Section 1115 Primary Care Network Demonstration Waiver Amendment

Managed Care Delivery System for Population Groups Authorized under Utah's Section 1115 Primary Care Network Demonstration

Background

The Division of Medicaid and Health Financing (DMHF), Utah's Medicaid agency in the Department of Health, administers the Medicaid program. DMHF has successfully operated a 1915(b) waiver program called the Choice of Health Care Delivery since 1982. Under this waiver, certain beneficiaries must enroll in a managed care plan for their physical health care services.

The waiver was a voluntary program until the State modified the program on October 1, 1995 requiring new Medicaid beneficiaries living in Utah's urban counties to enroll in a managed care plan. Between October 1, 1995 and June 30, 1996, all current enrollees transitioned into a managed care plan. Since July 1, 1996, a steady 93% to 96% of all urban Medicaid beneficiaries have been enrolled in managed care plans.

Effective January 1, 2013, the State offers the choice of four full-risk capitated MCOs to Medicaid beneficiaries living in Davis, Salt Lake, Utah, and Weber counties. On July 1, 2015, mandatory enrollment in a managed care plan was expanded to nine additional counties. These MCOs are Health Choice Utah, Healthy U, Molina Healthcare of Utah, and SelectHealth Community Care. These entities are also referred to as Accountable Care Organizations (ACO).

Utah has also operated a 1915(b) waiver program called the Prepaid Mental Health Plan (PMHP) since July 1, 1991. The overall objective of the PMHP is to maximize the contractors' flexibility to effectively and responsibly use Medicaid funds to ensure Medicaid beneficiaries have access to mental health services and to improve behavioral health outcomes for Medicaid beneficiaries. Under the PMHP, Medicaid beneficiaries have access to a coordinated, managed care delivery system that is responsible for inpatient and outpatient mental health care and outpatient substance use disorder care. The State contracts with the local Mental Health and Substance Abuse Authorities to establish full risk PIHPS and one PAHP to deliver all behavioral health services to Medicaid beneficiaries.

With the exception of individuals at the Utah State Hospital and the Utah Developmental Center, all other Medicaid enrollees are automatically enrolled in the PMHP serving their county of residence. Individuals dually eligible for Medicare and Medicaid are also enrolled in the PMHP. PMHPs are operating in 28 of Utah's 29 counties. Approximately 99.4% percent of Utah Medicaid beneficiaries are enrolled in the PMHP waiver.

The use of managed care as a service delivery system has proven to control costs for Utah's Medicaid program by reducing the rate of cost increases over time. The State is requesting authority to:

1. Enroll beneficiaries authorized under Utah's 1115 Primary Care Network Demonstration Waiver in managed care plans; and,
2. Create and operate an integrated managed care model combining the delivery of physical health and behavioral health services in five Utah counties for the Medicaid expansion groups authorized by this waiver.
3. Beneficiaries not enrolled in Utah Medicaid Integrated Care (UMIC) will be enrolled in Utah's Accountable Care Organizations (ACO) for their physical health service delivery system and in Prepaid Mental Health Plans (PMHP) for their behavioral health services delivery system.

In addition, the State is requesting expenditure authority to add behavioral health services listed in section III for the populations authorized under this waiver who are enrolled in managed care. These are the same 1915(b)(3) services authorized under the State's 1915(b) Prepaid Mental Health Plan Waiver for State Plan populations.

Section I. Program Description and Objectives

The State proposes to create four integrated care plans that will be responsible for providing physical, mental health and substance use disorder services for the Adult Expansion members in Weber, Davis, Salt Lake, Utah and Washington counties. In addition, the State is proposing to enroll Adult Expansion Medicaid members in existing ACOs in nine additional counties, and in a Prepaid Mental Health Plan (PMHP) in 23 other counties. Please see the chart under Section IV Delivery System that shows which plans Adult Expansion Medicaid members will be enrolled in.

Goals and Objectives

The primary objective of the amendment is to obtain authority to require the individuals in the Adult Expansion Population to enroll in integrated MCOs for delivery of their physical and behavioral health services in the five most populous counties in the state.

Operation and Proposed Timeline

Adult Expansion Medicaid beneficiaries in thirteen counties will be required to enroll in managed care entities who are responsible to assure their enrollees receive Medicaid covered physical health and behavioral health services. Adult Expansion Medicaid beneficiaries in Utah's five most populous counties will be required to enroll in one of four integrated care MCOs. These entities will be responsible for the physical and behavioral health care service delivery for their enrollees.

Adult Expansion Medicaid beneficiaries in the remaining eight counties will be required to enroll in one of four ACOs for their physical health service delivery. In addition, the individuals will be automatically enrolled in a Prepaid Mental Health Plan for their behavioral health service delivery.

The effective date of this demonstration will be January 1, 2020 for a five-year period.

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.

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 beneficiaries.The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
The demonstration will show that an integrated care delivery model results in better health outcomes for Medicaid beneficiaries	Selected HEDIS and Adult Core measures	Treatment Episode Data Set (TEDS) Claims/encounter data	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.
The demonstration will show that the Adult Expansion population has better health outcomes when enrolled in managed care	Selected HEDIS and Adult Core measures	Treatment Episode Data Set (TEDS) Claims/encounter data	Comparison and trending of measures. This will include setting a baseline (when available) and analyzing trends in measures over the length of the Demonstration.

Table 1

Section II. Demonstration Eligibility

Individuals meeting the following eligibility criteria will be enrolled in a Utah Medicaid Integrated Care Plan (UMIC) or will be enrolled in an ACO and a PMHP.

The Adult Expansion Medicaid population, that is comprised of parents and adults without dependent children earning up to 100% of the federal poverty level. This population is eligible for Medicaid under Utah's approved 1115 Demonstration Waiver. Individuals eligible for Targeted Adult Medicaid will remain fee for service but may be added to a managed care plan at a later date.

Exemptions to Enrollment

The following individuals will be exempted from enrollment in UMIC:

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

2. Individuals with presumptive eligibility

3. Individuals enrolled in the Healthy Outcomes Medical Excellence (HOME) program. HOME is a voluntary program that provides services to children and adults with a developmental disability and mental illness or behavioral problems. HOME covers both physical and mental health services for its enrollees. When individuals enroll in the HOME program they are not enrolled in any other managed care plan.

4. Medicaid members enrolled in Utah's Buyout Program. The Buyout Program purchases established health insurance for Medicaid members. Any Medicaid member who has a significant medical need and available health insurance that would cover the cost of that need may be referred to the Buyout Program. The Buyout Program population falls under the Health Insurance Premium Payment (HIPP) program that is authorized under Section 1906 of the Act through State Plan authority.

5. Adult Expansion Medicaid members required to enroll in a qualified Employee Sponsored Insurance (ESI) plan, as defined by the State.

Projected Enrollment

The enrollment for this Demonstration is projected to be up to 63,000 individuals enrolled in the UMIC Plan, and 27,000 in enrolled in an ACO and PMHP.

Section III. Demonstration Benefits and Cost Sharing Requirements

This demonstration has no impact on benefits or cost sharing for the individuals enrolled. In addition to current benefits, the State is requesting expenditure authority to allow coverage of the following benefits that are the equivalent of b (3) services under the State's 1915(b) Prepaid Mental Health Plan Waiver

Additional Services

The UMIC, ACO and PMHP plans will receive monthly premiums (PMPM) to cover State Plan services or services authorized by Utah's 1115 Demonstration waiver. In addition, the State seeks authority to cover the following services which are the same as the 1915 (b)(3) services authorized under Utah's 1915(b) PMHP waiver.

- **Psychoeducational Services**

Psychoeducational Services are services recommended by a physician or practitioner of the healing arts (licensed mental health therapist) that are furnished for the primary purpose of assisting in the rehabilitation of enrollees with serious mental illness or serious emotional disturbance. This rehabilitative service includes interventions that help enrollees achieve goals of remedial and/or rehabilitative educational and vocational adequacy necessary to restore them to their best possible functioning level.

- **Personal Services**
  Personal Services are services recommended by a physician or practitioner of the healing arts (licensed mental health therapist) that are furnished for the primary purpose of assisting in the rehabilitation of enrollees with serious mental illness or serious emotional disturbance. These services include assistance with instrumental activities of daily living (IADLs) that are necessary for individuals to live successfully and independently in the community and avoid hospitalization. Personal Services include assisting the enrollee with varied activities based on the enrollee's rehabilitative needs, such as picking up prescriptions; income management; maintaining the living environment including cleaning and shopping; the transportation related to the performance of these activities; and representative payee activities when the behavioral health provider has been legally designated as the enrollee's representative payee. These services assist enrollees to achieve their goals for remedial and/or rehabilitative IADL adequacy necessary to restore them to their best possible functioning level.

- **Respite Care**
  This service is recommended by a physician or practitioner of the healing arts (licensed mental health therapist) and is furnished for the primary purpose of giving parents/guardians temporary relief from the stresses of care for a child with a serious emotional disturbance. Respite Care can prevent parent/guardian burn-out, allow for time to be spent with other children in the family, reserve the family unit, and minimize the risk of out-of-home placement by reducing the stress families of children with serious emotional disturbance typically encounter.

- **Supportive Living**
  Supportive Living means the costs incurred in residential treatment/support programs when managed care plan enrollees are placed in these programs. These programs assist individuals avoiding and reducing risk for inpatient hospitalization. Costs include those incurred for 24-hour staff, facility costs associated with providing discrete covered services (e.g., individual psychotherapy, pharmacologic management, etc.) at the facility site, and apportioned administrative costs. Costs do not include the covered services

costs or room/board costs. This level of care is recommended by a physician or other practitioner of the healing arts (licensed mental health therapist), and helps to restore enrollees with serious mental illness or serious emotional disturbance to their best possible functioning level. managed care plans will provide this level of care when needed so that individuals may remain in a less restrictive community setting.

To ensure room and board costs are not covered by the managed care plans, the following methodology will be used for calculating room and board costs and will be included in managed care plan contracts as follows:

The MCOs will include as part of their financial reports all schedules and related allocations to support the full cost of providing Supportive Living services. The MCOs will provide detailed cost information in their financial report that will identify each material component of the full cost of Supportive Living, including, but not limited to:

* Direct wages and benefits
* Indirect wage and benefits
* Occupancy costs (depreciation, interest, insurance, utilities, etc.)
* Maintenance
* Other
* Allocated Managed Care plan administrative costs

Total facility space will be allocated between covered Supportive Living services and non-covered room and board services as follows:

Personal-use space (e.g., bedrooms, kitchen space, hallways, bathrooms and janitorial closets) is not covered by the Integrated Care MCOs. The MCOs will report the personal-use space costs as non-covered costs in the MCOs' financial reports. The MCOs will also report all dietary costs and laundry-related costs as non-covered costs in the MCOs' financial reports.

Shared space is used for both clinical services and for personal use by residents. The MCOs will divide shared space costs based on a 24-hour clock and will split the time between usage for clinical services and for residents' personal living. For example, if shared space is used for clinical services 5 hours in a day, 21 percent (5/24ths) of the cost for that period would be allocated to clinical services, and 79 percent (19/24ths) of the cost of the shared space would be allocated to non-covered room and board costs.

Clinical services space is used exclusively to provide clinical services. The MCOs will allocate this space to Supportive Living costs. Exclusive use means that this space is not used for any other purposes. Any personal use of the space by residents causes the space to be considered shared space subject to the 24-hour clock allocation.

Common space is that space occupied by support personnel such as a secretary's office, and is therefore allocated between clinical services space and personal-use space. The MCOs will allocate common space costs to Supportive Living services based upon the ratio of clinical services space (i.e., the sum of shared space used for clinical services and clinical services space) to the total of personal-use space, shared space and clinical services space. The remaining common space not allocated to clinical services is allocated to personal-use space.

The MCOs will report all salaries applicable to room and board (e.g., janitors, cooks, etc.) as non-covered costs in the MCOs' financial reports.

The MCOs will segregate non-routine repair and maintenance building costs between total non-covered personal-use space and total clinical services space based on reasonable and supportable usage allocations.

The MCOs will make cost-on-cost allocations of administrative costs that will reflect all non-covered costs and covered costs stemming from Supportive Living services.

Section IV. Delivery System and Rates

The Department will deliver services through either the Utah Medicaid Integrated Care Plan (UMIC) or through enrollment in an ACO and PMHP. MCOs are required to comply with all managed care regulations in 42 CFR 438 that are applicable to an MCO.

Table 2 below shows the proposed services delivery system for Adult Expansion Medicaid individuals. Purple shaded counties indicate current mandatory ACO enrollment.

Table 2

County	ACO Accountable Care Organization 1915(b)	PMHP Prepaid Mental Health Plan 1915(b)	FFS Fee for Service Network (for physical health care)	UMIC Utah Medicaid Integrated Care 1115
Beaver	●	●	●	
Box Elder	●	●		
Cache	●	●		
Carbon		●	●	
Daggett		●	●	
Davis				●
Duchesne		●	●	
Emery		●	●	
Garfield		●	●	

Grand		●	●	
Iron	●	●		
Juab		●	●	
Kane		●	●	
Millard		●	●	
Morgan	●	●		
Piute		●	●	
Rich	●	●		
Salt Lake				●
San Juan		●	●	
Sanpete		●	●	
Sevier		●	●	
Summit	●	●		

Tooele	•	•		
Uintah		•	•	
Utah				•
Wasatch	•	•		
Washington				•
Wayne		•	•	
Weber				•

Rate Methodology

Rates will be established by Milliman, Inc. in compliance with 42 CFR 438. Milliman will use Utah fee for service experience for the adults with children and adults without children, as well as experience from other states that have expanded Medicaid to similar populations. Utah intends to use a risk corridor based on an MLR benchmark to determine upside or downside risk. Utah is not suggesting any deviations from the payment or contracting requirements under 42 CFR 438.

Section V. Assurances

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

Services

The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

The State assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Self-referrals

The State requires ACOs, PMHPs and UMIC plans to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances:

- For female enrollees, MCOs must allow direct access to a women's health specialist within each MCO's provider network for covered care necessary to provide women's routine and preventive health care services (this is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist); and

- For enrollees determined through an assessment to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow enrollees to directly access a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Access

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

Access and Capacity Standards

The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

Coordination and Continuity of Care

The State will require Managed Care Plans to implement procedures to deliver care and to coordinate covered services for all Enrollees. These procedures must include the following:

1. Ensure that each Enrollee has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. The Enrollee must be provided information on how to contact their designated person or entity;

2. Coordinate the services the Managed Care Plan furnishes to the Enrollee:

    a. between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;

    b. with the services the Enrollee receives from any other MCO, PIHP or PAHP;

    c. with the services the Enrollee receives in FFS Medicaid; and

    d. with the services the Enrollee receives from community and social support workers.

Identification of Individuals with Special Health Care Needs

For those Managed Care enrollees with Medicaid fee for service (FFS) histories, the State will use FFS claims information (e.g., diagnoses, procedure codes, etc.) to identify enrollees who appear to have special health care needs and send the relevant information to the appropriate MCE.

In addition, based on referrals from Medicaid providers, community organizations, etc., the State will pass relevant information regarding Integrated Care enrollees with possible special needs to the appropriate MCO.

Assessment

Enrollees that the State identifies as possibly having special needs will be referred to the enrollee's MCO. The MCO will refer the enrollee's information to the MCO's case management program and, using screening and assessment tools, will determine if the enrollee has special conditions that require a course of treatment or regular care monitoring.

The MCO's case management program will have methodologies to determine the frequency and duration of case management services through application of the MCO's criteria, and mechanisms to refer to and coordinate with other state agencies and community resources, as necessary. The case management program will assist with and monitor enrollee's follow-up and

specialty care to ensure that enrollees receive recommended follow-up and specialty care. In addition, the program will coordinate with the MCO's disease management program, as appropriate.

Direct Access to Specialists

MCO contracts will require the contractors to provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services.

MCO contracts will require MCOs to have mechanisms in place to allow enrollees to directly access a specialist if the MCO determines through an assessment the enrollee needs a course of treatment or regular care monitoring. Examples of such mechanisms include a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified needs.

MCO contracts will require MCOs, where applicable, to provide female Enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventative health care services.

The State will require MCOs to have mechanisms in place to allow enrollees to directly access a specialist if the MCO determines through an assessment the enrollee needs a course of treatment or regular care monitoring. Examples of such mechanisms include a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified needs.

Quality

- The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

- If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

- Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

- State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on: 8-17-2015

- The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

Health Services Advisory Group, Inc. (HSAG) is Utah's current external quality review organization,(EQRO). https://www.hsag.com

HSAG performs all EQRO activities for Utah. Utah's most recent technical report can be found at:
https://medicaid.utah.gov/Documents/pdfs/annual%20reports/external/EQR_report2018.pdf

Marketing

- The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

- The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

- The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

- The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

Information to potential enrollees and enrollees

Assurances

- The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

Non English Languages

- Spanish is the language into which potential enrollee and enrollee materials must be translated. Each Integrated Care MCO contract will require the MCO's critical written enrollee materials be made available in the prevalent non-English languages in the MCO's service area. The contracts will specify that a language is prevalent when it is spoken by 5% or more of the MCO's enrolled population.

- Managed Care MCO contracts require oral interpretation services be available free of charge to each enrollee. The MCOs use various interpreter organizations to meet the needs of their enrollees. In addition, the MCOs have numerous network providers who speak other languages, so often interpreters are not needed.

The State Is Responsible for Enrollment

- Enrollees and potential enrollees are offered an orientation with a State-employed Health Program Representative (HPR) during which the HPR explains managed care, MCO options, services covered, how to get services not covered by MCOs, etc.

- Information will be distributed to potential enrollees by the State, not by the plans or a third party enrollment contractor.

Disenrollment

Assurances

- The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Outreach

- The State provides outreach workers in various locations such as community health centers, hospitals, local health departments, school districts, and state offices responsible for Aging and Adult Services and Services for People with Disabilities. Outreach workers instruct potential enrollees to contact a State Medicaid-employed Health Program Representative for information about managed care and help in choosing a managed care plan.

Section VI. Implementation-Enrollment in Demonstration

- Medicaid beneficiaries who live in one of the Utah's five urban counties and are in the Adult Expansion Medicaid Population will be required to enroll in an Integrated Care MCO effective January 1, 2020.

- Medicaid beneficiaries living in eight additional mandatory enrollment counties who are in the Adult Expansion Medicaid Population will be required to enroll in and ACO and a PMHP.

- An open enrollment period will be held for all potential enrollees from October 15 to December 15, 2019.

- Potential enrollees will have ten (10) days to choose a plan. If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

Auto-Assignment process

- If a potential enrollee does not select a plan within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

- Newly eligible beneficiaries who are in the Adult Expansion Medicaid Population and living in a mandatory Managed Care county will receive a pending MCO selection that will be placed on the beneficiary's case using a "round robin" method so that each MCO receives approximately the same number of new pending cases. Returning Medicaid beneficiaries will have their previous Managed Care plan reinstated if it has been less than two years since they were eligible. If it has been more than two years, their pending assignment will be based on the "round robin" method.

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

- Medicaid beneficiaries will have ninety (90) days after they choose a plan or a plan is auto-assigned, to change their plan.

Enrollment Exemptions

- The exemption policy was developed to ensure individuals with special health care needs have access to appropriate health care.

- The exemption process allows Medicaid beneficiaries who meet the exemption criteria to be exempted from choosing a managed care plan, including a Managed Care plan, when the plan cannot immediately meet the needs of the beneficiary. Exemption requests must be submitted for approval to the State's exemption committee. Medicaid beneficiaries may request an exemption through a Health Program Representative, or by sending a request to the Bureau of Managed Health Care's Director. The exemption may be approved by the State's exemption committee if there is a reasonable expectation that the beneficiary's health would suffer if the beneficiary were unable to obtain an exemption.

Disenrollment

- The State allows enrollees to disenroll from/transfer between plans. Regardless of whether a plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- The State has a lock-in period (i.e. requires continuous enrollment with a plan for 12 months. The State assures that it meets the requirements of 42 CFR 438.56(c).

- An enrollee may request disenrollment from a plan at any time for the following reasons:

    - The enrollee moves out of the plan's service area or out of a mandatory county;

    - The enrollee needs related services to be performed at the same time and not all services are available within the plan's network, and the

enrollee's primary care provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

- The plan does not, because of moral or religious objections, cover the service the enrollee seeks;

- The enrollee becomes emancipated or is added to a different Medicaid case;

- The plan makes changes to its network of providers that interferes with the enrollee's continuity of care with the enrollee's provider of choice; or

- Other reasons as determined by the State, including but not limited to, poor quality of care, lack of access to services covered under the plan's contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

Disenrollment by the Plan

- A Managed Care plan may initiate disenrollment for an enrollee based on one or more of the following reasons:

    - For reasons specifically identified in the Managed Care plan's enrollee handbook and approved by the State;

    - When the enrollee ceases to be eligible for medical assistance under the State Plan in accordance with 42 CFR USC, et seq. and as finally determined by the State;

    - Upon termination or expiration of the Managed Care plan's contract with the State;

    - Death of the enrollee;

    - Confinement of the enrollee in an institution when confinement is not a covered service under the MCO's contract;

- Violation of enrollment requirements developed by the MCO and approved by the State but only after the MCO and/or enrollee has exhausted the MCO's internal grievance procedure.

The State reviews and approves all plan-initiated requests for enrollee transfers or disenrollments. The enrollee remains an enrollee of the plan until another plan is chosen or assigned.

Enrollee Rights

- The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

- The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Grievance System

- The State requires enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

- The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

- The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an appeal is 60 days.

Program Integrity

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

- The prohibited relationships are:

- A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

- A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

- A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

- The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

    - Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;

    - Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;

    - Employs or contracts directly or indirectly with an individual or entity that is:

        - precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or

        - could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

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.

Section VIII. Proposed Waiver and Expenditure Authority

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

Table 3

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	This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM
Section 1902(a)(1) - Statewideness	This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State

Expenditure Authority

The State requests expenditure authority to provide services to Adult Medicaid Expansion individuals and to provide the additional services identified in Section III. Benefits.

Section IX. Compliance with Public Notice and Tribal Consultation

On May 10, 2019, State staff presented information to the Utah Indian Health Advisory Board (UIHAB) regarding the new Utah Medicaid Integrated Care (UMIC) waiver request to require certain Medicaid beneficiaries to receive physical and behavioral health services through a managed care organization (MCO) called an Integrated Care MCO. State staff explained that under the UMIC waiver, mandatory enrollment in an Integrated Care MCO will be limited to the Adult Medicaid Expansion population who live in one of Utah's urban counties (Davis, Salt Lake, Utah, and Weber). The proposed effective date of the UMIC waiver is October 1, 2019. Mandatory enrollment into an MCO will be effective January 1, 2020. The UIHAB had no objections to the proposed waiver request and requested no further consultation.

A public hearing to take public comment on the amendment request will be held during the monthly Medical Care Advisory Committee (MCAC) meeting on August 15, 2019 from 2:00 p.m. to 4:00 p.m. Telephonic conferencing is available for this meeting.

Section X. Demonstration Administration

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

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

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	42,175	40,554	43,348	46,335	
PMPM Cost	5.0%	18	$ 3,163.77	5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure					$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management										
Pop Type:	**Hypothetical**					*Started 5/1/19*				
Eligible Member Months	0.0%	0		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost	5.0%	0		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure					$ -	$ 468,738	$ 1,106,543	$ 1,161,870	$ 1,219,963	$ 3,957,113
Expansion Parents										
Pop Type:	**Expansion**					*Started 4/1/19*				
Eligible Member Months	2.5%			2.5%	-	91,291	374,293	383,650	393,241	
PMPM Cost	5.3%			5.3%	$ -	$ 671.61	$ 707.20	$ 744.68	$ 784.15	
Total Expenditure					$ -	$ 61,311,664	$ 264,700,846	$ 285,698,241	$ 308,361,254	$ 920,072,005
Expansion Adults w/out Dependent Children										
Pop Type:	**Expansion**					*Started 4/1/19*				
Eligible Member Months	2.5%			2.5%	-	138,400	567,439	581,625	596,166	
PMPM Cost	5.3%			5.3%	-	$ 784.97	$ 826.57	$ 870.38	$ 916.51	
Total Expenditure					-	$ 108,639,433	$ 469,029,024	$ 506,234,751	$ 546,391,823	$ 1,630,295,031
Expansion Parents - Integrated Care										
Pop Type:	**Expansion**						Assumes start of 10/1/19			
Eligible Member Months	2.5%			2.5%	-		196,306	268,285	274,992	
PMPM Cost	5.3%			5.3%	$ -		$ 543.76	$ 572.58	$ 602.93	
Total Expenditure					$ -		$ 106,743,215	$ 153,614,160	$ 165,799,603	$ 426,156,978
Expansion Adults w/out Dependent Children - Integrated Care										
Pop Type:	**Expansion**						Assumes start of 10/1/19			
Eligible Member Months	2.5%			2.5%	-		309,454	422,920	433,493	
PMPM Cost	5.3%			5.3%	-		$ 636.38	$ 670.11	$ 705.62	
Total Expenditure					-		$ 196,930,177	$ 283,402,218	$ 305,883,099	$ 786,215,495

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

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

Assumes start date of 10/1/19

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

ELIGIBILITY GROUP		DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
Current Eligibles				*Parent Caretaker Relative (PCR) population 45-60% FPL: transferred to Expansion Parents effective 4/1/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		377,866	0%	377,866	364,366	320,957	319,534	318,076	
PMPM Cost		$ 949.03	5.3%	$ 999.33	$ 1,052.29	$ 1,108.06	$ 1,166.79	$ 1,228.63	
Total Expenditure				$ 377,612,297	$ 383,419,793	$ 355,641,069	$ 372,829,701	$ 390,798,329	$ 1,880,301,189
Demo Pop I - PCN Childless Adults				*PCN ends 3/31/19*					
Pop Type:	**Medicaid**								
Eligible Member Months		70,097	4.9%	73,812	58,293	-	-	-	
PMPM Cost		$ 48.97	5.3%	$ 51.57	$ 54.30	$ 57.18	$ 60.21	$ 63.40	
Total Expenditure				$ 3,806,153	$ 3,165,223	$ -	$ -	$ -	$ 6,971,376
Demo Pop III/V - UPP Childless Adults									
Pop Type:	**Medicaid**								
Eligible Member Months		159	4.9%	167	175	184	193	202	
PMPM Cost		$ 68.45	5.3%	$ 72.08	$ 75.90	$ 79.92	$ 84.16	$ 88.62	
Total Expenditure				$ 10,702	$ 11,237	$ 11,799	$ 12,388	$ 13,008	$ 59,133
Targeted Adults									
Pop Type:	**Expansion**			*Started 11/1/17, suspended in this 1115 waiver and transferred to the new 1115 waiver 10/1/19*					
Eligible Member Months			0%	78,000	78,000	78,000	78,000	78,000	
PMPM Cost			5.3%	$ 979.53	$ 1,031.45	$ 1,086.11	$ 1,143.68	$ 1,204.29	
Total Expenditure				$ 76,403,340	$ 80,452,717	$ 84,716,711	$ 89,206,697	$ 93,934,652	$ 424,714,116
Dental - Targeted Adults					*Started 3/1/19*	*Porcelain crowns anticipated start date of 7/1/19*			
Pop Type:	**Expansion**								
Eligible Member Months				-	12,000	9,000	-	-	
PMPM Cost			5.3%	$ -	$ 33.33	$ 38.20	$ 40.22	$ 42.35	
Total Expenditure				$ -	$ 400,000	$ 343,778	$ -	$ -	$ 743,778
System of Care					*Start 6/1/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months				-	120	1,440	1,440	1,440	
PMPM Cost			5.3%	$ -	$ 2,100.00	$ 2,211.30	$ 2,328.50	$ 2,451.91	
Total Expenditure				$ -	$ 252,000	$ 3,184,272	$ 3,353,038	$ 3,530,749	$ 10,320,060
Demo Pop I - PCN Adults w/Children					*PCN ends 3/31/19*				
Pop Type:	**Hypothetical**								
Eligible Member Months		104,836	5.9%	111,042	88,212	-	-	-	
PMPM Cost		$ 46.18	5.3%	$ 48.63	$ 51.20	$ 53.92	$ 56.77	$ 59.78	
Total Expenditure				$ 5,399,479	$ 4,516,681	$ -	$ -	$ -	$ 9,916,160
Demo Pop III/V - UPP Adults with Children									
Pop Type:	**Hypothetical**								
Eligible Member Months		6,067	34.9%	$ 8,182	$ 11,034	$ 14,881	$ 20,068	$ 27,064	
PMPM Cost		$ 150.08	5.3%	$ 158.04	$ 166.41	$ 175.23	$ 184.52	$ 194.30	
Total Expenditure				$ 1,293,049	$ 1,836,227	$ 2,607,582	$ 3,702,963	$ 5,258,489	$ 14,698,309
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) 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 7/1/19*			
Eligible Member Months		0%	-	-	108,000	110,700	113,468	
PMPM Cost		3.0%	$ -	$ -	$ 30.75	$ 32.38	$ 34.10	
Total Expenditure			$ -	$ -	$ 3,321,000	$ 3,584,438	$ 3,868,774	$ 10,774,212
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 990.87	$ 1,038.43	$ 1,088.28	$ 1,140.51	$ 1,195.26	
Total Expenditure			$ 9,909	$ 10,384	$ 10,883	$ 11,405	$ 11,953	$ 54,534
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	39,456	42,175	40,554	43,348	46,335	
PMPM Cost		5.0%	$ 3,321.96	$ 3,488.06	$ 3,662.46	$ 3,845.58	$ 4,037.86	
Total Expenditure			$ 131,072,269	$ 147,108,390	$ 148,527,403	$ 166,698,858	$ 187,093,676	$ 780,500,596
Withdrawal Management								
Pop Type:	**Hypothetical**			*Starts 5/1/19*				
Eligible Member Months		0.0%	-	670	1,506	1,506	1,506	
PMPM Cost		5.0%	$ -	$ 700.00	$ 735.00	$ 771.75	$ 810.34	
Total Expenditure			$ -	$ 468,738	$ 1,106,543	$ 1,161,870	$ 1,219,963	$ 3,957,113
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Expansion Parents - Integrated Care								
Pop Type:	**Expansion**				Assumes start of 10/1/19			
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PMPM Cost		5.3%	$ -	$ -	$ 543.76	$ 572.58	$ 602.93	
Total Expenditure			$ -	$ -	$ 106,743,215	$ 153,614,160	$ 165,799,603	$ 426,156,978
Expansion Adults w/out Dependent Children - Integrated Care								
Pop Type:	**Expansion**				Assumes start of 10/1/19			
Eligible Member Months		2.5%	-	-	309,454	422,920	433,493	
PMPM Cost		5.3%	-	$ -	$ 636.38	$ 670.11	$ 705.62	
Total Expenditure			-	$ -	$ 196,930,177	$ 283,402,218	$ 305,883,099	$ 786,215,495

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

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

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

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 16 (SFY 18)	DY 17 (SFY 19)	DY 18 (SFY 20)	DY 19 (SFY 21)	DY 20 (SFY 22)	TOTAL WW
	Assumes start date of 10/1/19							