that the State did not include an estimate regarding the number of individuals that would lose eligibility due to failure to enroll in ESI coverage.

Response: The State estimates 100-200 members per year will lose eligibility due to failure to enroll in ESI coverage. This information has been added to the waiver application.

Changes through Administrative Rulemaking

52. Several commenters expressed concern that the request to allow the State to make certain changes through the administrative rule process would relinquish federal oversight of the areas where the State is allowed to make these changes. They also believe that bypassing the full notice and comment process could place the State at an undetermined financial risk should CMS come out later with a negative decision on something that had only been processed (and approved) at the state level.

Response: The intent of this proposal is to allow more flexibility and expedience to change approved waiver criteria in response to budget issues. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

Administrative rulemaking is governed under the Utah Administrative Rulemaking Title 63G Chapter 3, Utah Code Annotated. State law requires an opportunity for public comment on proposed rulemaking similar to the federal process for waiver amendments. Proposed rules are published on a public website. The State must allow at least 30 days for public comment. In addition, UDOH reports on all rulemaking at its Medical Care Advisory Committee and the Utah Indian Health Advisory Board, which are open to the public. While the state administrative rule process and the federal 1115 waiver amendment process both require UDOH meet certain transparency requirements, the administrative rule making process is more timely which allows the State to implement necessary changes without significant delays.

Finally, the State anticipates that the federal government will include language in the State's Standard Terms and Conditions that requires the State to notify CMS of any proposed and final rulemaking so

CMS can maintain its oversight of the State's waiver. Therefore, the State does not believe this process creates any additional or undetermined financial risk.

53. One commenter stated that if the State would like to make specific changes identified in this section of the waiver at this time, it should explicitly ask CMS to waive these provisions in its current application and include a more complete analysis of their impact on beneficiaries.

Response: Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver. The process the State is proposing will allow the State to make changes within the parameters established by the waiver in a transparent but more timely manner.

$25 Copay for Non-Emergent use of the Emergency Department

54. Many commenters are opposed to a $25 copay for non-emergent use of the emergency department. They believe this could deter individuals from seeking necessary care during emergency situations, and they should not be forced to self-diagnose. They believe patients should be educated regarding what is emergent vs. non-emergent, if this is approved and implemented. They also state a graduated cost structure combined with education efforts would promote the state's goal of reducing non-emergent use of the emergency room and could be of benefit to Medicaid beneficiaries.

Response: The State appreciates this feedback. The State is modifying its proposal to include additional education. The State anticipates providing education after the first non-emergent use of the emergency room and quarterly thereafter. If a beneficiary does not modify his/her behavior and continues to inappropriately use emergency departments for non-emergent reasons, a nominal surcharge will be added to their premium.

55. One commenter stated the proposal does not meet key criteria of the Section 1916(f) of the Social Security Act for when a Medicaid beneficiary can be charged a copay.

Response: The State appreciates this feedback. Because the State has changed its proposal regarding the $25 copay, Section 1916(f) will no longer apply.

Expansion of Targeted Adult Medicaid Subgroups

56. Several commenters stated they support new subgroups but do not support closing enrollment for individual subgroups under administrative rule. They believe the State's request to make changes to this

program without going through CMS' required notice and comment procedure is contrary to Medicaid's emphasis on transparency in the 1115 waiver review and approval process.

Response: The State currently has approval to suspend enrollment for Targeted Adult Medicaid. The State is requesting to continue this authority, and to apply this authority to the individual subgroups. If an individual is ineligible for the Targeted Adult Medicaid program due to enrollment being suspended, eligibility for Adult Expansion Medicaid will be determined. Through this waiver request, the State is seeking CMS approval of defined options for operating the State's Medicaid Expansion program. The State would then use its administrative rulemaking process to activate the options approved in the waiver.

Premiums

57. One commenter stated the Medicaid Act prohibits states from charging premiums to individuals with household income below 150 percent of FPL. These limits exist outside of § 1396a, and as a result, cannot be waived under § 1115. Time and again, Congress has made clear its intent to insulate the substantive limits on premiums and cost-sharing from waiver under § 1115.

Response: CMS has approved premiums in other States (e.g., Iowa and Michigan). As stated in Comment 1, Section 1115 of the Social Security Act gives the Secretary broad authority to waive certain provisions of the Act. CMS has encouraged the State to bring proposals to CMS without trying to determine ahead of time all of the authorities needed for obtaining approval for the proposal. CMS has offered to use the flexibility available to it under statute to determine if there is a legal pathway forward to allow the State to pursue the flexibility it was seeking.

58. Many commenters stated that premiums serve as a barrier to obtaining and maintaining Medicaid for those with low incomes. They also state premiums result in increases in disenrollment, shorter lengths of enrollment, and serve as a deterrent to those eligible from enrolling.

Response: Medicaid beneficiaries who will pay premiums are those who have been eligible for coverage in the federal marketplace and have likely paid premiums before. When members financially participate in their healthcare they are more engaged in their healthcare decisions and better prepared for future health coverage in the private sector.

59. One commenter stated the proposed waiver does not indicate whether services received during the suspended period would be retroactively covered.

Response: Individuals can request coverage for months in which they failed to pay premiums (up to 3 months). However, they must pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

60. One commenter stated they are concerned there is no grace period in which to pay the premium before they lose eligibility.

Response: The State is proposing to follow the process used for the Children's Health Insurance Program (CHIP), which is consistent with private health insurance. Individuals must pay their premium by the end of the month it is due or they will lose eligibility. Individuals may also need to pay past due premiums to regain eligibility. If it has been more than six months from when the coverage ended, they will not be required to pay past due premiums.

61. Several commenters stated there will be a high administrative cost to implementing and collecting premiums. They believe the State has not included any consideration of the administrative costs of a premium.

Response: The State intends to build upon existing infrastructure for collecting premiums from CHIP members. This is expected to mitigate the increased administrative cost of collecting premiums for Medicaid Expansion adults with incomes from 101-133 percent FPL. The State is still developing its estimates for the cost of implementing and collecting these new premiums.

62. One commenter stated the State is offering an overly optimistic percentage of people who would fail to pay a premium.

Response: The State is estimating that disenrollment due to non-payment of premiums will be similar to experience with Marketplace plan enrollees. The State used information from Washington State's Annual Grace Period Report (2017)[1] in which 5,077 enrollees out of 149,628 were terminated for non-payment of premiums. This equates to 3.4 percent and the State has assumed the same percentage.

[1] https://www.wahbexchange.org/wp-content/uploads/2018/01/HBE_EB_180112_Annual-Grace-Period-Report.pdf

ATTACHMENT 4

Tribal Consultation

UTAH DEPARTMENT OF HEALTH MEDICAID

Utah Indian Health Advisory Board (UIHAB) Meeting

10/11/2019
9:00 AM –1:00 PM
Utah Department of Health
Cannon Health Building
288 North 1460 West
Room 125
Salt Lake City, UT 84114

(801) 538-6771 or (801) 712-9346

Meeting called by:	UIHAB **DRAFT** **DRAFT** **DRAFT** **DRAFT** **DRAFT**
Type of meeting:	Monthly UIHAB NATIONAL LEAD PREVENTION MONTH!
Facilitator:	Melissa Zito
Note taker:	Dorrie Reese Call In **1-877-820-7831** **passcode 868079 #**
Please Review:	Board minutes, Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

9:00 AM	**UIHAB Meeting** Welcome & Introductions Approval of Minutes	Lorena Horse, Chair & Ed Napia, Vice Chair
9:15 AM	Medicaid Expansion "Fall Back" Option	Nate Checketts
10:00 AM	Committee Updates & Discussion • UT Medicaid Eligibility Policy • Medicaid & CHIP State Plan Amendments (SPA) & Rules • DWS Medicaid Eligibility Operations • Federal and State Health Policy Impacting I/T/U • MCAC & CHIP Advisory Committees • Opioid SOR Grant	 Jeff Nelson Craig Devashrayee Jacoy Richins Melissa Zito Donna Singer & Ryan Ward Jeremy Taylor & Kassie John
10:30 AM	I/T/U & UDOH Updates • "Take 10" – Emergency Preparedness • UTERC	ALL Melissa Zito Anna Boynton
11:10 AM	***BREAK***	
11:15 AM	Huntsman Cancer Institute Mobile Mammography	Lynette Phillips
11:30 AM	MCH Grant Follow Up from Survey	Lynne Nilson & Sharon Talboys
11:50 AM	Hemophilia Disease Management Program	Trevor Smith
12:05 PM	Utah Cancer Control Program Outreach	Marie Nagata
12:40 PM	Wrap Up	
1:00 PM	Adjourn	

THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

Submitted via email: Medicaid1115Waiver@utah.gov

October 27, 2019

Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Jennifer Meyer-Smart

RE: Amendment to the 1115 Primary Care Network Demonstration Waiver

Dear Division of Medicaid and Health Financing,

On behalf of the Navajo Nation please find the following comments in reference to the Fallback Plan on the proposed amendment of the Utah Section 1115 Demonstration waiver application pursuing to implement several new provisions that will increase coverage but impose restrictions for Utahns across the state. The Navajo Nation supports equitable health care access and quality of care to further reduce health care disparities. We support Utah to implement Medicaid Expansion as intended by the Affordable Care Act. Utah has fell short of these requirements in these proposed amendments.

Federal Trust Responsibility and Tribal Consultation

The Utah Medicaid Program and Centers for Medicaid and Medicare Services (CMS) have a responsibility to fulfill trust responsibilities in providing access to health services for American Indian and Alaska Natives (AIAN). This responsibility and federal laws support unique treatment for AIANs Medicaid enrollees. In accordance with the Utah Medicaid State Plan and section 1902(a)(73) of the Social Security Act, the state ensures meaningful consultation process and occurs in a timely manner on program decisions impacting Indian Tribes. The Tribal consultation with Tribal leaders is occurring in November, well after the waiver is submitted to CMS.

Section II. Program Overview and Demonstration Eligibility
A. Approved Demonstration Populations and Components
Continue the following components for the Adult Expansion and Targeted Adult Populations and Targeted Populations, which are currently authorized under the State's 1115 Demonstration Waiver.

Utah proposes an exemption for members of federally recognized Tribes from …

- community engagement requirements,
- enrollment limits, and
- Employer-Sponsored Insurance (ESI) coverage.

The Navajo Nation recommends continued exemption as a federally recognized Tribe and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Imposing work requirements is not aligned with the federal trust responsibility and congressional intent to increase access to Medicaid resources in the Indian health system.

The state is seeking federal approval to implement the following proposals:

B. New Demonstration Waiver Requests
1. Income Limit Increase for Adult Expansion Population
"Increase the income limit for the Adult Expansion Population to 133 percent federal poverty level (FPL), to receive the full Federal Medical Assistance Percentage (FMAP) allowable under 42 U.S.C. Section 1396d(y) for the Adult Expansion and Targeted Adult Population."

Utah proposes to increase the limit for the Adult Expansion Population to 133 percent FPL for Navajo members and federally recognized Tribes. The Navajo Nation recommends the increase to 138 percent at a minimum, but should further increase to 200 percent FPL. As well, the FPL apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Utah should fully expand so the state is not paying an extra $2.5 million every month.

3. Housing Related Services and Supports (HRSS)
The State intends to offer the following HRRS:

1. *Tenancy Support Services*
2. *Community Transition Services*
3. *Supportive Living/Housing Services*

Utah proposes to seek authority to evidence-bases services, provide housing supports, and administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. The Navajo Nation recommends clarity of the rulemaking process and any changes should not be at the expense of other services approved and proposed in the amendment for the targeted adult group.

4. Targeted Adult Medicaid Eligibility Definitions
Expansion of the Target Adult Group
- Chronic homeless
- Involved in the justice system AND in need of substance abuse or mental health treatment
- Needing substance abuse or mental health

Utah proposes to make this new group eligible for the "Targeted Adult Group." The Navajo Nation recommends continuous coverage/eligibility or 12 months; however, we oppose the ability for the state to suspend enrollment.

5. Flexibility to Make Changes through the State Administration Rule Making Process

Utah proposes the ability to make changes for the Medicaid Expansion through state administrative rulemaking process pursuant to Title 63G Chapter 3 of the Utah Code Annotated. The Navajo Nation recommends the state to conduct timely and proper Tribal Consultation to Tribal leaders in Utah. We recommend the state remove these provisions prior to submission to CMS.

Section IV. Demonstration Benefits and Cost Sharing Requirements
Cost Sharing for Non-Emergent Use of the Emergency Room, Cost Sharing for Individuals without ESI, Cost Sharing for Employer-Sponsored Insurance.

Utah proposes to raise premium amounts and certain cost sharing; however, exemptions exist for premium raises and certain cost sharing for individuals with verified members in a federally recognized Tribe. The Navajo Nation recommends exemption as a federally recognized Tribes and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U.

Section V. Delivery System – Managed Care

Utah proposes that Adult Expansion beneficiaries that live in non-mandatory managed care counties will receive services through the Fee-for-Service network. Beneficiaries living in mandatory managed care counties will be enrolled in managed care no later than the second month after the approved Medicaid Expansion. Utah proposes greater authority to administer its managed care delivery system. The Navajo Nation recommends exemption for federally recognized Tribes regardless of where the beneficiaries reside and should apply to all AIAN persons that are eligible to receive services from Indian Health Services, Tribally-operated and urban Indian health programs known as I/T/U. Navajos commute between non-mandatory and mandatory counties; therefore, increasing access to ACOs and/or non-ACOs is recommended based on existing health care access challenges.

Conclusion

Utahns voted for full expansion for Medicaid; however, this "Fallback Plan" amendment does increase coverage up to 138% with greater restrictions that could deter individuals from accessing necessary health care services. It is also critical for the Indian health system to receive 100% reimbursement to states for services provided to IHS-eligible individuals by Indian health care providers; else for non-Indian health care providers to limit reimbursement (FMAP) to a state's standard FMAP rate.

We understand that CMS has the ultimate authority to approve or disapprove Medicaid waivers, please consider the federal trust responsibility to all American Indian and Alaska Natives. The state should fully expand pursuant to the Affordable Care Act.

Thank you for this consideration for comments. If you have any questions, please contact Jill Jim at Jill.Jim@nndoh.org or (928) 871-6350.

Best Regards,

President Jonathan Nez
NAVAJO NATION

ATTACHMENT 4

Compliance with Budget Neutrality Requirements

UTAH DEPARTMENT OF HEALTH MEDICAID

Budget Neutrality Summary for the Period July 1, 2022 - June 30, 2027

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 21	DY 22	DY 23	DY 24	DY 25	
Medicaid Populations						
Medicaid Pop 1: Current Eligibles	$ 545,539,764	$ 588,012,196	$ 633,788,109	$ 683,129,219	$ 736,311,768	$ 3,186,781,056
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
Hypo 2: ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)	$ 6,649,503	$ 7,106,956	$ 7,595,879	$ 8,118,437	$ 8,676,945	$ 38,147,720
Hypo 3: Former Foster Care Youth From Another State	$ 213,468	$ 224,782	$ 236,696	$ 249,240	$ 262,450	$ 1,186,637
Hypo 4: Adult Expansion Pop	$ 1,388,812,259	$ 1,484,355,598	$ 1,586,471,841	$ 1,695,613,172	$ 1,812,262,880	$ 7,967,515,750
Hypo 5: Mandatory Employer Sponsored Insurance	$ 420,991	$ 449,954	$ 480,908	$ 513,992	$ 549,352	$ 2,415,198
Hypo 6: Targeted Adults	$ 104,614,439	$ 111,260,595	$ 118,328,980	$ 125,846,420	$ 133,841,443	$ 593,891,878
Hypo 7: Dental - Blind/Disabled	$ 11,146,349	$ 11,913,162	$ 12,732,728	$ 13,608,676	$ 14,544,885	$ 63,945,800
Hypo 8: Dental - Targeted Adults	$ 643,407	$ 687,670	$ 734,978	$ 785,541	$ 839,582	$ 3,691,178
Hypo 9: Dental - Aged	$ 8,961	$ 9,578	$ 10,237	$ 10,941	$ 11,693	$ 51,410
Hypo 10: SUD	$ 30,242,321	$ 31,845,164	$ 33,532,958	$ 35,310,204	$ 37,181,645	$ 168,112,292
Hypo 11: Withdrawal Management Services	$ 2,041,489	$ 2,149,688	$ 2,263,622	$ 2,383,593	$ 2,509,924	$ 11,348,316
Hypo 12: ISS Services	$ 3,640,609	$ 3,833,561	$ 4,036,739	$ 4,250,687	$ 4,475,973	$ 20,237,568
TOTAL	$ 2,093,973,560	$ 2,241,848,903	$ 2,400,213,674	$ 2,569,820,123	$ 2,751,468,542	$ 12,057,324,803

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 21	DY 22	DY 23	DY 24	DY 25	
Medicaid Populations						
Medicaid Pop 1: Current Eligibles	$ 252,558,974	$ 272,221,954	$ 293,416,166	$ 316,259,591	$ 340,878,820	$ 1,475,335,505
Medicaid Pop 2: ESI Childless Adults (3)/ COBRA Childless Adults (5) (Utah's Premium Partnership)	$ 31,670	$ 31,670	$ 31,670	$ 31,670	$ 31,670	$ 158,350
Expansion Populations						
Hypo 4: Adult Expansion Pop	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 4,716,942,834
Hypo 8: Dental - Targeted Adults	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 394,657,651
Excess Spending From Hypotheticals						$ 3,509,011,453
Other WW Categories						
Hypo 2: ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)	$ 577,328	$ 577,328	$ 577,328	$ 577,328	$ 577,328	$ 2,886,640
Hypo 3: Former Foster Care Youth From Another State	$ 265,111	$ 265,111	$ 265,111	$ 265,111	$ 265,111	$ 1,325,555
Hypo 5: Mandatory Employer Sponsored Insurance	$ 352,697	$ 352,697	$ 352,697	$ 352,697	$ 352,697	$ 1,763,483
Hypo 6: Targeted Adults	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 394,657,651
Hypo 7: Dental - Blind/Disabled	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 44,206,545
Hypo 8: Dental - Targeted Adults	$ 404,776	$ 404,776	$ 404,776	$ 404,776	$ 404,776	$ 2,023,880
Hypo 9: Dental - Aged	$ 8,501	$ 8,628	$ 8,758	$ 8,889	$ 9,022	$ 43,797
Hypo 10: SUD	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 132,806,260
Hypo 11: Withdrawal Management Services	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 8,810,395
Hypo 12: ISS Services	$ 3,640,609	$ 3,833,561	$ 4,036,739	$ 4,250,687	$ 4,475,973	$ 20,237,568
TOTAL	$ 1,396,255,932	$ 1,416,111,992	$ 1,437,509,512	$ 1,460,567,015	$ 1,485,411,664	$ 7,195,856,115
VARIANCE	$ 697,717,628	$ 825,736,911	$ 962,704,162	$ 1,109,253,108	$ 1,266,056,878	$ 4,861,468,688

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 2: ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)	$ 6,649,503	$ 7,106,956	$ 7,595,879	$ 8,118,437	$ 8,676,945	$ 38,147,720
Hypo 3: Former Foster Care Youth From Another State	$ 213,468	$ 224,782	$ 236,696	$ 249,240	$ 262,450	$ 1,186,637
Hypo 4: Adult Expansion Pop	$ 1,388,812,259	$ 1,484,355,598	$ 1,586,471,841	$ 1,695,613,172	$ 1,812,262,880	$ 7,967,515,750
Hypo 5: Mandatory Employer Sponsored Insurance	$ 420,991	$ 449,954	$ 480,908	$ 513,992	$ 549,352	$ 2,415,198
Hypo 6: Targeted Adults	$ 104,614,439	$ 111,260,595	$ 118,328,980	$ 125,846,420	$ 133,841,443	$ 593,891,878
Hypo 7: Dental - Blind/Disabled	$ 11,146,349	$ 11,913,162	$ 12,732,728	$ 13,608,676	$ 14,544,885	$ 63,945,800
Hypo 8: Dental - Targeted Adults	$ 643,407	$ 687,670	$ 734,978	$ 785,541	$ 839,582	$ 3,691,178
Hypo 9: Dental - Aged	$ 8,961	$ 9,578	$ 10,237	$ 10,941	$ 11,693	$ 51,410
Hypo 10: SUD	$ 30,242,321	$ 31,845,164	$ 33,532,958	$ 35,310,204	$ 37,181,645	$ 168,112,292
Hypo 11: Withdrawal Management Services	$ 2,041,489	$ 2,149,688	$ 2,263,622	$ 2,383,593	$ 2,509,924	$ 11,348,316
Hypo 12: ISS Services	$ 3,640,609	$ 3,833,561	$ 4,036,739	$ 4,250,687	$ 4,475,973	$ 20,237,568
TOTAL	$ 1,512,500,417	$ 1,615,998,716	$ 1,726,582,010	$ 1,844,735,479	$ 1,970,977,538	$ 8,670,794,161

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 2: ESI Adults w/Children (3)/ ESI Adult Children (3)/COBRA Adults with Children (5)	$ 577,328	$ 577,328	$ 577,328	$ 577,328	$ 577,328	$ 2,886,640
Hypo 3: Former Foster Care Youth From Another State	$ 265,111	$ 265,111	$ 265,111	$ 265,111	$ 265,111	$ 1,325,555
Hypo 4: Adult Expansion Pop	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 943,388,567	$ 4,716,942,834
Hypo 5: Mandatory Employer Sponsored Insurance	$ 352,697	$ 352,697	$ 352,697	$ 352,697	$ 352,697	$ 1,763,483
Hypo 6: Targeted Adults	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 78,931,530	$ 394,657,651
Hypo 7: Dental - Blind/Disabled	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 8,841,309	$ 44,206,545
Hypo 8: Dental - Targeted Adults	$ 404,776	$ 404,776	$ 404,776	$ 404,776	$ 404,776	$ 2,023,880
Hypo 9: Dental - Aged	$ 8,501	$ 8,628	$ 8,758	$ 8,889	$ 9,022	$ 43,797
Hypo 10: SUD	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 26,561,252	$ 132,806,260
Hypo 11: Withdrawal Management Services	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 1,762,079	$ 8,810,395
Hypo 12: ISS Services	$ 3,640,609	$ 3,833,561	$ 4,036,739	$ 4,250,687	$ 4,475,973	$ 20,237,568
TOTAL	$ 1,032,356,542	$ 1,032,356,542	$ 1,032,356,542	$ 1,032,356,542	$ 1,032,356,542	$ 5,161,782,708

HYPOTHETICALS VARIANCE	$ 480,143,875	$ 583,642,175	$ 694,225,469	$ 812,378,938	$ 938,620,997	$ 3,509,011,453

ATTACHMENT 5

Public Notice Requirements

UTAH DEPARTMENT OF HEALTH MEDICAID

90 S 400 W STE 700
SALT LAKE CITY, UT 84101-1431

The Salt Lake Tribune

PROOF OF PUBLICATION CUSTOMER'S COPY

CUSTOMER NAME AND ADDRESS

DIVISION OF MEDICAID AND HEALTH FINANCING
CRAIG DEVASHRAYEE
PO BOX 143102
SALT LAKE CITY, UT 84114

ACCOUNT NUMBER

8405

ACCOUNT NAME

DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE

801-538-6641

ORDER #

SLT0012122

CUSTOMER REFERENCE NUMBER

CAPTION

PUBLIC NOTICE Utah 1115 Demonstration Waiver Renewal The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss the renewal of the State's 1115 Demonstration Waiver.

TOTAL COST

$321.80

PUBLIC NOTICE
Utah 1115 Demonstration Waiver Renewal

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss the renewal of the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding the demonstration renewal during the 30-day public comment period from May 5, 2021, through June 4, 2021.

The Utah Department of Health is requesting a five-year renewal of Utah's demonstration waiver under Section 1115 of the Social Security Act. Utah's existing demonstration waiver is currently approved through June 30, 2022. With this application, Utah is seeking a renewal period from July 1, 2022, through June 30, 2027. This 1115 waiver renewal requests authority to continue to operate the currently approved programs and benefits listed below, with minimal changes:

- Primary Care Network (PCN) Program
- Current Eligibles/Non-Traditional Benefits
- Utah's Premium Partnership Program (UPP)
- Targeted Adult Medicaid
- Former Foster Care Youth from Another State
- Dental Benefits for Individuals with Blindness or Disabilities
- Substance Use Disorder (SUD) Treatment in Institutions for Mental Disease (IMD)
- Targeted Adult Dental Benefits
- Adult Expansion Medicaid
- Community Engagement Requirement
- Employer-Sponsored Insurance Reimbursement
- Dental Benefits for Aged Individuals
- Utah Medicaid Integrated Care (UMIC)
- Intensive Stabilization Services (ISS)
- Serious Mental Illness (SMI) Services in an IMD

In addition to the renewal of current waiver and expenditure authorities, the state is requesting the following changes:

- A name change of the state's 1115 waiver
- Technical changes to the Special Terms and Conditions (STCs) for ISS
- Combining Demonstration Populations III, V, VI, and Current Eligible CHIP Children (referred to as the UPP program)
- Technical changes to references to the American Recovery and Reinvestment Act (ARRA).

The state is also requesting that the following pending amendments be considered in addition to the waiver renewal, with the hope of gaining approval for these amendments prior to the approval of the full waiver renewal:

- UPP Premium Reimbursement Increase Amendment
- In-Vitro Fertilization and Genetic Testing for Qualified Conditions
- Medicaid Coverage for Justice-Involved Populations
- Housing-Related Services and Supports requested under the Fallback Plan Amendment.

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

Thursday, May 20, 2021, from 2:00 to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting
- Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yem-xgzo-hax
- Or join by phone: 1 929-329-2602 PIN:

Monday, May 24, 2021, from 4:30 to 5:30 p.m.
- Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/dbe-xqyt-ujd
- Or join by phone:

Individuals requiring an accommodation to fully participate in either meeting may contact Michelle Smith at michelle.smith@utah.gov or 801-574-0956 by 5:00 p.m. on Monday, May 17, 2021.

Public Comment:

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

The public may comment on the proposed amendment requests during the 30-day public comment period from May 5, 2021, through June 4, 2021.
Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health
Division of Medicaid and Health Financing
P.O Box 143106
Salt Lake City, UT 84114-3106
Attn: Michelle Smith

SLT0012122

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF PUBLIC NOTICE Utah 1115 Demonstration Waiver Renewal The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss the renewal of the State's 1115 Demonstration Waiver. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 05/02/2021

DATE 05/25/2021 SIGNATURE Jordyn Gallegos

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 25th DAY OF MAY IN THE YEAR 2021

BY Jordyn Gallegos

LaRee Whitmer

NOTARY PUBLIC SIGNATURE

PUBLIC NOTICE

Utah 1115 Demonstration Waiver Renewal

The Utah Department of Health, Division of Medicaid and Health Financing (DMHF), will hold public hearings to discuss the renewal of the State's 1115 Demonstration Waiver. The Department will also accept public comment regarding the demonstration renewal during the 30-day public comment period from May 5, 2021 through June 11, 2021.

The Utah Department of Health is requesting a five-year renewal of Utah's demonstration waiver under Section 1115 of the Social Security Act. Utah's existing demonstration waiver is currently approved through June 30, 2022. With this application, Utah is seeking a renewal period from July 1, 2022 through June 30, 2027. This 1115 waiver renewal requests authority to continue to operate the currently approved programs and benefits listed below, with minimal changes.

- Primary Care Network (PCN) Program
- Current Eligibles/Non-Traditional Benefits
- Utah's Premium Partnership Program (UPP)
- Targeted Adult Medicaid
- Former Foster Care Youth from Another State
- Dental Benefits for Individuals with Blindness or Disabilities
- Substance Use Disorder (SUD) Treatment in Institutions for Mental Disease (IMD)
- Targeted Adult Dental Benefits
- Adult Expansion Medicaid
- Community Engagement Requirement
- Employer Sponsored Insurance Reimbursement
- Dental Benefits for Aged Individuals
- Utah Medicaid Integrated Care (UMIC)
- Intensive Stabilization Services (ISS)
- Serious Mental Illness (SMI) Services in an IMD

In addition to the renewal of current waiver and expenditure authorities, the state is requesting the following changes:

- A name change of the state's 1115 waiver
- Technical changes to the Special Terms and Conditions (STCs) for ISS
- Combining Demonstration Populations III, V, VI and Current Eligible CHIP Children (referred to as the UPP program)
- Technical changes to references to the American Recovery and Reinvestment Act (ARRA).

The state is also requesting that the following pending amendments be considered in addition to the waiver renewal, with the hope of gaining approval for these amendments prior to the approval of the full waiver renewal:

- UPP Premium Reimbursement Increase Amendment
- In Vitro Fertilization and Genetic Testing for Qualified Conditions
- Medicaid Coverage for Justice Involved Populations
- Housing Related Services and Supports requested under the Fallback Plan Amendment.

Public Hearings:

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

- Thursday, May 20, 2021 from 2:00 to 4:00 p.m., during the Medical Care Advisory Committee (MCAC) meeting
    - Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/yem-zgzo-hux
    - Or join by phone: 1 929-329-2502 PIN: 858 146 797#
- Monday, May 24, 2021 from 4:30 to 5:30 p.m.
    - Video Conference: Google Hangout Meeting (only works in the Chrome web browser) meet.google.com/dbe-xqyt-ujd
    - Or join by phone: (US) +1 218-301-2537 PIN: 928 511 112#

Individuals requiring an accommodation to fully participate in either meeting may contact Michelle Smith at michellesmith@utah.gov or 801-574-0956 by 5:00 p.m. on Monday, May 17, 2021.

Public Comment:

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

The public may comment on the proposed renewal during the 30-day public comment period from May 5, 2021 through June 11, 2021.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health
Division of Medicaid and Health Financing
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Michelle Smith

Medical Care Advisory Committee Agenda

Meeting:	Medical Care Advisory Committee
Date:	May 20, 2021
Start Time:	2:00 p.m.
End Time:	4:00 p.m.
Location:	meet.google.com/yem-zgzo-hux (Google Chrome) By Phone: 1-929-329-2502 PIN# 858 146 797#

Agenda Items

1.	Welcome • Approve Minutes for April 2021 MCAC* • Public Meetings – Anchor Location*** • New Committee Member – Luis Rios	Jessie Mandle	2:00 / 5 min
2.	Committee Member Updates	Committee Members	2:05 / 5 min
3.	1115 Demonstration Waiver Renewal – Public Hearing**	Michelle Smith / Members of the Public	2:10 / 10 min
4.	Caregiver Compensation HCBS Waiver Amendments Public Comment Period**	Josip Ambrenac	2:20 / 10 min
5.	CMS Interoperability and Patient Access Rule**	Brian Roach	2:30 / 10 min
6.	State Quality Strategy**	Matt Ahern	2:40 / 15 min
7.	Enrollment and Expansion Discussion** • CHIP Maintenance of Effort Plan	Jeff Nelson / Muris Prses	2:55 / 15 min
8.	State Agency Consolidation- Workgroups Update	Emma Chacon	3:10 / 10 min
9.	Director's Report • American Rescue Plan Act • Legislative Updates • Medicaid Focus Groups Update • Medicaid Vaccine Update • Medicaid Policies, SPAs, and Rules	Emma Chacon	3:20 / 30 min
10.	Additional Comments from the Public Hearing	Jessie Mandle / Members of the Public	Time Remaining
11.	Reminder: June MCAC meeting: Presentations for FY23 Budget Recommendations - Time Change: 4:00 - 6:00 To sign up email Sharon Steigerwalt (ssteigerwalt@utah.gov)	Jessie Mandle	

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
** Informational handout in the packet sent to committee members
*** In accordance with the Open and Public Meetings Act Utah Code 52-4-207, the Chair of the MCAC committee has determined providing an anchor location for the MCAC meeting presents substantial risk to the health and safety of the attendees due to the COVID-19 pandemic. The May MCAC meeting will be conducted remotely via electronic means only. The committee members and the public may attend via Google Meet or by calling in to the Google Meet session as listed on the meeting agenda. MCAC meetings will be held in an electronic format until further notice.

Next Meeting: June 17, 2021 from 4:00 p.m. – 6:00 p.m.

Medical Care Advisory Committee

Minutes of May 20, 2021

Participants

Committee Members (via phone)

Jessie Mandle (Chair), Michael Hales, Stephanie Burdick, Jenifer Lloyd, Christine Evans, Luis Rios, Muris Prses for Dale Ownby, Brian Monsen, Adam Cohen, Dr. Robert Baird, Nate Checketts, Dr. Cosgrove, Alan Ormsby, Jennifer Marchant, and Mary Kuzel.

Committee Members Absent

Joey Hanna, Pete Ziegler, Gina Tuttle, and Mike Jensen

DOH Staff (via phone)

Emma Chacon, Tonya Hales, Eric Grant, Brian Roach, Dave Lewis, Greg Trollan, Jeff Nelson, Jennifer Meyer-Smart, Jennifer Strohecker, Jeremy Taylor, John Slade, Josip Ambrenac, Kolbi Young, Krisann Bacon, Lainey Davis, Laura Belgique, Matt Lund, Matt Ahern, Melissa Zito, Michelle Smith, Todd Neff, Tracy Barkley, Sharon Steigerwalt, and Dorrie Reese.

Guest (via phone)

Andrew Riggle, Audry Wood, Becky Gonzales, Beth Smith, Caitlin Schneider, Caitlin Schneider, Connie Mendez, Courtney Bullard, Destiny Rockwood, Geoff Harding, Jeannie Edens, Jesse Liddell, Joni Nebeker, Julie Ewing, Kevin Eastman, Kristeen Jones, Kristen Tjaden, Leigha Rodak, Linzi Waldrop, Madison Moffet, Marc Watterson, Matt Hansen, Melissa Huntington, Michael Allred, Michelle Jenson, Nathan Strait, Neal Erickson, Rachel Craig, Randal Serr, Rebecca Brown, Russell Frandsen, Rylee Curtis, Sarah Leethan, Sherri Wittwer, Stacy Stanford, and Todd Wood.

Approval of Minutes:

Adam Cohen made the motion to approved the April 15, 2021 MCAC minutes. Christine Evans seconded that motion. The group unanimously agreed.

Committee Member Update:

The Committee Members gave updates.

Jessie Mandle mentioned one issue that has been brought up in past meetings about letter and communication. Muris Prses I do appreciate you talking a little bit about this with Gina and myself. I hope this is an issue that we can continue to look at, just on how the information that is on letters how that can be simplified.

Muris Prses stated that they do recognize that eRep notices are not as good as we would like them to be, as we embark on the process to continue to improve our notices a collaborated effort between DOH and DWS, so as those notices are sent to me Jeff has asked to please copy him or Michelle on them as well.

Christine Evans stated that she would also like to be included on those emails as well.

Christine Evans shared what the Utah Parent Center is doing for children with Autism.
https://theautismlifespan.com/

Jessie Mandle shared a parenting resource guide.
https://covidparenting.org/

1115 Demonstration Waiver Renewal-Public Hearing:

Michelle Smith gave an overview of the 1115 Demonstration Waiver - Public Hearing.

The document which was presented is embedded in this document.

Public Hearing-Overview-111

Questions:

Michael Hales asked about the community engagement provision that CMS issued notices to several states that they are withdrawing that authority. I know you are requesting that to be continued, what have you heard from CMS, and how do you anticipate that being handled during the renewal.

Emma Chacon stated that we have received a letter from the acting Administer of CMS stating g that they are compilating terminating our community engagement amendment because it is inconsistent with the purpose of the Medicaid program. The state was given 30 days to submit a response to CMS which we did. We were told that this is a high priority for CMS and that CMS will likely respond to our letter before the end of the calendar year.,

Michael Hales mentioned so understanding that they are not going to have any states implementing this during the maintenance of effort requirements during the public health emergency, they are probably planning on acting somewhere later in the year, but not doing anything sooner than they need to, this will probably be resolved outside of this renewal process?

Emma Chacon stated yes, technically is part of our waiver we are asking for the continuation but we suspect they will try to resolve this issue outside of the waiver renewal.

Jessie Mandle asked a question on some of the other provisions that are in the Fall Back plan that are not included in this waiver. Is that correct, such as IPV.

Emma Chacon stated there are a number of amendments that are still pending CMS approval that are not part of our waiver renewal.

Michael Hales asked that the link be shared with the group.

Jesse Mandle asked was there any discussion about taking out non -traditional package?

Emma Chacon stated that there has been discussion off and on about this. When PCN was created the reduced package for the Parent Caretaker Relative (PCR or Non-Trad) group created the savings that allows this waiver to move forward, and the differences in benefits are pretty minor. 1115 waivers must be budget neutral.

Michael Hales asked how much room do you have on your budget neutrality.

Emma Chacon stated this is a fairly complex discussion, because in addition to adding a lot of different amendments to this waiver, CMS decided to re-base all budget neutrality. In essence they wipeout 75% of our savings, which have been accumulating since the beginning of the waiver. They have taken this approach with all states.

Michael Hales asked because the state did not expand under the adult expansion during the past several years of the waiver, until April 2019, CMS is going to be using the reduced benefit from the non-traditional population to measure against what savings you would have as of the point the state would have started covering the adult expansion population that should all be a state plan option even though it is being done as an 1115 waiver, so I hope that is not being counting against us and into the future.

Emma Chacon stated it shouldn't count against us in the future, because we can adjust what our expected per member per month expenditures are, and because under the new expansion population, even under the 1115 they should be counted on with & without the waiver side, we think the expansion population should not be impacting the waiver overall.

Michael Hales asked Could the State propose to provide Non-trad with a full coverage package r prospectively at the renewal point recognizing that it might be tight for the 5-year demonstration your wrapping up in the next year or so.

Emma Chacon stated we would likely not propose to make changes to the non-traditional benefit package anytime soon. We have a lot of provisions in this waiver, and additional amendments we need to add based on recent legislation. We have not determined what the overall impact will be on budget neutrality. My recommendation is, that we move forward with the waiver renewal as it is, and if we find that we still have some room within budget neutrality we can always submit an amendment in the future, to do away with the non-traditional benefit package.

Michael Hales stated, that is something that Jesse Mandle can make in public comment.

Jesse Mandle stated that there is no eyeglass coverage.

Michael Hales asked if community engagement would generate any savings.

Nate Checketts stated that community engagement does not have a direct impact on budget neutrality, because it is still on a per capita per person basis.

Welcome Luis Rios as a new MCAC member

Caregiver Compensation HCBS Waiver Amendments Public Comment:

Josip Ambrenac discussed Caregiver Compensation HCBS Waiver Amendment Public Comment

The document which was presented is embedded in this document.

Caregiver Comp Executive Summary.pc

CMS Interoperability and Patient Access Rule:

Brian Roach discussed CMS Interoperability and Public Access Rule

The document which was presented is embedded in this document

Interoperability - MCAC.pptx

State Quality Strategy:

Matt Ahern discussed State Quality Strategy

The document which was presented is embedded in this document.

Managed Care Quality Strategy 2021

Medicaid Managed Care Quality Strategy.

Enrollment and Expansion Discussion:

Jeff Nelson and Muris Prses discussed Eligibility Enrollment and Expansion, CHIP Maintenance of Effort Plan.

The documents which were presented are embedded in this document

Medicaid Trends.pdf

Expansion Report_20210513.pdf

Questions:

Brian Monson mentioned that they have been contacting Medicaid and CHIP members to encourage them to get their renewals done.

State Department Consolidation Workgroups Update:

Emma Chacon gave an update on the State Agency Consolidation Workgroups.
https://sites.google.com/utah.gov/hhsplan/home

The workgroups have been tasked with identifying 1-3 big issues that we need to address as we move forward with this department consolidation. These recommendations will be presented to the Consolidation Steering Committee. The Steering Committee will vote to on whether or not to move forward on those items. Some of those might involve coordination changes, program changes, or organizational changes. All of the approved items as well as any proposed organizational changes will be included in the report to the Governor and the legislature on December 1ste.

With regards to the Medicaid/CHIP Eligibility Workgroup, the recommendation may be to move only one staff person from Medicaid to DWS from Medicaid. The group is also discussing how to move the Medicaid Quality Control function (MEQC) to DWS, not in eligibility itself, but with the DWS internal audit group. We are also recommending change to the administrative hearings appeal process consistent with HB 365. We are also seeking input from CMS to make sure they have no concerns with these changes.

Director's Report:

Emma Chacon discussed CHIP Outreach Plan, American Rescue Act, Medicaid Vaccine Update, and Medicaid Policies, SPAs, and Rules.

American Rescue Plan Act:

Increase FMAP for spending on Medicaid Home and Community-Based Services (HCBS) by 10%, received guidance CMS last Friday. Plan due CMS by June 12th. Recommended that we work with Senator Vickers and Representative Gibson to come up with a plan.

Memorandum and Report on FMAP.pdf

Question:

Matt Hansen asked how the funds will be used over the 3-year option to jump start projects that we wouldn't otherwise be able to fund. Correct? A rate increase would be great, but there are not also a number of great ideas that might not get funded otherwise. It might be used to establish programs that could save the system dollars and expand services.

Emma Chacon stated that we have a list of items that also support compliance with the DLC Settlement Agreement in terms of moving individuals out of ICFs into Home and Community Based Services, compensation for caregivers in the home who are providing that service of taking care of family members.

Legislative Updates:

- Potential Study items include
- Substance abuse and mental health
- Transgender issues
- Statutory Reports
- Merger DOH/DHS
- Wrap around services kids (DHS) system of care
- Review governmental units (DOH) state or local level

Medicaid Vaccine Update:

Emma Chacon stated that our staff and ACOs continue to do make outbound calls to Medicaid members to encourage individuals to get vaccinated, so far they have contacted 22,400. 10,800 left messages. 5,000 contact information was bad. About 2,400 do not want the vaccination. 2,300 want help getting vaccination. We are collaborating with Community Health Workers.

Medicaid Policy

- Logisticare (non-Emergency Transportation): Provide transportation to our Non-Traditional Medicaid members for the purpose of getting COVID vaccination, amending contract.
- Looking at adopting a policy of no more than 50 mme for opioid naïve patients
- Working on changes to allow Physician Assistants and Dental Hygienists to bill independently
- Implementing COVID Vaccine 12-15-year olds
- Removed Pregnancy exclusion for COVID vaccine
- Based on our report on Medicaid funding in Schools we are making the first changes to the reimbursement mythology effective July 1st – removing 180 minutes day

SPA's Rules:

The documents which were presented are embedded in this document

MCAC SPA Matrix 5-20-21.pdf

Adjourn

Meeting was adjourned at 4:02 pm. The next meeting is scheduled for June 17, 2021 4:00-6:00 p.m.

ATTACHMENT 6

Public Comments and State Responses

UTAH DEPARTMENT OF HEALTH MEDICAID

Utah 1115 Waiver Renewal

Summary of Public Comments and State Responses

The state received comments from 16 individuals, advocacy groups and other community partners. The state appreciates all comments and feedback submitted regarding this waiver renewal. A summary of the comments submitted related to the waiver renewal and the state's responses to those comments are detailed below. Some comments were outside the scope of the waiver renewal and are not addressed in the state's responses.

General Comments

1. One commenter stated that although the state is not requesting action on the Fallback Plan and the Per Capita Cap waiver amendments as part of the waiver renewal, they believe the state should request these amendments withdrawn. They believe approval of these waivers would be harmful to the efficiency and effectiveness of the Medicaid program, and lead to significant disruptions, costs and barriers for program administration, beneficiaries and the state as a whole.

Response: Senate Bill 96 (2019 General Session) required the state to submit these amendments. The legislation does not give the state authority to withdraw these amendments at this time. Because of this, the amendments are currently pending a decision from CMS.

2. One commenter recommended the state imbed more explicit goals to reduce health disparities in the demonstration project. They believe Utah Medicaid is a critical tool to advance health equity in Utah and ensure all Utahns are able to achieve their full health potential. They would like the state to do the following: 1) Include a waiver goal to reduce health disparities; 2) Ensure quality data is disaggregated by race/ ethnicity; 3) Identify strategies to improve collection and reporting of race/ethnicity/ language data; 4) Evaluate waiver programs through a lens of reducing health disparities. They also encourage Medicaid to continue its practice of working with stakeholders and partners as a key component to advancing health equity within the program.

Response: The state requests race, ethnicity and language information on the application and review forms. However, these data elements are not required for eligibility determinations. Because of this, the state does not have complete data. The state will work with its independent evaluator to incorporate health disparity components into the waiver evaluation. The state also intends to continue working with stakeholders and partners in advancing health equity for Medicaid members.

Adult Expansion

3. One commenter stated they applaud the state for finally proceeding with full Medicaid expansion. They further state this eligibility extension to those earning up to 138% FPL has been revolutionary for low-income parents, essential workers, students, individuals with disabilities and chronic health needs who were previously unable to qualify on the basis of disability, and so many others. They also state that had Utah's Per Capita Cap waiver request been approved, the state could have found itself in its own unique crisis within the capped program. It has also been important for enrollees to face as few barriers to enrollment as possible, and therefore the lack of premiums and the suspension of work reporting requirements has been hugely beneficial. They remain concerned that the employer sponsored insurance requirement poses a burden for enrollees. Especially with enrollees needing to pay the first premium before being reimbursed. They also state that Utah's full Medicaid expansion has been a phenomenal financial success. The state began a 0.15% increase in the non-food sales tax in 2020, which has provided sufficient funding to the program. Although Utah has had the highest increase in Medicaid enrollment in the nation since March 2020, the Medicaid budget has continued to produce savings from closing previous programs and adding the financial benefits of less uninsured individuals in our state. Additionally, Utah's Medicaid expansion budget has accrued a higher surplus than was anticipated. At the end of fiscal year 2019, the expansion budget had $62.7 million extra to be used the next year. At the end of the 2020 fiscal year, there was $109 million in surplus. This is in addition to the $74.8 million that exists in the Medicaid Fund Stabilization Restricted Account. This is the account that can only be used if cost exceeds 8% of projections. This reserve account was not used throughout the pandemic because of the ample amount of sales tax dollars accrued to pay for the program. Utah is a prime example of how to make Medicaid expansion work financially for states.

Response: The state appreciates the comments provided in support of Medicaid expansion. In regards to the concern regarding the timing of the first ESI reimbursement, the state issues ESI reimbursements once per week for new ESI reimbursements approved that week. Ongoing, individuals who are eligible for an ESI reimbursement receive the reimbursement at the beginning of each month, which allows them to be reimbursed prior to any premium payments being deducted from their paycheck.

4. One commenter stated that while Utah's Medicaid expansion is currently part of this demonstration waiver, they recommend that the new program move into SPA authority. They believe this will ensure clearer management and efficiency of the expansion program, including an easier and faster approval process and the need to re-submit approval every few years. Moving expansion into SPA Authority is in line with current state efforts to streamline government and will help Medicaid achieve even greater program efficiency.

Response: A state plan amendment has to be available to all Medicaid members on a statewide basis. The legislature did not appropriate funds to implement these services for all Medicaid members statewide.

Housing Related Services and Supports (HRSS)

5. Several commenters voiced their support of the state including a request for approval of the "Housing Related Supports and Services" in the renewal proposal for Utah's 1115 waiver. They also state it appears the plan is to at least initially limit access to these housing related supports to the Targeted Adult population. They are worried that this would exclude pregnant women and at least some parents with children who have been homeless four or more times from receiving these services intended to reduce homelessness. They encourage the state to expand eligibility for these services to pregnant women and parents with children who are eligible for TANF who meet the hardship requirements to receive these benefits.

Response: Based on the estimated cost to provide housing related services and the amount of funding designated for these services within overall Medicaid Expansion funding, the state determined to initially limit coverage to the Targeted Adult Population. Based on program flexibility the State is seeking to modify covered populations through administrative rule. After gaining additional cost and utilization experience, if funding is available, the state will consider covering housing related services for additional populations.

6. One commenter stated while they support any initiative designed to help Utah's extremely low-income populations, they believe Medicaid is medical insurance, not a housing program, and therefore they do not support this proposal. They believe precious resources should not be directed away from core functions of the Medicaid program.

Response: Language in Senate Bill 96 requires UDOH to seek CMS authority to provide housing supports for eligible Medicaid expansion enrollees. In addition to the statutory mandate, the State acknowledged that a growing body of empirical evidence shows that addressing social determinants of health such as housing supports, has the potential to reduce medical utilization and cost. For example, a health care utilization study conducted in Seattle by Mackelprang and colleagues (2014) examined EMS utilization before and after entering a single-site Housing First program. The 91 program participants had substance use disorders. The study did not monitor health outcomes, but examined and categorized the reasons for EMS calls through examination of administrative data, both for two years prior to enrollment in supported housing and two years following enrollment. The study found a 54 percent reduction in EMS calls for those who entered supportive housing.

Medicaid Coverage for Justice Involved Populations

7. Several commenters stated that while they support the state's amendment request to provide Medicaid coverage to qualified justice involved individuals in the 30-day period prior to release, they believe the state should extend the request to cover all individuals who qualify for Medicaid coverage 30 days prior to release, not just those with physical or behavioral health conditions. They believe other individuals may have undiagnosed health conditions and will benefit from a regular source of health coverage. One commenter also noted they encourage CMS to approve the original waiver request as soon as possible, consistent with Sec. 5032 of the SUPPORT Act which promotes 1115 waivers to improve transitions for individuals moving from incarceration to the community. Additionally, they

believe this program should be implemented as soon as possible upon approval to expedite the benefits for incarcerated people and help address the COVID-19 risks they face.

Response: Senate Bill 38 (2020 General Session) required the state to seek a waiver to provide Medicaid coverage for up to 30 days immediately prior to the date a qualified inmate is released from a correctional facility. A qualified inmate is defined by this legislation as an individual who is: incarcerated in a correctional facility; and has a chronic physical or behavioral health condition; a mental illness as defined in Section 62A-15-602 of Utah State Code, or an opioid use disorder. As such, the state does not have authority to expand the definition of a qualified inmate. If approved, the state does plan to implement as soon as the necessary system and policy changes can be made.

Utah's Premium Partnership for Health Insurance (UPP)

8. One commenter states they support renewing the UPP program, and that the program provides needed assistance to low-income people who have the option of employer sponsored insurance or COBRA. However, they also added that given the rising cost of health insurance premiums and for the program to be effective and attract participation, they believe the state should increase the UPP reimbursement.

Response: The state has submitted an amendment request to increase the UPP reimbursement through state administrative rulemaking. If approved by CMS, the state plans to increase the reimbursement amount from $150 per month to $300 per month for adults.

9. One commenter is very supportive of the state's proposal to increase the state's contribution to UPP premiums from $150 per month to $300 per month; if the state is going to continue the UPP program, the state's contribution to premiums should mirror actual costs. In regards to this request, the commenter also remains strongly opposed to making any change to Utah's 1115 waiver that would permit Utah Medicaid to make changes through a state administrative rulemaking process rather than the full review and approval process through CMS. Any such change would be contrary to the Final Rule for the Review and Approval Process for Section 1115 Demonstrations that places a great emphasis on the need for adequate public notice and comment. Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed Reg 28 (February 27, 2012). Reducing the notice and comment process to just the state level would remove an additional opportunity for the public to respond to proposed changes, and for CMS to review proposed changes prospectively.

Response: With this renewal request, the state is only requesting to increase the UPP reimbursement through state administrative rulemaking. The state considers this as having a positive impact on UPP eligible individuals. As stated above, the state plans to increase the reimbursement amount from $150 per month to $300 per month for adults. The state did request in the Fallback Plan to implement defined flexibilities and cost savings provisions for Medicaid Expansion through the state administrative rulemaking process, but the state is not asking for a decision on that request at this time.

Targeted Adult Medicaid (TAM)

10. One commenter stated there is still room for improvement in the TAM program. Specifically, the intersection between Medicaid and the social service sector, and the way broader social determinants of health are addressed. Housing supports, and long-term access to services are required to maintain health stability. They also state they hope the state will keep these gaps top of mind as the merger of the Department of Health and Department of Human Services proceeds. They also request that the current income limit of 5% FPL be increased. They state many individuals who are released from jail or prison are required to find employment within a certain time frame, once released. There are some people who end up not being eligible for TAM because they find employment before their application is processed. They believe by expanding the income limit or barring it entirely would expand the TAM program for more individuals who would greatly benefit.

Response: Without legislative appropriation the state will not be able to pursue such a change.

Dental Benefits

11. One commenter stated that while they are supportive and encouraged by the decision to collaborate with the University of Utah to restore dental benefits to certain key populations, they believe the state should go further by restoring dental benefits to PCR and Adult Expansion Medicaid populations. They believe that when individuals have dental coverage, they are better able to find and secure work, and less likely to experience unnecessary dental pain, disease or emergencies.

Response: Without legislative appropriation the state will not be able to pursue such a change.

12. One commenter stated that although they believe dental coverage in Medicaid is limited, the current coverage ensures that some of the most vulnerable populations - kids, individuals with blindness or disabilities, individuals with substance use disorder, and those aged 65 years and old - receive oral health care. They also state that protecting the Medicaid benefits for this population is imperative in ensuring access to preventative health care that will not only improve physical health, but overall wellbeing.

Response: The state appreciates the commenter's support of the request to continue dental coverage for Medicaid members who receive dental benefits under Utah's 1115 demonstration waiver.

13. One commenter stated they support continued access to TAM enrollees to utilize dental benefits while in residential treatment for substance use disorder (SUD). However, they would like to see dental benefits expanded to all TAM enrollees, or ideally, all Medicaid enrollees.

Response: Without legislative appropriation the state will not be able to pursue such a change.

Non-Traditional Benefits

14. Several commenters addressed the state's request to receive continued authority to provide reduced benefits for adults with dependent children. Commenters stated that this proposal will limit access to care and pose a serious risk to the health of individuals they serve. They also believe that because the state has now fully expanded Medicaid, that all Medicaid eligible adults should now receive state plan benefits. In addition, commenters specifically pointed out the exclusion of non-emergency medical transportation (NEMT) as a benefit. They believe the NEMT benefit is used primarily to access recurring appointments for critical services such as dialysis, medication-assisted substance use disorder treatment and other behavioral health services. They also state it is critical that the benefit be available for all demonstration eligible populations and that the service be safe, reliable and provided with the most appropriate, lowest cost transportation modality. In light of the recent codification of NEMT requirements into the Social Security Act as part of the Consolidated Appropriations Act, 2021, and preceding regulatory guidance since 1966, they request that CMS deny Utah's request to eliminate the NEMT benefit to current beneficiaries and adults with dependent children for the five years of this waiver extension.

Response: The state's non-traditional benefit package helps the state achieve budget neutrality, which is required for the administration of 1115 demonstration waivers. The differences between the state's traditional and non-traditional benefits are minimal, and allow the state to meet this requirement.

Serious Mental Illness in an Institution for Mental Diseases (IMD)

15. Two commenters stated the disability community has spent decades fighting for deinstitutionalization and community-based care, and IMD waivers continue to support the systemic bias that promotes institutional care. They believe that while there will always be individuals that require an intensive level of care, all efforts should be made to encourage treatment of serious mental illness in less-restrictive settings. IMD waivers should be extremely limited, and institutional treatment utilized as a last resort rather than first instinct. In addition, they encourage an expansion of home and community-based services and community-based, peer-driven treatment options.

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

16. One commenter stated the purpose of an 1115 demonstration waiver is to test novel approaches to improving medical assistance for low-income individuals. They believe this amendment request does not propose an actual experiment, with stated goals, hypotheses and measures, and it is not clear that this amendment will improve the currently inadequate mental health system for serious mental illness. They also believe CMS has granted states authority to waive the IMD exclusion, despite the illegality of these

waivers. They state that it is no longer plausible for States to claim that providing FFP for IMD services is an experiment, after more than 25 years of these waivers.

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

17. One commenter stated CMS lacks authority to grant waivers of provisions outside § 1396a. The only waiver Utah seeks through this amendment is waiver of a provision of the Medicaid Act that prohibits FFP for IMDs for individuals under age 65. This provision is found in 42 U.S.C. § 1396d(a)(30)(B) and 42 U.S.C. § 1396d(i). Section 1115 permits waiver of only those provisions contained in 42 U.S.C. § 1396a of the Medicaid Act. Because the IMD provision lies outside of § 1396a, this is not a provision that can be waived via § 1115, and the request is not approvable.

Response: See response to #16 above.

18. One commenter stated that while Utah proposes FFP for acute hospital stays, there is not a sufficient system of community-based services. They believe Utah appears to be underutilizing some of the most effective community-based interventions available for individuals at risk of hospitalization, while requesting more funding for inpatient crisis services. They further state that while H.B. 35 from the 2020 General Session provides for an additional ACT Team, expanding further would be a much better use of state funds, as the solution for any shortage of community based resources is to invest more in those resources because they are often the optimal and most effective treatment modality.

Response: The 1115 waiver requires several milestones that support community integration and bolstering community-based programs. The details can be found in the State Medicaid Director letter that announced this 1115 opportunity, which can be found at https://www.medicaid.gov/federal-

policyguidance/downloads/smd18011.pdf. The required milestones are listed below. Each milestone comes with extensive metrics and analysis that must be audited by an external party and reported to CMS. As part of the approval process, the State must create an implementation plan that outlines how each milestone will be accomplished. If the State is not accomplishing these milestones, CMS can revoke the 1115 waiver approval.

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

Enrollment Limit for Adult Expansion and Targeted Adult Medicaid

19. One commenter stated they are concerned that the state requests permission to continue its enrollment limits for the Adult Expansion and Targeted Adult Populations when projected costs exceed annual state appropriations. They also state that although the state could not have known in advance about the global pandemic, this proposal is specifically concerning in light of the COVID-19 pandemic which has resulted in millions of individuals losing jobs, and with it, their employer-based insurance. They believe this policy is not in line with the state's demonstration goals of providing continuity of coverage.

Response: This request was included in the Fallback amendment, which CMS previously denied. The state is not requesting an enrollment limit for Adult Expansion or Targeted Adult Medicaid with this renewal request.

Community Engagement Requirement

20. Many commenters stated they strongly object to the community engagement requirement and request it be removed from the renewal request. While they support the goals of helping people to find work to become more self-sufficient, a work requirement that penalizes individuals with the potential loss of coverage is not the way to meet those goals and is actually counterproductive. Ensuring access to needed health care supports an individual's ability to seek and retain employment; taking it away will have the opposite effect. They also state it is clear that community engagement requirements result in significant coverage loss as seen in Arkansas. They also state the complexity and red tape associated with the exemptions, as well as the reporting requirements to maintain coverage more generally, creating barriers to compliance.

They also state the work requirements not only increase the administrative complexity and burden for enrollees, but also for our state eligibility and enrollment system. Other states have estimated fiscal impacts in their projections. For example, Indiana has said its work search program would cost $90/month to administer and run per enrolled member. Virginia estimated its work requirement case management could cost anywhere from $200 million per year for a "high touch" approach to $7 million per year for a "low touch" approach, with nominal case management. Yet Utah does not address the

costs of training and employment supports relative to the cost of administering and enforcing the requirement.

In addition, the state Federal courts have repeatedly struck down Medicaid work requirements, ruling that the primary objective of Medicaid is to provide health coverage. Additionally, the Biden Administration has made clear that they will not approve work requirements and has sent letters to Utah and other states preliminarily disapproving work requirements. Recent analysis from the Department of Health and Human Services (HHS) determined that policies like work requirements risk access to care and can have significant public health consequences.
If Utah truly wants to encourage work and self-sufficiency, there are models that do so without penalizing individuals and parents and causing them to become uninsured.

Response: The state has not been instructed by state leadership to withdraw approval of the community engagement requirement. In addition, the state has not received any additional communication from CMS regarding the community engagement provision. As such, the state is including the community engagement in its renewal.

21. One commenter stated they oppose disenrolling from coverage individuals who are non-compliant with the community engagement requirement. The Department offers individuals who have failed to demonstrate compliance with the requirement "good cause" exceptions, but it is unclear if an appeal process is offered, how long the appeal process could take, and whether the beneficiary would lose health coverage during that process.

Response: An individual may claim good cause for not being able to participate in the community engagement requirement at any time during the 3-month participation period, up until the last day of the month of closure for non-participation in the required activities. A valid good cause reason excuses the individual from participation until their next review. Applicants and recipients have the right to ask for a fair hearing if they disagree with the agency's decision about their eligibility for Medicaid benefits or if they disagree with a point in the eligibility process that affected their case. They must request a hearing in writing or orally within 90 days of the date on the notice with which they disagree. Recipients receive continued medical benefits pending a hearing decision if they request a fair hearing before the effective date of the action or within 10 calendar days of the receipt of the notice, whichever is longer. The notice is considered to be received 5 days from the date on the notice, unless the recipient can show they did not receive the notice within the 5-day period.

22. Many commenters stated this requirement will increase the administrative burden on impacted individuals, likely decreasing the number of people with coverage. They cited Arkansas as an example of individuals losing coverage. They also believe the administrative cost to the State will be high.

Response: Utah's community engagement requirement is significantly less onerous than Arkansas's requirement. Utah has structured its community engagement requirement to be similar to SNAP. Individuals who are meeting the SNAP requirement or who are already exempt under the SNAP

requirement will meet the Medicaid community engagement requirement. In addition, due to similarity to SNAP, Utah already has the technology and the infrastructure to support a community engagement requirement for Medicaid. Therefore, the administrative cost to Utah will be minimal. Finally, due to the simplicity of Utah's community engagement requirement and the options for exemption or hardship, Utah's estimates on the impact on enrollment may differ from those estimated by other states.

23. Several commenters stated concerns with the impact to children if their parents lose coverage due to the community engagement requirement and enrollment limit. They state that studies show that if parents do not have medical coverage, their children are less likely to have medical coverage.

Response: Children may be determined eligible for Medicaid independently from their parents. Many children receive Medicaid or CHIP even though their parents were not previously eligible for coverage or are currently not covered by Medicaid. Members will be provided with clear information on how to meet the community engagement requirement. In addition, the state has provided members with multiple pathways to meet an exemption or request a hardship waiver when one is warranted. The state intends to monitor and evaluate the community engagement requirement to minimize any potential negative impact on children.

24. Several commenters stated the implementation and administrative costs will be high, as indicated by other states.

Response: Other states have designed their community engagement requirements very differently than Utah. Some states designed entirely new systems to capture information for their community engagement program. Utah's program relies on existing resources at DWS that already provide job assessment, training, and search reporting for SNAP recipients. The state will operate the community engagement requirement within its existing resources.

Employer-Sponsored Insurance (ESI) Requirement

25. One commenter stated they are concerned about the affordability of care for enrollees using employer-sponsored insurance (ESI). Although eligible individuals can be reimbursed for the full amount of their monthly premium costs and wrap-around benefits may be provided, the proposal does not clearly state what amounts this population pays for cost-sharing, or whether this amount is limited to five percent of family income. Being required to pay deductible, copayments and co-insurance amounts charged in a typical ESI plan will lead to much higher costs than traditional Medicaid for these individuals.

Response: Individuals who are required to enroll in the ESI requirement are reimbursed the full amount of their monthly premium costs. In addition, they receive full Medicaid coverage as a wrap-around benefit. This means that Medicaid will pay any ESI co-pays, deductibles or other out-of-pocket expenses for Medicaid covered services.

26. One commenter stated Utah should not proceed forward with its imposition of mandatory ESI enrollment. They urge Utah to eliminate the mandatory ESI enrollment requirement on Medicaid expansion enrollees as a condition of Medicaid coverage. They state reimbursing families and individuals later for their share of the ESI premiums not only provides families with economic assistance too late, it will place an extraordinary burden and stress on already struggling families and individuals to cope with immediate costs. Instead of increasing financial burden on enrollees leading to poorer health outcomes, Utah should focus on how to increase access to care that helps its Medicaid enrollees achieve greater wellbeing and independence.

Response: Individuals who are eligible for an ESI reimbursement receive the reimbursement at the beginning of each month, which allows them to be reimbursed prior to any premium payments being deducted from their paycheck.

27. One commenter stated they continue to have concerns about how reimbursement for the expansion population who are required to enroll in employer sponsored insurance (ESI) will be administered and monitored, and the impact of such administrative complexity. they are concerned about the beneficiary communications around the wraparound benefit offered. They believe this will create unnecessary complexity and barriers to care for beneficiaries. They state national research shows states have not sufficiently explained the availability of wraparound services.

Response: For those beneficiaries that have access to ESI we will notify them in advance of the requirement to enroll and allow time for them to enroll in their coverage. After the ESI coverage is added, all future claims are processed by the ESI coverage first and the Medicaid coverage second. As stated above, Medicaid will pay any ESI co-pays, deductibles or other out-of-pocket expenses for Medicaid covered services. This is a routine and regular process for health insurance companies and Medicaid has years of experience in processing these types of claims. Some individuals may receive additional services if their health plan covers beyond the scope of Medicaid's services.

External Quality Report

28. One commenter suggested having the annual external quality review on managed health care organizations performed by HSAG, collect larger, independent random samples in order to provide a more thorough examination of access to medications within the Health Choice program.
They also express concern with regards to the veracity of the evaluation of provider networks, grievance, and prior authorizations and appeals. They state it seems that the HSAG only reviewed a very small sample of each (10 provider records, 10 prior authorization denial records, one grievance record, and one prior authorization appeal record). They believe the sample size seems rather too small to provide much insight into an assessment of compliance, much less to provide an overview of the Health Choice program.

Response: This comment is not regarding the waiver amendment itself. We appreciate the feedback and will take this back for consideration.

ATTACHMENT 7

Tribal Consultation

UTAH DEPARTMENT OF HEALTH MEDICAID

Utah Indian Health Advisory Board (UIHAB) Meeting

5/14/2021
8:30 AM –11:30 AM

Utah Department of Health
Google Meeting Format Web Link:
meet.google.com/krh-kvdf-svj

Salt Lake City, UT 84114
(801) 712-9346

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
	Melissa Zito
Note taker:	Dorrie Reese Call In: **1-617-675-4444 PIN: 760 419 415 5523#**
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM	**UIHAB Meeting** Welcome & Introductions	Jessica Sutherland, Chair Felecita FoolBear, Vice Chair
8:40 AM	Committee Updates & Discussion	
	▪ UT Medicaid Eligibility Policy SPA's Medicaid & CHIP	Jeff Nelson, UT Medicaid, BMEP
	▪ Medicaid & CHIP State Plan Amendments (SPA) & Rules	Craig Devashrayee, UT Medicaid
	▪ DWS Medicaid Eligibility Operations	Jacoy Richins, AI/AN Eligibility Spec.
	▪ Dept. Public Safety /Div. Emergency Mgmt.	Anna Boynton, Tribal Liaison, DEM
	▪ MCAC & CHIP Advisory Committees	Mike Jensen & Ryan Ward
	▪ Opioid Grant Updates	Hilary Makris, OAIANHA
	▪ Federal and State Health Policy Impacting I/T/U	Jeremy Taylor/Melissa Zito, OAIANHA
09:30 AM	**Medicaid 1115 Waiver Renewal**	Jennifer Meyer-Smart & Michelle Smith
10:00 AM	**Family Spirit Opportunity for Funding**	Alisa Lee, DHS
10:20 AM	**HIV/AIDS Federal Grant Program Opp.**	Peter Best, University of Utah
10:35 AM	**State Agency Merger; DOH, DHS, DWS**	DOH & DHS (invited)
11:00 AM	**UIHAB Priorities: Establish 1 Goal** ▪ Quality Health Services Data linkages & Equitable access ▪ Mental Behavioral Health Wrap around services; Integrating MH services to overall well-being of 'the people'.	UIHAB & OAIANHA
11:30 AM	**ADJOURN**	

Utah Indian Health Advisory Board
Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC

CHIP Advisory Committee

Opioid Crisis

Data Updates

Agenda Item Updates: